



September 28, 2022

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One Ashburton Place, 11th Floor Room 1109  
Boston, MA 02108

Dear Assistant Secretary Kraft:

The Centers for Medicare & Medicaid Services (CMS) is approving Massachusetts' request to extend the demonstration entitled, "MassHealth" (Project Number 11-W-00030/1 and 21-W-00071/1), in accordance with section 1115(a) of the Social Security Act (the Act). Approval of this request will extend many longstanding demonstration authorities and allow the Commonwealth, through various waiver and expenditure authorities, to test the efficacy of innovative practices aimed at promoting consistently high-quality, evidence-based, coordinated, and integrated care with the combined goals of providing medical assistance and improving the health of the communities and populations served through the demonstration. The extension also will lead to additional populations being served by Medicaid, as well as additional services being furnished to Medicaid beneficiaries. This approval is effective October 1, 2022, through December 31, 2027.

CMS has determined that the MassHealth demonstration is likely to assist in promoting the objectives of the Medicaid statute and, as relevant, the CHIP statute by increasing access to high-quality medical assistance and coverage for targeted low-income children. With this extension, Massachusetts is introducing new initiatives and investments to assist the Commonwealth in improving health coverage, access, and consistent provision of high-quality services for Medicaid and CHIP beneficiaries, while additionally making important gains in advancing health equity among its beneficiary populations.

As reflected in the statute, the primary objective of the Medicaid program is to furnish medical assistance. Massachusetts already maximizes the populations eligible for medical assistance through MassHealth. This demonstration is expected to promote the objective of furnishing medical assistance by strengthening access to high-quality equitable care for all those with Medicaid coverage. This demonstration also is intended to enhance the Commonwealth's ability to identify substandard health outcomes of Medicaid beneficiaries that may result from uneven access to high-quality care and by incentivizing improvements to achieve consistent access to high-quality care.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STC), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The Commonwealth may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or not applicable to expenditures under the demonstration.

### **Extent and Scope of the Demonstration Extension**

Extension of the MassHealth demonstration includes the extension of longstanding authorities and programs, which make up a crucial part of the Commonwealth's Medicaid system. This approval includes, among other elements, the extension of 1) delivery systems that provide services to the majority of the Commonwealth's Medicaid population, including both primary care case management (PCCM)-based delivery systems, which include the Primary Care Clinician (PCC) Plan and Primary Care Accountable Care Organizations (ACO), with behavioral health services provided through the managed behavioral health vendor (PIHP) and Managed Care Organization (MCO)-based delivery systems, which include MCOs and Accountable Care Partnership Plans; 2) the Safety Net Care Pool (SNCP) that provides uncompensated care payments to safety net providers that serve Medicaid and low-income, uninsured individuals; 3) expenditures for demonstration populations, such as CommonHealth and former foster care youth who were in foster care in another state; 4) premium and cost-sharing subsidies for low- and moderate-income residents purchasing health insurance through the Health Connector; 5) expenditures for substance use disorder (SUD) and serious mental illness (SMI) treatment services and ongoing recovery support; and 6) diversionary behavioral health services. With this extension approval, CMS is removing the waiver of retroactive eligibility for pregnant persons and for children up to age 19, effective no later than July 1, 2023. The Commonwealth will retain the authority for the waiver as it applies to most other Medicaid beneficiaries but will be required to conduct more rigorous evaluation of the waiver's effects on beneficiary debt and uncompensated care.

Massachusetts also is introducing new initiatives and delivery system reforms to assist in improving health coverage and equitable access to high quality care for Medicaid beneficiaries and other low-income individuals in the Commonwealth. In this approval, CMS is granting the Commonwealth's request for expenditure authority to implement an innovative Hospital Quality and Equity Initiative for private acute care hospitals and the Commonwealth's only non-state-owned public hospital, Cambridge Health Alliance. This initiative is a key component of the Commonwealth's strategy to link provider payments directly to improving the quality of care for all Medicaid beneficiaries. The initiative is expected to reduce health inequities by improving outcomes in populations that are likely to face barriers to quality health care. As such, the demonstration is likely to help improve quality of care and is also likely to reduce health disparities through this value-based care approach. CMS will authorize up to \$400 million annually in expenditure authority for participating private acute care hospitals and up to \$90 million annually in expenditure authority for the Cambridge Health Alliance to strengthen and improve care quality and health outcomes among Medicaid beneficiaries.

This expenditure authority is expected to promote the objectives of the Medicaid program by enhancing the Commonwealth's ability to identify substandard health outcomes among Medicaid beneficiaries and by incentivizing improvements to achieve consistent access to high-quality care. Participating hospitals will be incentivized to improve completeness of demographic data pertaining to their beneficiary populations, screening for health-related social needs, and improving health outcomes. Complete and accurate data are essential to understanding beneficiaries' access to quality care and any barriers and challenges, including geographic, demographic or other challenges that beneficiaries might experience in accessing high quality care and evaluating the effectiveness of the Hospital Quality and Equity Initiative to consistently provide high quality care. Comprehensive data and robust analyses will help inform hospital and community-level outreach and interventions, and can facilitate rewarding progress in improving quality of care and health outcomes as evidenced by achieving defined targets over time. To the extent participating hospitals implement care delivery and other initiatives that succeed in improving the care that is furnished to Medicaid beneficiaries, including improving care to Medicaid populations experiencing health disparities, they are eligible to earn performance-based incentive payments based upon improvement on measures identified jointly by the Commonwealth and CMS. Participating hospitals also will be rewarded for successfully achieving improvement in building organizational/workforce competence to enhance their ability to provide accessible and culturally appropriate services based upon health status and health needs, and thereby more effectively address gaps in access to and quality of care. Participating hospitals also will implement clinical and delivery system performance initiatives targeted at driving improvement in health outcomes and reduction in health disparities that are inconsistent with the delivery of high-quality care to all Medicaid beneficiaries.

Section 1901 of the Act makes clear that a core purpose of Medicaid is to “enabl[e] each State ... to furnish ... medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services[.]” The new Hospital Quality and Equity Initiative aims to improve the quality of medical assistance furnished to these individuals, thereby more meaningfully achieving the core purpose stated in section 1901 of the Act. This new initiative is also likely to assist in promoting Medicaid statutory objectives by helping to ensure that Massachusetts furnishes high-quality medical assistance to demonstration beneficiaries, regardless of their background and circumstances. In this way, the demonstration is also expected to narrow gaps in health disparities between demonstration subpopulations in availability of and access to quality health care. Section 1902(a)(30)(A) of the Act, among other requirements, provides that state payments for covered services must be consistent with efficiency, economy, and quality of care. Section 1902(a)(19) of the Act separately recognizes the objectives of providing care and services consistent with the best interests of beneficiaries. These longstanding, important Medicaid statutory provisions demonstrate Congressional intent to ensure that high-quality Medicaid services be accessible to all beneficiaries. Other provisions of the Act highlight the importance of Medicaid beneficiaries receiving high quality and effective care, and the critical importance of measurement of quality of care and beneficiary health outcomes, among other measures. For example, sections 1139A and 1139B of the Act require the development of core sets of quality measures for children and adults enrolled in Medicaid, respectively. Initiatives like the Hospital Quality and Equity Initiative that include financial incentives for both improving quality of care and reducing health disparities are likely to be more effective and

meaningful for achieving improvements in quality of care, since otherwise, quality improvement efforts might risk leading to unintended results of increasing health disparities.<sup>1</sup> Accordingly, the Hospital Quality and Equity Initiative is likely to assist in promoting the objectives of Medicaid by incentivizing improved quality and health outcomes. The Initiative is also likely to help improve provision of care that best meets the needs of beneficiaries, regardless of their backgrounds or circumstances.

CMS also is authorizing Massachusetts to provide or increase coverage of certain services that address health related social needs (HRSN). CMS is authorizing increased coverage of certain services that address HRSN, as evidence indicates that these HRSN are a critical driver of an individual's health outcomes.<sup>2,3</sup> These services include critical nutritional services and nutrition education, as well as housing supports for individuals with a clinical need and who are transitioning out of institutional care or congregate settings, out of homelessness or a homeless shelter, or the child welfare system. They also include case management, outreach, and education, as well as infrastructure investments and transportation services, to support access to those services.

Services authorized in this demonstration to address HRSN must be medically appropriate for the beneficiary. This authority is likely to assist in promoting the objectives of Medicaid because it is expected to help individuals stay connected to coverage and access needed health care. For example, housing instability or inadequate nutrition may impede an individual's ability to enroll in coverage and access needed health care. Such circumstances may create physical, social or emotional conditions that are counterproductive to the otherwise positive effects of the health care services an individual does receive, including through Medicaid.<sup>4</sup> The time-limited housing and nutritional support services authorized in the demonstration can be expected to stabilize the housing and nutritional circumstances of certain eligible Medicaid enrollees and thus increase the likelihood that they will keep receiving and benefiting from the Medicaid-covered services to which they are entitled.

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<sup>1</sup> Dzau, V.J., Mate, K., O'Kane, M. *Equity and Quality—Improving Health Care Delivery Requires Both*. JAMA. 2022;327(6):519–520. doi:10.1001/jama.2022.0283; <https://jamanetwork.com/journals/jama/fullarticle/2788482>; O'Kane, M., Agrawal S., Binder, L., et al. *An Equity Agenda for the Field of Health Care Quality Improvement*. National Academy of Medicine; 2021; <https://nam.edu/an-equity-agenda-for-the-field-of-health-care-quality-improvement/>.

<sup>2</sup> As discussed in a letter to State Health Officials issued on January 7, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While “social determinants of health” is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. *See also* <https://www.healthaffairs.org/doi/10.1377/forefront.20191025.776011/full/>

<sup>3</sup> Bachrach, D., Pfister, H., Wallis, K., Lipson, M. *Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment*. The Commonwealth Fund; 2014; [https://www.commonwealthfund.org/sites/default/files/documents/media\\_files\\_publications\\_fund\\_report\\_2014\\_may\\_1749\\_bachrach\\_addressing\\_patients\\_social\\_needs\\_v2.pdf](https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf).

<sup>4</sup> Schilbach, F., Schofield, H., Mullainathan, S. *The Psychological Lives of the Poor*. American Economic Review: Papers & Proceedings; 2016; <http://dx.doi.org/10.1257/aer.p20161101>.

Moreover, the Medicaid statute, including both sections 1905 and 1915 of the Act, reflects the critical role of upstream services (i.e., those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities). For example, medical assistance made available under a waiver authorized under section 1915(c) of the Act is provided as a home and community-based alternative to avoid the need for more intensive institutional-based care. Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of home and community-based services to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care. Both provisions authorize services, including habilitation services like pre-tenancy and tenancy support services, with a goal of preventing decline in beneficiary health that would require more intensive services. Similarly, medical assistance covering interventions aimed at improving asthma management and mitigating asthma triggers is another example of how the Medicaid statute gives states authority to help reduce beneficiary need for acute care services (e.g., emergency department visits).

Available evidence<sup>5</sup> suggests that there may be populations in addition to those eligible under 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services that would benefit targeted populations, and that additional research is needed on the effects of providing those types of services to a broader group of people. This demonstration will test whether expanding eligibility for these services to additional populations or providing additional services will improve the health outcomes of certain Medicaid beneficiaries. The demonstration will also test whether a broader range of Medicaid beneficiaries maintain their coverage by helping to prevent the health-related incidents that could lead to enrollment churn.<sup>6</sup> Covering these services for a broader range of beneficiaries, which may improve their ability to access care, is also expected to enable the Commonwealth's Medicaid program to reach more eligible individuals by promoting recipients' health, reducing the future and downstream cost of medical interventions, and thus allowing the program's resources to go farther. These services are also expected to further help reduce health disparities that are often rooted in social and economic disadvantages.<sup>7</sup> Thus, broadening the availability of certain HRSN services is expected to promote coverage, access to and quality of care, improve health outcomes, reduce health disparities, and create long-term, more cost-effective alternatives or supplements to traditional medical services. CMS's authorization of limited infrastructure spending as part of this HRSN framework, such as paying for health information technology system investments and provider workforce investments, is expected to help providers that furnish covered services to beneficiaries improve the availability and quality of their services, thereby improving health outcomes for beneficiaries. CMS also expects the Commonwealth to maintain existing state level funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place

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<sup>5</sup> September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. <https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions>

<sup>6</sup> April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>

<sup>7</sup> April, 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>

partnerships with other Commonwealth and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

Over the life of the MassHealth demonstration, the Commonwealth has taken steps to introduce programs and services that address HRSN for individuals meeting certain clinical and risk-based needs criteria, specifically through Specialized Community Support Programs (CSPs) and the Flexible Services Program (FSP). CMS is extending the expenditure authority to continue delivery of Specialized CSP services and FSP services, as well as authorizing the expansion of eligibility and the coverage of new services. CSP services are outreach and supportive services to enable beneficiaries with a history of a psychiatric or substance use disorder, and/or for whom a psychiatric or substance use disorder diagnosis interferes with their ability to access essential medical services, to use clinical treatment services and other supports. Specialized CSPs will target populations in need of specialized supports, including a more intensive form of CSP for beneficiaries who are experiencing homelessness or are justice-involved while living in the community, and targeted CSP tenancy supports for beneficiaries facing eviction as a result of behavior related to their condition. FSP enables MassHealth ACOs to address targeted HRSNs for eligible beneficiaries. Beneficiaries who are enrolled in an ACO, and who have clinical needs and meet risk-based criteria may be eligible for tenancy preservation and nutrition sustaining supports. Approved FSP services include time-limited housing supports, nutrition education, medically-tailored and time-limited food assistance. FSP services also include additional meal support for the household when an eligible beneficiary is a child or pregnant person meeting the risk-based and needs-based criteria, as this support is expected to help the household to avoid difficult choices about whose nutritional needs should be met first with limited resources, and thereby could better ensure the needs of the beneficiary are met when the beneficiary's nutritional needs are especially important.

CMS is authorizing the Commonwealth's proposal to test changes in primary care delivery and payment by piloting a new primary care payment model intended to shift primary care payment to a value-based structure. This payment model includes increased clinical and care delivery expectations under which all primary care practices (PCPs) must, for example, work towards enhanced team-based care, behavioral health integration, and to increase access and promote integrated primary care. In this model, Massachusetts will contract with Primary Care ACOs to make a prospective payment to participating PCPs in accordance with the Commonwealth's requirements. Massachusetts will no longer make fee-for-service payments for a defined set of primary care services delivered to Primary Care ACO enrolled beneficiaries by PCPs that receive the primary care payments. This payment model meets Category 4 Population-Based Payment as described in the Alternative Payment Model (APM) Framework<sup>8</sup> and the Commonwealth must submit the payment methodology, including annual updates, for CMS review and approval.

CMS is also authorizing an additional year of disbursement of previously-approved Delivery System Reform Incentive Payment (DSRIP) funds to allow the Commonwealth to continue disbursing approved DSRIP program funds, in order to complete the final performance year activities, close out administrative and operational requirements, and distribute the remaining performance-based incentive payments to participants based on services provided in the final performance year.

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<sup>8</sup> APM Framework: <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

Massachusetts, like other states, continues to face health care provider shortages, as well as challenges in recruiting and retaining a diverse workforce, and the COVID-19 public health emergency (PHE) magnified these issues. In this extension, CMS is authorizing federal financial participation (FFP) for expenditures related to provider workforce recruitment and retention activities, specifically primary care and behavioral health provider student loan repayment programs and a family nurse practitioner residency program. This authority is likely to assist in promoting the objectives of Medicaid because it is intended to reduce shortages of qualified health care providers and expand access to care for beneficiaries by requiring that participants in these Medicaid-funded programs provide services in community-based settings serving substantial Medicaid and uninsured populations, which is expected to support the key Medicaid objective of furnishing medical assistance.

The MassHealth extension includes authority for 12-month continuous eligibility for Medicaid and CHIP beneficiaries upon release from correctional settings (including youth), and 24-month continuous eligibility for beneficiaries with a confirmed status of homelessness. CMS is authorizing this continuous eligibility to support consistent coverage and continuity of care by keeping beneficiaries enrolled for up to 24 months, regardless of income fluctuations or other changes that otherwise would affect eligibility (except for death or ceasing to be a resident of the Commonwealth). The continuous eligibility policy is likely to assist in promoting the objectives of Medicaid as it is expected to minimize coverage gaps and to help maintain continuity of access to program benefits for the relevant populations.

The Commonwealth is modifying and expanding eligibility for the CommonHealth program to support goals of providing comprehensive coverage for individuals with disabilities in order to meet their health care needs. Massachusetts stated in its MassHealth extension application that the original design of the CommonHealth program created work incentives for individuals with disabilities, but that may have resulted in unintended disincentives for beneficiaries (e.g., beneficiary concerns about losing health coverage if they are unable to maintain stable employment and meet CommonHealth criteria).<sup>9</sup> CMS is approving the Commonwealth's request to streamline the CommonHealth adult eligibility process by eliminating the one-time deductible for non-working adults with disabilities and enable adults with long-term disabilities to retain their coverage after age 65 to support ongoing coverage and care in the community, regardless of their working status.

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to promote coverage, access to and quality of care for all beneficiaries, thereby helping to strengthen coverage and mitigate health disparities. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care received.<sup>10</sup> To that end, as a condition of approval

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<sup>9</sup> MassHealth Section 1115 Demonstration Extension Request. (2021). Retrieved from:

<https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-pa7.zip>.

<sup>10</sup> Polsky, D., Richards, M. Basseyn, S., et al. *Appointment Availability after Increases in Medicaid Payments for Primary Care*. The New England Journal of Medicine; 2015; <https://www.nejm.org/doi/10.1056/NEJMsa1413299>; Decker, S. L., *Medicaid Physician Fees and the Quality of Medical Care of Medicaid Patients in the USA*. Review of Economics in the Household; 2007; <https://link.springer.com/article/10.1007/s11150-007-9000-7>.

for expenditure authority for both the Hospital Quality and Equity Initiative and the HRSN services and related infrastructure, the state will be required to increase and (at least) sustain Medicaid fee-for-service provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care, should the state's Medicaid-to-Medicare provider rate ratio be below 80 percent in any of these categories.

### *Budget Neutrality*

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be “budget neutral,” meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the “without waiver” (WOW) costs). Historically, if a state's “with waiver” (WW) costs for a demonstration approval period were less than the expenditure limit for that period, the unspent funds or “savings” rolled over into the next approval period, which meant that the state could incur higher WW costs during the new approval period.

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 State Medicaid Director (SMD) Letter.<sup>11</sup> The approach described in the 2018 SMD Letter included certain features that limited the extent to which states could roll over unspent “savings” from one approval period to the next when CMS extended a demonstration, and which were thereby intended to preserve the fiscal integrity of the Medicaid program. Based on CMS's and states' experience implementing the approach described in the 2018 SMD Letter, it has become apparent to CMS that this approach may limit states' future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid. Therefore, in this approval, CMS has reevaluated and is modifying certain aspects of the budget neutrality approach described in the 2018 SMD Letter, in an attempt to better support state innovation, in line with section 1115 of the Act, while maintaining its commitment to fiscal integrity. While CMS evaluates each demonstration proposal on a case-by-case basis, CMS anticipates that it will consistently apply these or similar updates in its approach to budget neutrality to all similarly situated states going forward.

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<sup>11</sup> August 22, 2018. SMD#18-009 RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf>



Under this approval, CMS is departing from the budget neutrality approach described in the 2018 SMD Letter in two key ways. First, CMS is making several changes that are intended to give states greater access to funding, including “savings” from prior approval periods, while still maintaining fiscal integrity. These changes include an updated approach to calculating the WOW baseline, which refers to the projected expenditures that could have occurred absent the demonstration and which, as described above, is the basis for the budget neutrality expenditure limit for each approval period. Under this approval, CMS calculated the WOW baseline by using a *weighted average* of the Commonwealth’s *historical* WOW per-member-per-month (PMPM) baseline and its *recent actual* PMPM costs, rather than taking the approach described in the 2018 SMD Letter, which was to adjust WOW PMPM cost estimates to reflect only the *recent actual* PMPM costs. This updated approach is expected to result in a slightly higher WOW baseline, while still primarily reflecting the state’s most recent expenditures. In addition, under this approval, projected demonstration expenditures associated with each Medicaid Eligibility Group in the WOW baseline have been trended forward using the President’s Budget trend rate to determine the maximum expenditure authority for the new approval period. In contrast, under the approach described in the 2018 SMD Letter, CMS would use the *lower of* the state’s historical trend or the President’s Budget trend rate. Using the President’s Budget trend rate instead aligns the demonstration trend rate with federal budgeting principles and assumptions. Additionally, while CMS will still limit the extent to which demonstration “savings” can be “rolled over” to a new approval period, the limitations will be less narrow than those that apply under the approach described in the 2018 SMD Letter. In the 2018 SMD Letter, CMS explained that it expected to permit states to roll over “savings” to a demonstration extension from only the most recent 5 years of prior approvals, and that there would be a transitional phase-down of accrued “savings.” Under this approval, the “savings” amount available for the extension approval period has been limited to the lower of (1) the “savings” available to the Commonwealth in the current extension approval period plus net savings from up to 10 years of the immediately prior demonstration approval period(s); or (2) 15 percent of the Commonwealth’s projected total Medicaid expenditures in aggregate for the demonstration extension period. This change will permit Massachusetts to access more “savings” from prior approval periods than it would otherwise be able to do under the approach described in the 2018 SMD Letter, and thus will better permit Massachusetts to fund the program innovations described above. At the same time, CMS will limit the “savings” Massachusetts can access, thereby preserving the Medicaid program’s fiscal integrity. These adjustments to the 2018 approach improve the balance between the availability of expenditure authority to support program innovation and the need for fiscal restraint. CMS expects these updates will continue to ensure fiscal integrity by limiting “savings” rollover from one approval period to the next. However, they are also expected to give Massachusetts access to more funding than it would otherwise have been able to access, and thus, more ability to implement demonstration projects that are likely to assist in promoting the objectives of the Medicaid program, than it would have had under the approach described in the 2018 SMD Letter.

In a second key change from the approach described in the 2018 SMD Letter, CMS is treating certain HRSN expenditures as “hypothetical” for purposes of Massachusetts’s budget neutrality calculation. As described in the 2018 SMD Letter, CMS effectively treats a hypothetical expenditure like an expenditure that the state could have made absent the demonstration, when calculating budget neutrality. As a result, hypothetical expenditures are included in both the

WOW baseline and the estimate of the WW expenditures under the demonstration, and states do not have to find demonstration “savings” to offset hypothetical expenditures. However, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued “savings” from hypothetical expenditures. That is, “savings” are not generated from a hypothetical population or service if the state does not spend up to the hypothetical expenditure limit. To allow for hypothetical expenditures, while preventing them from resulting in “savings,” CMS applies a separate, independent budget neutrality “supplemental test” for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to predetermined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state’s WW hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by finding “savings” elsewhere in the demonstration or to refund the federal matching funds to CMS. In the 2018 SMD Letter, CMS explained that it has historically considered demonstration expenditures to be “hypothetical” in the following circumstances: (1) when they are for populations or services that the state could otherwise have covered under its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act; or (2) when a WOW spending baseline is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates (e.g., CMS has treated demonstration expenditures on the “adult group” described in section 1902(a)(10)(A)(i)(VIII) of the Act as hypothetical for this reason).

Under this approval, certain HRSN expenditures are considered “hypothetical” expenditures and are included in the budget neutrality WOW baseline. Some of these expenditures, as discussed above, are expenditures for services that the Commonwealth could otherwise cover under other title XIX authority, such as tenancy and nutrition supports for beneficiaries. Treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. While other approved HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915(c) and 1915(i) services for beneficiaries who would not otherwise be eligible for them under section 1915, there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures. As discussed above, based on robust academic-level research, it appears likely that these state expenditures could improve the quality and effectiveness of downstream services that can be provided under state plan authority.<sup>12</sup> And, as also discussed below, covering HRSN services might improve enrollees’ health, reducing the future downstream costs of medical care for these beneficiaries. At the same time, predicting these downstream effects on overall Medicaid program costs of covering certain evidence-based HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these expenditures on demonstration budget neutrality or on the Commonwealth’s overall Medicaid program. Treating demonstration HRSN expenditures as hypothetical will give

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<sup>12</sup> Lipson, D. J. *Medicaid’s Role in Improving the Social Determinants of Health: Opportunities for States*. National Academy of Social Insurance; 2017; [https://www.nasi.org/wp-content/uploads/2017/06/Opportunities-for-States\\_web.pdf](https://www.nasi.org/wp-content/uploads/2017/06/Opportunities-for-States_web.pdf); Whitman, A., De Lew, N., Chappel, A., et al. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Assistant Secretary for Planning and Evaluation; 2022; <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>.

the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs.

Historically, CMS has often authorized expenditures through section 1115 demonstrations subject to expenditure limits. In this case, to ensure that treating certain HRSN expenditures as hypothetical will not have a significant negative impact on Medicaid fiscal program integrity, CMS is applying a budget neutrality spending cap to HRSN services expenditures and an additional sub-cap to HRSN infrastructure expenditures, and is referring to these expenditures as “capped hypothetical expenditures” in the STCs. The caps on expenditures for these HRSN services and related infrastructure activities differ from the usual limit CMS places on hypothetical expenditures under the “supplemental test” discussed above in several respects. First, ordinarily, if a state exceeds the hypothetical expenditure limit it can offset the additional costs with savings from the rest of the demonstration. That will not be permitted with the HRSN expenditures. However, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. Second, the expenditures subject to the cap are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects, as discussed above. Third, the upper limit on the cap is based on a range of estimates of the likely cost of these expenditures over the course of a 5-year period, and set at a mid-point in that range. While this cap deviates from the traditional approach to hypothetical expenditures, it is consistent with CMS’s historical approach to maintaining budget neutrality in Medicaid demonstrations and it does not alter the underlying financing structure of the Medicaid program. This cap will ensure that the state maintains its investment in the state plan benefits to which enrollees are entitled while testing the benefit of the HRSN services described above. This cap will not apply to any other benefits or services.

Finally, CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for “mid-course” budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicate a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state’s baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state’s control (e.g., expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (e.g., unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the Commonwealth to propose an amendment to the demonstration) is likely to further strengthen access to care (e.g., a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

### *Requests Not Being Approved at this Time*

CMS and Massachusetts are continuing discussions of the Commonwealth's pending requests related to the Commonwealth's strategy to improve and strengthen access to care and health outcomes for individuals enrolled in Medicaid, including justice-involved populations that have experienced increased challenges to accessing health care. Massachusetts requested to provide MassHealth coverage to qualified individuals in Department of Youth Services juvenile justice facilities during their commitment and to justice-involved adults 30 days prior to being released from carceral settings. The Commonwealth anticipates such coverage would help to stabilize beneficiary health pre-release, ensure continuity of coverage through Medicaid pre-release enrollment strategies, increase access to mental health services, and support re-entry into the community. CMS is generally supportive of increasing pre-release services for justice-involved populations in order to assist in making successful transitions from the carceral system back into the community and will continue to work with the Commonwealth on this request.

CMS also continues to review the Commonwealth's requests for flexibilities related to place of service, that were offered by CMS during the COVID-19 public health emergency. Specifically, these are requests for expenditure authority to operate a Hospital at Home program based on the CMS Acute Hospital Care at Home program and expenditure authority to pay for clinic services delivered via telehealth (when neither the provider nor member is at the clinic) and in other non-clinic locations, including but not limited to the member's home and other community locations. CMS recognizes the significant value these flexibilities have provided during the public health emergency, and will continue to work with the Commonwealth on these requests.

### **Monitoring and Evaluation**

Consistent with the STCs in the MassHealth demonstration, the Commonwealth submitted its draft interim evaluation report for the prior demonstration approval period on September 30, 2021.<sup>13</sup> The report indicated improvements in diabetes and high blood pressure management, appropriate use of emergency departments among the ACO population, and timely follow-up after an emergency department visit. Additionally, findings suggest that the demonstration was successful at keeping the uninsurance rate low—around 3 percent. It also exhibited positive findings for beneficiaries with SUD, such as decreases in the rate of overdoses and increases in the number of providers treating SUD, although findings related to initiation and engagement of SUD treatment demonstrated both positive and negative results. Furthermore, analysis of the impact of various components on demonstration costs all showed that per-member per-month costs for MassHealth beneficiaries were lower than they would have been without the demonstration. Since the report also identified room for improvement in the frequency and standardization of HRSN screenings during the previous demonstration approval period, CMS and the Commonwealth are setting more ambitious goals and are developing a variety of tools to monitor and evaluate these policies in this demonstration approval period, as described in more detail below.

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<sup>13</sup> Draft Independent Evaluation Interim Report. Massachusetts Medicaid 1115 Demonstration Extension 2017-2022. September 2021. The Commonwealth submitted a revised report in March 2022. CMS and the Commonwealth are working toward finalization and approval of this report; once approved, the report will be posted publicly.

With this extension of the MassHealth demonstration, consistent with CMS requirements for section 1115 demonstrations as outlined in the demonstration's STCs, the Commonwealth is required to conduct systematic monitoring and robust evaluation of the demonstration per applicable CMS guidance and technical assistance. The overall demonstration, and specifically the novel initiatives, such as the HRSN initiative and Hospital Quality and Equity Initiative that are authorized within the demonstration, must be rigorously monitored and evaluated. Evidence indicating substantial and sustained directional change inconsistent with the demonstration goals, such as sustained trends indicating substantially increased difficulty accessing services, could form the basis for CMS to initiate the process for withdrawing specific authorities within the demonstration.

The demonstration's monitoring activities must support tracking the Commonwealth's progress toward meeting the goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments. The Commonwealth must report on metrics that relate to the demonstration's key policy components, including but not limited to: SUD, serious mental illness (SMI), the new Hospital Quality and Equity Initiative, workforce development initiatives, continuous eligibility policy, and HRSN services. In addition, the Commonwealth must undertake reporting on metrics related to premiums and premium assistance programs (e.g., tracking beneficiaries subject to premiums, enrollment continuity and disenrollment rates) and the waiver of retroactive eligibility (e.g., tracking beneficiaries with unpaid medical bills at the time of application and those who experienced a gap in coverage).

The demonstration's metrics reporting must cover categories including, but not limited to: enrollment and renewal, access to providers, utilization of services, and quality of care and health outcomes. The Commonwealth is required to do robust reporting of quality of care and health outcomes aligned with the demonstration's policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the Commonwealth's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the Commonwealth's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers of health. In coordination with CMS, the Commonwealth is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate.

For this demonstration's HRSN initiatives, in addition to reporting on the metrics described above, the Commonwealth must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the Commonwealth or partner entities

assisting in the administration of the demonstration and social services organizations. Specifically in the context of the HRSN initiatives, the Commonwealth's enrollment and renewal metrics must capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible. These reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives. Finally, if the Commonwealth, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the Commonwealth must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the Commonwealth's HRSN initiatives and the projects hospitals may undertake as part of the Hospital Quality and Equity Initiative.

Furthermore, under the STCs, and consistent with current CMS guidance, Massachusetts must develop, for the demonstration extension period, a rigorous Evaluation Design using robust data sources and sound analytic approaches that support a comprehensive and meaningful evaluation of the demonstration to assess whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as for the Commonwealth's overall Medicaid program. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact on beneficiary coverage, access to and quality of care, and health outcomes, as well as its effectiveness in achieving the policy goals and objectives. Furthermore, to the extent feasible, the Commonwealth must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

For all components of the demonstration, including those that are being extended from the prior approval period, the Commonwealth must—as applicable—develop and test evaluation hypotheses and research questions in alignment with program goals, and assess care coordination, access to and utilization of primary and behavioral health services, and reductions in use of avoidable inpatient and emergency department (ED) services. Specifically, to evaluate the impact of the premium policy, the Commonwealth must continue to assess beneficiary access to and utilization of health care services, enrollment continuity, number and frequency of coverage gaps, and beneficiary experiences with care. The Commonwealth also must collect necessary data to accommodate CMS's evaluation expectations to rigorously assess the effects of the Commonwealth's waiver of retroactive eligibility on beneficiaries and providers, for example, by examining outcomes such as likelihood of enrollment and enrollment continuity, health status, and financial status.

Evaluation hypotheses for the HRSN initiatives must focus on areas such as provision of and beneficiary utilization of HRSN services, severity of beneficiaries' social needs, the effectiveness of the services received in mitigation of identified needs, utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. In alignment with the demonstration's objectives to improve outcomes for the Commonwealth's overall beneficiary populations eligible for the HRSN initiatives, the Commonwealth must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities. For example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population and/or community level.

In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. It also is required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the Commonwealth's state plan authority, and associated cost implications.

The Commonwealth's evaluation efforts must also include developing thoughtful hypotheses and research questions to assess the effectiveness of the Hospital Quality and Equity Initiative in ensuring provision of consistent high-quality care to all beneficiaries, and must provide evidence of the Commonwealth's efforts to collect stratified data for selected performance measures. The evaluation of the Initiative must also include robust analyses that help demonstrate whether the Commonwealth is succeeding in improving the quality and completeness of reporting on stratified data elements.

The Commonwealth must evaluate whether the targeted loan repayment and residency grant programs, and any other authorized workforce initiatives under the demonstration improve access to covered services for Medicaid beneficiaries. To that end, the Commonwealth must investigate—to the extent feasible—the effects of the workforce initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention especially in the concentration areas such as primary care, behavioral health and family practice. For the continuous eligibility policy, the Commonwealth must evaluate the impact of the program on all relevant populations appropriately tailored for the specific time span of eligibility. For example, the Commonwealth must evaluate how the continuous eligibility policy affects coverage, enrollment, and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled and re-enroll within 12 months), as well as population-specific appropriate measures of service utilization and health outcomes. In addition, the Commonwealth may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

Finally, as part of its evaluation efforts, the Commonwealth must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the Commonwealth must analyze the budgetary effects of the HRSN services, and the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the Commonwealth must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the Commonwealth's Medicaid program.

CMS underscores the importance of the Commonwealth undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policies, including but not limited to Flexible Services and the waiver of retroactive eligibility, beneficiary experience with access to and quality of care, as well as changes in incidence of beneficiary medical debt. In addition, the Commonwealth is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. The implementation evaluation can inform the Commonwealth's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

### **Consideration of Public Comments**

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary. Massachusetts completed its state level public comment period, as required, from August 18, 2021 to September 20, 2021. The Commonwealth also completed tribal consultation in accordance with section 1902(a)(73) of the Act by providing a summary to tribal leaders and designees on August 18, 2021, with a request for comment by September 20, 2021.

Section 1115(d)(2)(A) and (C) of the Act further specifies that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline but will not necessarily provide written responses to all public comments (42 CFR 431.416(d)(2)).

The federal comment period opened on January 4, 2022 and closed on February 3, 2022. There were thirty-three public comments received during the federal comment period; however, two of these comments did not contain any feedback or information about the commenter; therefore,



they were not considered. A majority of comments supported the demonstration's extension proposals. The most widely supported proposals from these commenters included the Commonwealth's new initiatives promoting consistent high-quality care to all beneficiaries served and delivery of services to address HRSN, continuous eligibility for homeless and justice-involved individuals, delivery system reform through sub-capitated payments to providers, the expansion of FSP and CSP services, changes to the retroactive eligibility waiver authority, initiatives supporting the community health center workforce, and justice-involved coverage initiatives. Supporters of the continuous eligibility provisions emphasized that it would mitigate coverage gaps and churn and improve health outcomes.

Some commenters opposed certain elements within the extension. One commenter raised multiple concerns and did not recommend approval of several elements within the demonstration. This commenter opposed the institutions for mental diseases (IMD) provisions of the demonstration, arguing that the IMD payment exclusion cannot be waived. CMS is approving the expenditures for services delivered while beneficiaries are residents of IMD under section 1115(a)(2) of the Act. Section 1115(a)(2) of the Act grants the Secretary the authority, in the context of a demonstration project under section 1115(a), to provide federal matching of state expenditures that would not otherwise be federally matchable under the terms of section 1903. Specifically, with respect to state expenditures under a section 1115 "demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [Medicaid]," expenditures that would "not otherwise" be matchable under section 1903 may "be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans . . . as may be appropriate." This expenditure authority has been exercised by the Secretary for decades to conduct demonstration projects that provide coverage for individuals or services that could not otherwise be covered under a state's Medicaid state plan. This has allowed the Secretary to expand eligibility for benefits to individuals who would not otherwise be eligible, and for services that would not otherwise be covered. This interpretation has been upheld in court as a valid exercise of the Secretary's demonstration authority under section 1115. For example, federal courts have upheld demonstration projects that covered individuals under section 1115(a)(2) who would not otherwise be eligible for coverage. *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007); *Wood v. Betlach*, No. CV-12-08098, 2013 WL 3871414 (D. Ariz. July 26, 2013).

Additionally, this commenter argued that it does not view the Commonwealth receiving FFP for these IMD expenditures as a valid experiment. CMS has determined that Massachusetts's request serves a research and demonstration purpose as outlined in State Medicaid Director Letter #18-011. As noted above, testing the benefits of covering individuals and services that could not otherwise be covered promotes the coverage objective of Medicaid, and helps states and CMS gather information to inform any potential future legislation. CMS believes that this authority will yield useful data as this demonstration includes robust monitoring and evaluation requirements.

This commenter expressed concern that the continuous coverage component does not constitute a clear experiment. CMS has determined that this component will test whether specific expansions of uninterrupted coverage to vulnerable beneficiaries will promote access to medical assistance and improve care, and does not agree with the comment. This is an expansion solely allowable

under demonstration authority, and has otherwise not been tested to date in the Medicaid population.

This commenter stated there is nothing experimental about Massachusetts's proposal to extend its waiver for eliminating retroactive coverage because Massachusetts has possessed a waiver of retroactive coverage since 1997. The commenter also argued that waiving retroactive coverage does not promote Medicaid objectives and evidence suggests it reduces access to coverage and care among low-income individuals, leaving them with unmet needs and/or medical debt. They noted that this could cause significant hardship for individuals and that Massachusetts did not justify its request. Multiple other commenters shared similar concerns about the Commonwealth's request to continue its retroactive coverage waiver, in part, indicating that it serves as a barrier to care and does not promote the objectives of the program. We appreciate the concerns raised regarding waiving retroactive eligibility. CMS is requiring the Commonwealth to conduct more rigorous monitoring and evaluation of the effects of this longstanding waiver, and CMS is continuing to examine this authority.

This commenter also expressed concern about the Commonwealth's statement that, when compiling data to assess and understand the extent of existing health disparities, it will "consider the use of imputed social risk factor data as needed" when self-reported data are unavailable. CMS understands the commenter's concern that there may be potential biases in imputed data sources. CMS will work closely with the Commonwealth on developing Implementation Plans and Monitoring Protocols to track and monitor data sources and data completeness, emphasize the importance of prioritizing self-reported data for collection and analysis where possible, and implement guardrails to minimize bias when self-reported data are unavailable. In addition, CMS is explicitly requiring that payments to providers under this demonstration cannot be based on imputed data.

Another commenter shared a number of concerns and suggestions for the Commonwealth's proposal to provide sub-capitated payments to primary care providers. The comment encouraged CMS to ensure that providers were prepared to assume the risk associated with sub-capitated payments, and that sufficient protections were in place to prevent cherry-picking of patients and stinting on care. The commenter shared several suggested protections to address potential issues, such as requiring detailed and public reporting on service utilization and panel composition patterns, complaints and grievances, and other appropriate information. The commenter also recommended to CMS that it carefully review the sub-capitation arrangements, based on the different populations that MassHealth and its providers service and their varying needs.

CMS appreciates the comments on how critical program design and oversight will be for this program to properly operate and not jeopardize provider stability or service delivery. CMS will apply stringent review standards to the payment arrangements that will be authorized as part of this program. CMS reserves the right to take appropriate corrective action or terminate this authority if it is found that providers are adopting excessive risk and/or failing to provide Medicaid-covered services to Medicaid beneficiaries and will implement regular program integrity and oversight in order to actively observe the operations of this initiative.

Another commenter shared concerns about how the demonstration extension and its promotion of the integration of behavioral and physical healthcare might lack sufficient oversight, potentially leading to improper care for those with both physical and behavioral health conditions. The commenter suggested safeguards and monitoring for integration of behavioral and physical health. CMS thanks this commenter for their concerns, and CMS will work with the Commonwealth to ensure adherence to applicable regulations related to ensuring delivery of quality care, and to conduct systematic monitoring and comprehensive evaluation.

One commenter suggested that the Commonwealth's Hospital Quality and Equity Initiative consider recognizing beneficiaries with psychiatric disorders as a vulnerable population at particular risk of receiving substandard care. We thank the commenter for the suggestion and will consider it while developing the operational details of the program with the Commonwealth.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid and, as relevant, CHIP.

### **Other Information**

The award is subject to CMS receiving written acceptance by the Commonwealth within 30 days of the date of this approval letter. Your project officer is Ms. Rabia Khan. Ms. Khan is available to answer any questions concerning implementation of the Commonwealth's section 1115(a) demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
Mail Stop: S2-25-26  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850  
Email: [Rabia.Khan1@cms.hhs.gov](mailto:Rabia.Khan1@cms.hhs.gov)

We appreciate the Commonwealth's commitment to improving the health of its Medicaid beneficiaries, and we look forward to our continued partnership on the MassHealth section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

A black rectangular redaction box covering the signature of Chiquita Brooks-LaSure.

Chiquita Brooks-LaSure

Enclosure

cc: Marie DiMartino, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**WAIVER AUTHORITY**

**NUMBER:** 11-W-00030/1 and 21-00071/1  
**TITLE:** MassHealth Medicaid and CHIP Section 1115 Demonstration  
**AWARDEE:** Massachusetts Executive Office of Health and Human Services  
(EOHHS)

Under the authority of Section 1115(a)(1) of the Social Security Act (“the Act”), the following waivers are granted to enable the Commonwealth of Massachusetts (referred to herein as the state or the State/Commonwealth) to operate the MassHealth Medicaid and CHIP Section 1115 Demonstration. These waivers are effective beginning October 1, 2022 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document. The following waivers are also applicable to Medicaid Expansion CHIP populations unless otherwise specified.

As discussed in the Centers for Medicare & Medicaid Services’ (CMS) approval letter, the Secretary of Health and Human Services has determined that the MassHealth Medicaid and CHIP Section 1115 Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

Except as provided below with respect to expenditure authority, 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 for the period beginning October 1, 2022 through December 31, 2027.

**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.

To enable Massachusetts to provide health-related social needs (HRSN) services or certain types of HRSN services, only in certain geographical areas of the Commonwealth.

**2. Comparability/Amount, Duration, and Scope** **Sections 1902(a)(10)(B),  
1902(a)(17)**

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

To the extent necessary to enable the Commonwealth to provide benefits that vary from those specified in the State plan, as specified in Table 2, 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.

To the extent necessary to enable the Commonwealth to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs identified through assessment, and/or their Medicaid delivery system.

**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)**

**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 or part of a fiscal year in which Massachusetts is authorized to make provider payments from the Safety Net Care Pool (the amount of any DSH payments made during a partial fiscal year must be prorated if necessary so that DSH payments will not exceed the percentage of the DSH allotment corresponding to the percentage of the federal fiscal year for which payment of DSH payments is required).

**5. Financial Responsibility/Deeming/Comparability**

**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.

To enable Massachusetts to use MAGI-like financial eligibility determination methodologies for disabled adults in determining eligibility for MassHealth Standard and CommonHealth.

To enable Massachusetts to treat the state veteran annuity as non-countable income in making any calculations related to the post-eligibility treatment of income (PETI) rules and other forms of cost sharing.

**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). Freedom of choice of family planning provider will not be restricted.

To limit primary care clinician plan (PCC) plan and Primary Care ACO enrollees to a single Prepaid Insurance Health Plan (PIHP) for behavioral health services, to limit enrollees who are clients of the Departments of Children and Families or Youth Services and who do not

choose a managed care option to the single PIHP for behavioral health services, 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 to permit the state to limit 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 4 and Table 9. No waiver of freedom of choice is authorized for family planning providers.

**7. Payment for Care and Services** **Section 1902(a)(30)(A)**

To permit the state to pay providers using rates that vary from those set forth under the approved state plan to the extent that the payment varies based on shared savings or shared losses in an incentive arrangement.

**8. 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.

**9. 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 9. Effective no later than July 1, 2023, this waiver does not apply to Medicaid-eligible pregnant individuals or to children up to age 19, as defined in the Medicaid and CHIP state plans.

**10. 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 (i.e., members who are deceased, voluntarily withdraw, or moves out of state), and to not consider enrollment in a demonstration-only eligibility category or CHIP (title XXI) eligibility category in determining eligibility for Transitional Medical Assistance.

**11. Payment to Providers** **Sections 1902(a)(15),  
1902(a)(30)(A)**

To allow the Commonwealth to establish primary care services payment rates for Primary Care ACO-participating primary care providers on an individual or class basis without regard to the rates set forth in the approved state plan. Such primary care services payment rates

may vary based on factors such as provider class or clinical practice tier, or on the health status or rating category of the beneficiary served. Payments will not be reconciled to cost or utilization, however, the state will ensure that any Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) that participate in the primary care payment program with a Primary Care ACO are paid an amount at least equal to what they would be paid under their applicable PPS rates.

**12. Comparability and Provision of Medical Assistance**

**Sections 1902(a)(10)(B),  
1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the Commonwealth to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 15 of the STCs, and to allow the state to limit the number of beneficiaries receiving HRSN services subject to the HRSN cap described in STCs 19.13-19.14 .



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

**NUMBER:** 11-W-00030/1 and 21-00071/1  
**TITLE:** MassHealth Medicaid and CHIP Section 1115 Demonstration  
**AWARDEE:** Massachusetts Executive Office of Health and Human Services  
(EOHHS)

Under the authority of section 1115(a)(2) of the Social Security Act (“the Act”), expenditures made by the Commonwealth of Massachusetts (referred to hereing as the state or the State/Commonwealth) for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from October 1, 2022 through December 31, 2027, unless otherwise specified, be regarded as expenditures under the state’s title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services’ (CMS) approval letter, the Secretary of Health and Human Services has determined that the MassHealth Medicaid and CHIP Section 1115 Demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the Commonwealth to operate the above-identified section 1115(a) demonstration.

1. **CommonHealth Adults.** Expenditures for health care-related costs for:
  - a. Adults aged 19 through 64 who are totally and permanently disabled and not eligible for comprehensive coverage under the Massachusetts state plan.
  - 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 plans, or, for otherwise Title XXI eligible children, if the Title XXI allotment is exhausted.
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 or the CHIP state plan due to having insurance at application, or if the CHIP allotment is exhausted.
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. **EAEDC Recipients.** Expenditures for health care related costs for individuals receiving Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of EAEDC benefits, not based on an income determination.
  6. **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.
  7. **Provisional Coverage Beneficiaries.** Expenditures for MassHealth Coverage for individuals who self-attest to any eligibility factor, except disability, immigration and citizenship; provided that expenditures for MassHealth Coverage for individuals who self-attest to income not otherwise verified through data hubs are limited to the following populations:
    - a. Pregnant women with attested modified adjusted gross income (MAGI) at or below 200% of the federal poverty level (FPL);
    - b. Adults 21 through 64 years of age who are HIV positive and have attested MAGI income at or below 200% FPL;
    - c. Individuals with breast and cervical cancer who are under 65 years of age and have attested MAGI income at or below 250% FPL; and
    - d. Children under age 21.
  8. **Presumptively Eligible Beneficiaries.** Expenditures for individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration by qualified hospitals that elect to do so.
  9. **Out-of-state Former Foster Care Youth.** Expenditures to extend eligibility for full Medicaid State Plan benefits (MassHealth Standard) to former foster care youth who are

under age 26, were in foster care under the responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends, and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.

10. **Recipients of State Veteran Annuities.** Expenditures to extend eligibility for the populations of individuals specified below.
  - a. **Recipients of State Veteran Annuities.** Except as described in 10(b), expenditures to extend eligibility for MassHealth Standard, MassHealth CarePlus, MassHealth Family Assistance and MassHealth Limited benefits for individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income, provided that individuals described above are not otherwise eligible to receive comparable coverage on the state exchange.
  - b. Expenditures to extend eligibility for MassHealth Standard and CommonHealth benefits for disabled individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income.
  - c. Expenditures to extend eligibility for individuals who would be eligible to enroll in PACE but for the receipt of a state veteran annuity or but for the inclusion of such annuity in the household income
11. **Continuous Eligibility.** Expenditures for health care related costs for individuals who have been determined eligible under groups specified in STC 4.10 for continued benefits during any periods within the continuous eligibility period when these individuals would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.10(b). Along with other populations, this authority includes providing continuous eligibility for certain individuals in the Adult Group
  - a. For expenditures related to 1905(z)(2) expansion state individuals in the Adult Group who are eligible for continuous eligibility based on their release from a correctional institution, the state shall make a downward adjustment by claiming 2.6 percent of expenditures at the state's regular Federal Medical Assistance Percentage (FMAP) instead of at the 1905(z)(2) expansion state increased FMAP.
  - b. For expenditures related to 1905(z)(2) expansion state individuals in the Adult Group who are eligible for continuous eligibility because they are experiencing homelessness as defined in STC 4.10, no downward adjustment of the 1905(z)(2) expansion state increased FMAP will be required.
12. **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 in accordance with STC 8.13 and Table 9.
13. **Diversiónary Behavioral Health Services.** Expenditures for benefits specified in Table 5 to the extent not available under the Medicaid state plan.

14. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services and benefits specified in Table 6 to the extent not available under the Medicaid state plan, furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD). Expenditures for benefits specified in Table 6 to the extent coverable under the Medicaid state plan that are delivered in non-IMD settings.
15. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).** Expenditures for otherwise covered Medicaid services, including inpatient psychiatric hospital services, and benefits specified in STC 7.1 furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) or serious emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD). And expenditures for benefits specified in STC 7.1 to the extent coverable under the Medicaid state plan that are delivered in non-IMD settings.
16. **Full Medicaid Benefits for Presumptively Eligible Pregnant Individuals.** Expenditures to provide full MassHealth Standard plan benefits to presumptively eligible pregnant individuals (including Hospital Presumptive Eligibility) with incomes at or below 200 percent of the FPL.
17. **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 Standard members with incomes at or below the 133 percent of the FPL and for monthly Medicare Part B premiums, including through the Qualifying Individual program, for MassHealth Standard members with incomes at or below 165 percent of the FPL, who are also eligible for Medicare (without applying an asset test).  
  
Effective through June 30, 2026, 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).
18. **Enhanced Case Management Payment.** Expenditures for the Commonwealth to directly pay providers participating in either the PCC Plan or a Primary Care ACO an additional case management fee, which does not duplicate payment the PCC Plan or Primary Care ACO makes to the providers.
19. **PCCM Entities.** Expenditures for shared savings payments to participating Primary Care ACOs that include risk-based (upside and downside) payments to these Primary Care ACOs, and that may allow or require the Primary Care 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.

- a. **Primary Care Payment.** Expenditures for primary care payments to Primary Care ACOs. These payments will be prospective PMPM rates that vary from state plan rates, set using actuarial principles, and will not be reconciled to cost or utilization.
20. **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.
- a. **DSRIP and Related Initiatives.** Expenditures for incentive payments and state infrastructure payments for the DSRIP program specified in Section 12 of the STCs, and for flexible services provided to Primary Care ACO, Accountable Care Partnership Plan, and MCO-contracted ACO enrolled beneficiaries, to the extent not otherwise available under the Medicaid state plan, under other state or federal programs, or under this demonstration. The only expenditures permitted after April 1, 2023, are incentive payments for prior periods of performance and administrative activities to close out the DSRIP program.
  - b. **Public Hospital Transformation and Incentive Initiatives (PHTII).** Expenditure authority for close-out activities of the Public Hospital Transformation and Incentive Initiatives program from previous demonstration period that ended June 30, 2022, for up to two years following the conclusion of the demonstration.
  - c. **Disproportionate Share Hospital-like (DSH-like) Pool.** As described in Attachment E, limited to the extent set forth under the SNCP limits, 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 eligible individuals (Medicaid shortfall), and low-income uninsured individuals, in accordance with the Massachusetts' Uncompensated Cost Limit Protocol approved December 17, 2013 (including any subsequent amendments), and expenditures for payments for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD). Expenditure authority to make Safety Net Provider Payments tied to contractual withholds to providers, per STC 11.2(b), for up to two years following the conclusion of the demonstration. Expenditure authority for close-out activities for Safety Net Provider payments associated with the previous demonstration period.
  - d. **Uncompensated Care Pool.** As described in Attachment E, expenditures for supplemental payments to hospitals to reflect uncompensated charity care costs beyond the expenditure limits of the DSH Pool. Specifically, expenditures for additional Health Safety Net payments to hospitals that reflect care provided to certain low-income, uninsured patients; and Department of Public Health (DPH) and Department of Mental Health (DMH) hospital expenditures for care provided to uninsured patients. This expenditure authority does not entitle low-income or uninsured individuals to coverage under the demonstration.
21. **Marketplace Subsidies.** Expenditures for the payments made through the Commonwealth's state-operated program to:

- a. Provide premium subsidies for individuals with incomes at or below 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 state, is at or below 300 percent of the FPL.
  - b. 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 at or below 300 percent of the FPL.
  - c. Health Connector Gap Coverage. Expenditures for individuals as defined in STC 10.1 who are determined eligible QHP coverage, for up to 100 days while they select, pay and enroll into a health plan.
22. **Health- Related Social Needs (HRSN) Services.** Expenditures for health-related social needs services not otherwise covered furnished to individuals who meet the qualifying criteria as described in Section 15 of the STCs. This authority is contingent upon adherence to the requirements within Section 21 of the STC, as well as all other applicable STCs.
- a. Time-limited authority for the Commonwealth to continue providing Flexible Services under its existing Flexible Services program without adherence to the delivery system expectations within Section 15, STC 15.7 through 15.9, as well as 15.15(b), of the STC for both managed care and, if applicable, fee-for-service delivery systems, until January 1, 2025, as described in STC 15.7. Delivery of Flexible Services must fully comply with Section 15 of the STCs and applicable regulations for managed care and, if applicable, fee-for-service delivery systems no later than January 1, 2025.
23. **Expenditures for HRSN Services Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized in Section 15 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 21 of the STCs, as well as all other applicable STCs.
24. **Workforce Initiatives.** Expenditures for behavioral health student loan repayment, primary care provider student loan repayment and family nurse practitioner residency programs that meet the criteria as specified in Section 13 of the STCs.
- a. Time limited expenditure authority is granted until four years following the conclusion of the Workforce Initiatives, in order for the Commonwealth to pay close-out administrative costs of operating the program and monitoring service commitments.
25. **Hospital Quality and Equity Initiative.** Expenditures for incentive payments to participating private acute hospitals and the Cambridge Health Alliance for meeting data collection requirements, reporting expectations, and demonstrating improvement in health care quality and equity, as specified in the STCs.

- a. Time limited expenditure authority is granted until two years following the conclusion of the approval period for the Hospital Quality and Equity Initiative, in order for the Commonwealth to pay close-out costs of operating the program, and incentive payments associated with periods of performance within the approval period for the Hospital Quality and Equity Initiative.

This expenditure authority does not entitle uninsured individuals to any benefits under the demonstration. This expenditure authority is contingent upon adherence to the requirements of Section 21 of the STCs.

- 26. **Community Partner Enhanced Care Coordination Funding.** Expenditures for payments to Long Term Services and Supports (LTSS) Community Partners (CPs) (paid directly by the state) to support LTSS CPs’ enhanced care coordination responsibilities, as specified in the STC.
- 27. **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.
- 28. **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.

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.**

- 29. **Premiums and 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 Treatment programs.

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

To enable Massachusetts to treat the state veteran annuity as non-countable income in making any calculations related to the post-eligibility treatment of income (PETI) rules.

- 31. **Comparability/Amount, Duration, and Scope** **Section 1902(a)(17)**

To enable Massachusetts to treat the state veteran annuity as non-countable income in making any calculations related to the post-eligibility treatment of income (PETI) rules and for any cost sharing calculations.

Effective no later than July 1, 2023, to enable Massachusetts to not apply a paid employment hours restriction to CommonHealth enrollees that have been enrolled in the program for at least 10 years.

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

To the extent necessary to enable Massachusetts to provide health-related social needs (HRSN) services or certain types of HRSN services, only in certain geographical areas of the Commonwealth.

**33. Comparability; Amount, Duration, and Scope.** **Section 1902(a)(10)(B), Section 1902(a)(17)**

To the extent necessary to enable the Commonwealth to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs.

**34. Comparability and Provision of Medical Assistance & Reasonable Promptness**  
**Sections 1902(a)(10)(B), 1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the Commonwealth to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 16 of the STCs.

To the extent necessary to allow the Commonwealth to delay the application review process for HRSN services in the event the Commonwealth does not have sufficient funding to support providing these services to eligible beneficiaries.

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

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

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) does not apply to individuals eligible for the Family Assistance program.

**36. Assurance of Transportation** **Section 1902(a)(4)**

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



37. **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:**

38. **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 and Marketplace Subsidies.**

**The Following Title XIX Requirements are not Applicable to Expenditures for the CommonHealth program.**

39. **Income Disregards under Section 1902(r)(2)(A)**

To enable Massachusetts to not apply financial eligibility determination methodologies required under section 1902(r)(2)(A) for CommonHealth adults eligible under expenditure authority #1.

**Title XXI Expenditure Authorities**

All requirements of the Children’s Health Insurance Program (CHIP) shall apply to the demonstration populations and expenditures listed below, except those identified below as “not applicable.” All CHIP rules not expressly waived or identified as not applicable in this document shall apply to the demonstration. These expenditure and “non-applicable” authorities, as well as the associated Special Terms and Conditions (STCs), are in effect as of October 1, 2022, through December 31, 2027, except where otherwise noted in these expenditure authorities.

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 2107(e)(2)(A)) shall, for the period of this demonstration in accordance with the STCs, be regarded as matchable expenditures under Massachusetts’ title XXI state plan:

40. **Continuous Eligibility.** Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 4.10 for continued benefits during any periods within the continuous eligibility period when these individuals would be found ineligible if subject to redetermination in accordance with section 2102(b)(2) of the Act (regarding continuous eligibility). Along with other populations, this authority

includes providing continuous eligibility for certain targeted low-income children enrolled in CHIP.

- a. For expenditures related to 2110(b)(1) targeted low-income children who are eligible for continuous eligibility based on their release from a correctional institution.
- b. For expenditures related to 2110(b)(1) targeted low-income children who are eligible for continuous eligibility because they are experiencing homelessness as defined in STC 4.10(b).

## CENTERS FOR MEDICARE & MEDICAID SERVICES

### SPECIAL TERMS AND CONDITIONS

**NUMBER:** 11-W-00030/1 and 21-W-00071/1

**TITLE:** MassHealth Medicaid and Children’s Health Insurance Program (CHIP) Section 1115 Demonstration

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

#### 1. PREFACE

The following are the Special Terms and Conditions (STCs) for the “MassHealth” section 1115(a) Medicaid and Children’s Health Insurance Program (CHIP) demonstration (hereinafter “demonstration”), to enable the Massachusetts Executive Office of Health and Human Services (which is the single state agency that oversees the MassHealth program), to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the Commonwealth of Massachusetts (hereinafter, the state or the Commonwealth) waivers of requirements under section 1902(a) and 2102(b)(2) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the Commonwealth’s obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs are effective as of October 1, 2022 through December 31, 2027, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the Commonwealth’s expenditures relating to dates of service during this demonstration extension, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment
5. Demonstration Programs and Benefits
6. Opioid Use Disorder/Substance Use Disorder (SUD)
7. Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)
8. Delivery System
9. Cost Sharing
10. Marketplace Subsidies
11. The Safety Net Care Pool
12. Delivery System Reform Incentive Payment (DSRIP)
13. Workforce Initiatives

14. Hospital Quality and Equity Initiative
15. Health-Related Social Needs
16. Monitoring and Reporting Requirements
17. Evaluation of the Demonstration
18. General Financial Requirements under Title XIX
19. Monitoring Budget Neutrality for the Demonstration
20. Monitoring Allotment Neutrality
21. Provider Rate Increase Requirements
22. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A. Preparing the Evaluation Design
- Attachment B. Preparing the Interim and Summative Evaluation Reports
- Attachment C. Cost Sharing
- Attachment D. SUD Health IT Plan (Reserved)
- Attachment E. Safety Net Care Pool Payments (Reserved)
- Attachment F. SMI/SED Implementation Plan (Reserved)
- Attachment G. SUD Monitoring Protocol (Reserved)
- Attachment H. Safety Net Care Pool Uncompensated Care Cost Limit Protocol (Reserved)
- Attachment I. Uncompensated Care Payment Protocol (Reserved)
- Attachment J. Hospital Quality and Equity Initiative Implementation Plan (Reserved)
- Attachment K. SMI/SED Monitoring Protocol (Reserved)
- Attachment L. Accountable Care Organization (ACO) Payment Methodology (Reserved)
- Attachment M. DSRIP Protocol
- Attachment N. Safety Net Provider Payment Eligibility and Allocation (Reserved)
- Attachment O. Continuous Eligibility Implementation Plan (Reserved)
- Attachment P. Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications (Reserved)
- Attachment Q. Medicaid Managed Care Plan/ACO Performance Based Incentive Payment Mechanisms (Reserved)
- Attachment R. DSRIP Flexible Services Protocol
- Attachment S. Evaluation Design (Reserved)
- Attachment T. HRSN Implementation Plan (Reserved)
- Attachment U. Primary Care Payment Protocol (Reserved)
- Attachment V. Provider Rate Increase Attestation Table (Reserved)
- Attachment W. Monitoring Protocol for Other Policies (Reserved)

## **2. PROGRAM DESCRIPTION AND OBJECTIVES**

In the extension of the demonstration awarded on November 4, 2016, the Commonwealth and CMS 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 Payment (DSRIP) Program to transition the Massachusetts delivery system into accountable care models. The Safety Net Care Pool (SNCP) aligns 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.

- As of October 1, 2022, CMS approved an extension of the demonstration to enable the Commonwealth to achieve the following goals:
- Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model;
- Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care;
- Continue to improve access to and quality and equity of care, with a focus on initiatives addressing health-related social needs and specific improvement areas relating to health quality and equity, including maternal health and health care for justice-involved individuals who are in the community;
- Support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care; and
- Maintain near-universal coverage including updates to eligibility policies to support coverage and equity.

### 3. GENERAL PROGRAM REQUIREMENTS

- 3.1. **Compliance with Federal Non-Discrimination Statutes.** The Commonwealth 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 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The Commonwealth must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with changes in 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 Commonwealth to submit an amendment to the demonstration under STC 3.7. CMS will notify the Commonwealth 30 days in advance of the expected approval date of the amended STCs to allow the Commonwealth to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The Commonwealth must accept the changes in writing.

**3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

- 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 Commonwealth must adopt, subject to CMS approval, a modified budget neutrality agreement and/or a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality and/or modified allotment neutrality 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. Further, the Commonwealth may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.
- b. If mandated changes in the federal law, regulation, or policy require state legislation, unless otherwise prescribed by the terms of the federal law, 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, whichever is sooner.

**3.5. State Plan Amendments.** The state will not be required to submit title XIX or 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 is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

**3.6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements authorized through 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 Commonwealth must not implement or begin operational changes to these demonstration elements without prior approval. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available for amendments to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3 or as otherwise specified in the STCs.

3.7. **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 the failure by the Commonwealth to submit required elements of a complete amendment request as described in this STC, and failure by the Commonwealth to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public notice process used by the Commonwealth, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the Commonwealth in the final amendment request submitted to CMS;
- b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
- c. 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 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) the impact of the amendment;
- d. An up-to-date CHIP allotment worksheet, if necessary;
- e. The Commonwealth must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR § 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The Commonwealth may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination.** The Commonwealth must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The Commonwealth must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration’s suspension or

termination. Prior to submitting the draft transition and phase-out plan to CMS, the Commonwealth must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the Commonwealth must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the Commonwealth must provide a summary of the issues raised by the public during the comment period and how the Commonwealth considered the comments received when developing the revised transition and phase-out plan.

- b. **Transition and Phase-out Plan Requirements.** The Commonwealth 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 Commonwealth will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the Commonwealth will undertake to notify affected beneficiaries, including community resources that are available.
- c. **Transition and Phase-out Plan Approval.** The Commonwealth must obtain CMS approval of the transition and phase-out plan prior to the implementation of the transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d. **Transition and Phase-out Procedures.** The Commonwealth must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1) or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid and CHIP, the Commonwealth must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The Commonwealth must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to a review consistent with 42 CFR 457.1180. In addition, the Commonwealth must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the Commonwealth must maintain Medicaid benefits as required in 42 CFR §431.230.
- e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).



- f. **Enrollment Limitation during Demonstration Phase-Out.** If the Commonwealth elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the Commonwealth's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
  - g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers are suspended by the Commonwealth, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.
- 3.10. **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 Commonwealth has materially failed to comply with the terms of the project. CMS must promptly notify the Commonwealth in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- 3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the Commonwealth in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the Commonwealth an opportunity to request a hearing to challenge CMS's 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.
- 3.12. **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.
- 3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The Commonwealth must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the Commonwealth must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The Commonwealth must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the

consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers in accordance with 42 CFR §431.408(b)(2).

- 3.14. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 3.15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care plans, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 3.16. **Common Rule Exemption.** The Commonwealth shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects that are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs; procedures for obtaining Medicaid or CHIP benefits or services; possible changes in or alternatives to those Medicaid or CHIP programs or and procedures; or possible changes in methods or levels of payment for Medicaid and CHIP benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

#### 4. ELIGIBILITY AND ENROLLMENT

- 4.1. **Eligible Populations.** This demonstration affects mandatory and optional Medicaid and CHIP State plan populations as well as populations eligible for benefits only through the demonstration. Table 2 of section 4 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.
  - a. 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.
  - b. 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.

- 4.2. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance with STC 8.13 and Table 9. except that pregnant individuals and children up to the age of 19, of any eligible income level, are eligible for retroactive coverage up to the first day of the third month prior to the date of application for individuals that meet these definitions. The Commonwealth shall implement this STC by July 1, 2023.
- 4.3. **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 and making related calculations of deductibles and cost sharing for MassHealth Standard and CommonHealth for disabled adults, the Commonwealth may consider state veteran annuity as non-countable income as described below, and apply the five percent income disregard that is also applied to non-disabled adults.
- a. Section 6b of Chapter 115 of Massachusetts General Law authorizes a state veteran annuity payment to eligible disabled veterans and surviving Gold Star parents and spouses who have lost their child or spouse in combat. Except as described in the next sentence, the Commonwealth may consider such payment as non-countable income for purposes of determining eligibility for MassHealth Standard, MassHealth CarePlus, MassHealth Family Assistance and MassHealth Limited benefits for individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income, provided that, except with respect to disabled individuals and Programs of All-Inclusive Care for the Elderly (PACE) enrollees described in the next two sentences, individuals described above are not otherwise eligible to receive comparable coverage on the state exchange. The Commonwealth may consider such payment as non-countable income for purposes of determining eligibility for MassHealth Standard and MassHealth CommonHealth benefits for disabled individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income. In addition, the Commonwealth may consider the state veteran annuity as non-countable income for purposes of determining eligibility for individuals who would be eligible to enroll in PACE but for the receipt of a state veteran annuity or but for the inclusion of such annuity in the household income. The Commonwealth will not count the state veteran annuity when calculating a beneficiary’s premium, deductible, and/or other cost sharing obligations. The Commonwealth may treat the state veteran annuity as non-countable income in making calculations related to the post-eligibility treatment of income (PETI) rules as described in 42 C.F.R. 435.700 et seq. as applicable for all MassHealth members.

- 4.4. **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 under 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 under age 21.
  - c. Childless adults whose SNAP verified income is at or below 163 percent FPL.
  - d. 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.
- 4.5. **EAEDC Recipients.** The Medicaid agency shall extend MassHealth eligibility to individuals receiving 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 EAEDC benefits. Individuals in this demonstration population would not be described in the Adult Group, because that is a group defined by an income determination. Therefore, the enhanced increased federal match for individuals in the Adult Group is not available for this population. If an individual loses his/her EAEDC eligibility then he/she must apply for MassHealth benefits and receive an income eligibility determination in order to receive MassHealth benefits.
- 4.6. **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 Demonstration Program under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan.
- a. The hospital determined presumptive eligibility benefit for pregnant individuals and unborn children (as authorized under the Title XXI State Plan) is a full MassHealth Standard benefit.
- 4.7. **Provisional Eligibility.** MassHealth will accept self-attestation for all eligibility factors, except for disability status, immigration and citizenship status and, for certain individuals described below, income, in order to determine eligibility, and may require post-eligibility (after determination of financial or categorical 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 provide individuals with a 90-day

“provisional eligibility period,” during which MassHealth will require further verifications from the applicant.

Applicants whose self-attested income is not otherwise verified through data hubs are eligible to receive provisional eligibility consistent with the previous paragraph only if they fall within any one of the following populations:

- a. Pregnant individuals with comprehensive coverage and regardless of attested modified adjusted gross income (MAGI);
- b. Adults 21 through 64 years of age who are HIV positive and have attested MAGI income at or below 200 percent of the FPL;
- c. Individuals with breast and cervical cancer who are under 65 years of age and have attested MAGI income at or below 250 percent of the FPL; and
- d. Children under age 21.

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. For individuals not eligible for provisional eligibility as described in the previous paragraph, income verifications are required within 90 days of the date the individual receives notice requesting income verification in order to maintain original application date.

Under the demonstration, benefits for children under age 21 and pregnant individuals 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 individuals 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 individual’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 or before the end of the 90-day verification period for those not receiving provisional

eligibility, retroactive coverage is provided for the verified coverage type in accordance with Table 9. 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.

- 4.8. **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 4.7. 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.
- 4.9. **Eligibility Exclusions.** Notwithstanding the criteria outlined in this section or in Table 2, the following individuals are excluded from this demonstration. Payments or expenditures related to uncompensated care for such individuals as defined in section 11, and as described in STC 10.1, however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP). In addition, SUD services described in section 6, diversionary behavioral health services described in STC 5.11, and SMI/SED services described in section 7 provided to MassHealth eligible individuals age 65 and over as well as benefits provided to recipients of state veteran annuities, regardless of age, described in the expenditure authority, may be included as an allowable expenditure under the demonstration.
  - a. 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.

- b. Participants in Program of All-Inclusive Care of the Elderly (PACE), except as otherwise described at STC 4.3(a).
- c. Refugees served through the Refugee Resettlement Program.
- d. Individuals 65 years and older who are eligible for coverage under the State Plan and who have income within the range of Qualified Individual eligibility.

**4.10. Continuous Eligibility Period.**

- a. **Continuous Eligibility Duration.** The Commonwealth is authorized to provide continuous eligibility for the populations and associated durations specified in Table 1 below, regardless of the delivery system through which these populations receive Medicaid benefits.
  - i. For individuals who are released from a correctional institution, each individual's 12-month continuous eligibility period shall begin at the date of their release and will extend through the end of the 12th month following release. Eligible individuals for whom an eligibility determination is made after their release date but before 12 months after their release date shall be eligible for continuous eligibility through the end of the 12th month following release. This may result in continuous eligibility periods of less than 12 months for some individuals.
  - ii. For individuals experiencing homelessness who qualify for 24 months of continuous eligibility, the continuous eligibility period begins on the effective date of the individual's Medicaid eligibility under 42 CFR §435.915 or CHIP eligibility under 42 CFR 457.340(g) or effective date of the most recent renewal of eligibility. Given these individuals are continuously eligible regardless of changes in circumstances, the Commonwealth will conduct renewals of eligibility consistent with 42 CFR §§ 435.916 and 457.343 for individuals who qualify for 24 months of continuous eligibility at the end of the continuous eligibility period.
- b. **Continuous Eligibility Exceptions.** Notwithstanding subparagraph (a) and Table 1, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be terminated, suspended or re-determined, as the state determines is appropriate:
  - i. The individual is no longer a Massachusetts resident
  - ii. The individual requests termination of eligibility
  - iii. The individual dies
  - iv. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual

- v. Except as specified in subparagraph (b), continuous eligibility applies to individuals in all eligibility categories who meet the criteria in this Table 1:

<b>Table 1: Eligible Populations and Associated Duration for Continuous Eligibility</b>	
<b>Population</b>	<b>Duration of Continuous Eligibility</b>
Individuals released from a correctional institution, defined as County Correctional Facilities (CCFs), state Department of Corrections (DOC) Facilities, and Department of Youth Services (DYS) juvenile justice facilities	12 months following release
Individuals who are experiencing homelessness (i.e., individuals with a confirmed status of homelessness for at least 6 months from the Statewide Homeless Management Information System Data Warehouse or from the Department of Housing and Community Development Emergency Assistance shelter system for families experiencing homelessness.)	24 months

- c. **Beneficiary-Reported Information and Periodic Data Checks.** The Commonwealth must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information potentially relevant to the state’s evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. Additionally, the state must attempt to confirm the individual is not deceased at least once every 12 months, consistent with the data sources outlined in the state’s verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d) and 42 CFR 457.380. The state must continue to redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) and in accordance with 42 CFR 435.940 through 435.960 and the state’s verification plan developed under 42 CFR 435.945(j) or 42 CFR 457.380.

- d. As part of a deliverable titled Continuous Eligibility Implementation Plan (see STC 4.11), the Commonwealth must submit a description of the processes to perform the verifications described above. Furthermore, the Commonwealth is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. The information can be provided in the demonstration’s Annual Monitoring Reports (see STC 16.5).
- e. **Annual Updates to Beneficiary Information.** For all continuous eligibility periods longer than 12 months, the Commonwealth will be required to attempt to update



beneficiary information on an annual basis. The Commonwealth must have procedures and processes in place to accept and update beneficiary contact information and attempt to update beneficiary contact information on an annual basis, which could include annually checking data sources and partnering with managed care organizations (MCOs), Behavioral Health Prepaid Inpatient Health Plan (BH PIHP), Primary Care ACOs (PCACOs), and Accountable Care Partnership Plans (ACPPs) to encourage beneficiaries to update their contact information. This must include procedures to annually check data sources and to partner with MCO, BH PIHP, PCACOs, and ACPPs to encourage beneficiaries to update their contact information. The Commonwealth is reminded that updated contact information from third-party sources with an in-state address is not an indication of a change affecting eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to State residency, but without additional follow up by the Commonwealth per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination as to whether beneficiaries no longer meet State residency requirements.

- f. The Commonwealth must submit a description of the processes to update beneficiary contact information on an annual basis in an Implementation Plan, as described in STC 4.11. Furthermore, each demonstration year, through the Annual Monitoring Reports (see STC 16.5), the Commonwealth must submit to CMS a summary of activities and outcomes from these efforts.

4.11. **Continuous Eligibility Implementation Plan.** The Commonwealth must submit to CMS no later than 90 days after the approval of the demonstration extension a Continuous Eligibility Implementation Plan describing the timeline for implementation, the processes to perform verifications on beneficiary residency or other checks and to update beneficiary contact information on an annual basis, as described in STCs 4.10(c)-(d). The Commonwealth is required to submit a revised Implementation Plan if CMS provides any feedback on the original submission no later than 60 days after receiving CMS's comments. Once approved, the Implementation Plan will become affixed to the STCs as Attachment O.

4.12. **Mandatory and Optional State Plan Groups.** Massachusetts includes in the demonstration almost all the mandatory and optional populations under age 65 eligible under the state plan. The Massachusetts title XIX and XXI state plans establish and define all covered eligibility groups that do not derive their eligibility authority from this demonstration. Benefits are described in the title XIX and XXI state plans and these STCs. All MassHealth Standard, CommonHealth, CarePlus and Family Assistance members who have access to qualifying private health insurance may receive premium assistance plus wrap-around benefits.

Coverage for mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in the waiver list as further detailed in these STCs, or as made inapplicable to the expenditure authorities for this demonstration that may provide demonstration-only benefits to state plan groups.

Any Medicaid SPAs modifying the eligibility standards and methodologies for these eligibility groups will apply to this demonstration. Massachusetts includes in the demonstration Lawfully Present infants, children under age 21, and pregnant individuals eligible under any coverage type in this demonstration, one of the state plans, or both.

- 4.13. **Other Demonstration Expansion Populations.** Coverage for these populations, which derive their eligibility from this demonstration, is subject to all applicable Medicaid laws and regulations, except as expressly not applicable to the relevant expenditure authority, as further detailed in the STCs. This includes the application of modified adjusted gross income (MAGI) based methodologies and exceptions for non-MAGI based methodologies, as appropriate, used to determine financial eligibility for expansion populations. The general categories of populations affected, or made eligible, by the demonstration are:

**Table 2: MassHealth State Plan Base Populations**

<b>Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)</b>	<b>Federal Poverty Level (FPL) and/or Other Qualifying Criteria</b>	<b>Funding Stream</b>	<b>Expenditure and Eligibility Group (EG) Reporting</b>	<b>MassHealth Demonstration Program</b>	<b>Comments</b>
AFDC-Poverty Level infants	< Age 1: 0 through 185%	Title XIX	Base Families	Standard	
Medicaid Expansion infants	< Age 1: 185.1 through 200%	<ul style="list-style-type: none"> <li>• Title XIX if insured at the time of application</li> <li>• Title XXI if uninsured at the time of application, as a Medicaid Expansion Child</li> <li>• Funded through title XIX if title XXI is exhausted</li> </ul>	1902(r)(2) Children  1902(r)(2) XXI RO	Standard	Medicaid Expansion child is described both in the Title XXI plan and authorized under this 1115 demonstration, including premium assistance for ESI or direct benefits.
AFDC-Poverty Level Children and Independent Foster Care Adolescents	Age 1 - 5: 0 through 133%  Age 6 - 17: 0 through 114%  Independent Foster Care Adolescents aged out of DCF up to age 21 without regard to income or assets	Title XIX	Base Families	Standard	

**Table 2: MassHealth State Plan Base Populations**

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
	Former Foster Care Children up to age 26 without regard to income or assets				
<p>AFDC-Poverty Level Children</p> <p>Medicaid Expansion Children I</p>	<p>Age 6 - 17: 114.1% through 133%</p> <p>Age 18: 0 through 133%</p>	<ul style="list-style-type: none"> <li>Title XIX if insured at the time of application</li> <li>Title XXI if uninsured at the time of application as a Medicaid Expansion Child</li> <li>Funded through title XIX if title XXI is exhausted</li> </ul>	<p>Base Families</p> <p>Bas Fam XXI RO</p>	Standard	Medicaid Expansion child is described both in the Title XXI plan and authorized under this 1115 demonstration, including premium assistance for ESI or direct benefits.
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	<ul style="list-style-type: none"> <li>Title XIX if insured at the time of application</li> <li>Title XXI if uninsured at the time of application, as a Medicaid expansion child</li> </ul>	<p>1902(r)(2) Children</p> <p>1902(r)(2) XXI RO</p>	Standard	Medicaid Expansion child is described both in the Title XXI plan and authorized under this 1115 demonstration including premium assistance for ESI or direct benefits.

**Table 2: MassHealth State Plan Base Populations**

<b>Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)</b>	<b>Federal Poverty Level (FPL) and/or Other Qualifying Criteria</b>	<b>Funding Stream</b>	<b>Expenditure and Eligibility Group (EG) Reporting</b>	<b>MassHealth Demonstration Program</b>	<b>Comments</b>
		<ul style="list-style-type: none"> <li>Funded through title XIX if title XXI is exhausted</li> </ul>			
Medicaid Expansion Children II	Ages 19 and 20: 133.1 through 150%	Title XIX	1902(r)(2) Children	Standard	
5 year bar and other non-qualified lawfully present infants and children	< Age 1: 0-200% Age 1-18: 0-150%	Title XXI CHIP Medicaid expansion funding at option of state agency, as authorized under the Title XXI State Plan	1902(r)(2) Children  1902(r)(2) XXI RO	Standard	
Pregnant individuals	0 through 185%	Title XIX	Base Families	Standard	Pregnant individuals
Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance	0 through 133%	Title XIX	Base Families	Standard	Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance
Disabled children under age 19	0 through 150%	Title XIX	Base Disabled	Standard	
Disabled adults ages 19 through 64	0 through 114%	Title XIX	Base Disabled	Standard	
Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	Base Disabled	CommonHealth	
Pregnant individuals	185.1 through 200%	Title XIX	1902(r)(2) Children	Standard	
“Non-qualified Aliens” or “Protected Aliens”	Otherwise eligible for Medicaid under the State Plan	Title XIX	Base Families	Limited	Member eligible for emergency services only

**Table 2: MassHealth State Plan Base Populations**

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
			Base Disabled  1902(r)(2) Children  1902(r)(2) Disabled  New Adult Group		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	1902(r)(2) Disabled	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 • Require hospital or nursing facility level of care • Income < or = to \$72.81, or deductible • \$0 through \$2,000 in assets	Title XIX	Base Disabled	Standard	Income and assets of their parents are not considered in determination of eligibility
Children receiving title IV-E adoption assistance	Age 0 through 18	Title XIX	Base Families	Standard	Children placed in subsidized adoption under title IV-E of the Social Security Act

**Table 2: MassHealth State Plan Base Populations**

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"> <li>0 through 300% SSI Federal Benefits Rate</li> <li>\$0 through \$2,000 in assets</li> </ul>	Title XIX	Base Disabled	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	<ul style="list-style-type: none"> <li>Ages 19 and 20: 0 through 133%</li> <li>Individuals with HIV or breast or cervical cancer: 0 through 133%</li> <li>Individuals receiving services or on a waiting list to receive services through the Department of Mental Health: 0 through 133%</li> <li>Adults ages 21-64: 0 through 133%</li> </ul>	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
TANF	Referred eligibility	Title XIX	Base Families	Standard	

**Table 3: Demonstration Expansion Populations**

Population Name	Population Description	Benefits
CommonHealth Adults	<p>Adults aged 19 through 64 who are totally and permanently disabled and not eligible for comprehensive coverage under the Massachusetts state plan. For 19 and 20 year olds, income is above 150% of the FPL. Income above 133% FPL for adults aged 21 through 64. Individuals who have retained CommonHealth coverage for at least 10 years may retain coverage after age 65, regardless of employment status. These individuals must meet eligibility requirements for MassHealth Standard (or be subject to a spend down to qualify for MassHealth Standard).</p> <p>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. Net income above 100% FPL and/or Assets &gt;\$2,000.</p>	<p>CommonHealth benefits as described in the Medicaid state plan and benefits described in these STCs. Individuals aged 21-64 who met the asset test under the State plan receive MassHealth Standard, individuals aged 19 and 20 must also meet the deductible requirements. For adults aged 65 and over, no deductible and no asset test, provided they are first determined to be ineligible for MassHealth Standard under non MAGI eligibility rules (which includes an asset test).</p> <p>Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.</p>



**Table 3: Demonstration Expansion Populations**

Population Name	Population Description	Benefits
CommonHealth Children	<p>Children from birth through age 18 who are totally and permanently disabled with incomes greater than 150% of the FPL and who are not eligible for comprehensive coverage under the Medicaid state plan due to income or under the CHIP state plan due to having insurance at application, or if the Title XXI allotment is exhausted</p> <p>Higher income children with disabilities if insured at the time of application or when Title XXI funding is exhausted:</p> <ul style="list-style-type: none"> <li>• &lt; Age 1: 200.1% through 300% FPL</li> <li>• Ages 1 - 18: 150.1% through 300% FPL</li> </ul> <p>Higher income children (above 300% FPL) with disabilities ages 0 through 18</p>	<p>CommonHealth benefits as described in the CHIP state plan and benefits described in these STCs.</p> <p>Certain children derive eligibility from both the authority granted under this demonstration and the separate XXI program, including premium assistance for ESI or direct benefits. These are disabled children with income over Medicaid and up to 300% who are uninsured at application. They are eligible under the CHIP State Plan but also use the authorities granted under the 1115 demonstration.</p> <p>Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.</p>

**Table 3: Demonstration Expansion Populations**

Population Name	Population Description	Benefits
Out-of-state Former Foster Care Youth	<p>Youth under age 26 who were in foster care under the responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18 (or a higher age at which the state’s or Tribe’s foster care assistance ends), and were enrolled in Medicaid under that state’s Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.</p>	<p>MassHealth Standard benefits, as described in the Medicaid state plan and Section 5 of these STCs.</p>
Family Assistance Children	<p>Non-disabled children with incomes above 150% through 300% of the FPL, if insured at the time of application or Title XXI funding is exhausted, who are not otherwise eligible under the Medicaid state plan due to family income or under the CHIP state plan due to having insurance at application.</p> <ul style="list-style-type: none"> <li>• Children ages 1 through 18: above 150% through 300% FPL</li> <li>• Children less than age 1: Above 200% through 300% FPL</li> </ul>	<p>Family Assistance benefits as described in the CHIP state plan and Section 5 of these STCs.</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 including premium assistance for ESI or direct benefits. The premium assistance payments and FFP will be based on the children’s eligibility. Parents are covered incidental to the child.</p> <p>A benefit wrap is provided for MassHealth covered services not provided through the ESI</p>

**Table 3: Demonstration Expansion Populations**

Population Name	Population Description	Benefits
Family Assistance HIV/AIDs	Individuals with HIV not otherwise eligible under the Medicaid state plan with income above 133% through 200% FPL.	<p>Family Assistance benefits as described in Section 5 of these STCs. This includes 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 HIV-positive health status.</p> <p>Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.</p> <p>Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.</p>
EAEDC	Individuals who receive Emergency Aid to Elders, Disabled and Children (EAEDC). Individuals in this eligibility group are eligible for MassHealth Standard based on receipt of EAEDC benefits, not an income determination.	MassHealth Standard

**Table 3: Demonstration Expansion Populations**

Population Name	Population Description	Benefits
Provisional Eligibility	Self-Attested income level to qualify for other group, pending verification. Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority in accordance with STC 4.7.	MassHealth Standard
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. The individuals are ineligible for MassHealth Standard and are eligible for QHP up to 400% FPL. 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 5.1.	
Breast and Cervical Cancer Demonstration Program (BCCDP)	Individuals determined eligible for the BCCDP under the demonstration with income above 133.1% of the FPL through 250% of the FPL	MassHealth Standard (ABP)
Presumptively Eligible	Individuals determined presumptively eligible for HIV-Family Assistance (with income above 133% FPL through 200% FPL) or the BCCDP (with income above 133% through 250% FPL) under the demonstration by qualified hospitals that elect to do so.	MassHealth Standard (ABP) (BCCDP) Family Assistance (HIV)

**Table 3: Demonstration Expansion Populations**

<b>Population Name</b>	<b>Population Description</b>	<b>Benefits</b>
Continuous Eligibility	<p>Individuals released from a correctional facility who no longer would be eligible for Medicaid or CHIP if subject to redetermination but are still within a 12-month continuous eligibility period following the date of the individual's release.</p> <p>Individuals who are experiencing homelessness as defined in Table 1 of STC 4.10(b) who would no longer be eligible for Medicaid or CHIP if subject to redetermination but are still within a 24-month continuous eligibility period.</p>	Benefits by CHIP or Medicaid eligibility group according to most recent eligibility determination.

## 5. DEMONSTRATION PROGRAMS AND BENEFITS

- 5.1. **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.
- 5.2. **Demonstration Program Benefits.** Massachusetts provides health care benefits through specific benefit programs. The benefit program for which an individual is eligible is based on the criteria outlined in Tables 2 and 3 of Section 4 of the STCs. Table 4 in STC 5.10, provides a side-by-side analysis of the benefits offered through these MassHealth programs.
- 5.3. **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.
  - a. MassHealth's Standard Alternative Benefit Plan (ABP) is for individuals in the 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.
  - b. 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 8.13.
  - c. MassHealth Standard benefits include, for individuals with incomes at or below 165 percent of FPL who are also eligible for Medicare, (1) payment of monthly Medicare Part B premiums, including through the Qualifying Individual program (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.

- 5.4. **MassHealth CarePlus.** MassHealth’s CarePlus ABP is for individuals in the 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 8.13.
- 5.5. **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 and are uninsured according to the Commonwealth.
- 5.6. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under MassHealth 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 8.13. 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 for children, including those eligible under the Title XXI State Plan if uninsured at application and for adults under age 65 without applying an asset test. Effective no later than July 1, 2023, individuals over 65 that have retained coverage for at least 10 years are not subject to paid employment hours restrictions;
- a. For CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth may pay the cost of the monthly Medicare Part B premium until June 30, 2026; provided, however, that the Commonwealth may continue to accept new applicants or re-applicants into the program who apply or reapply on or before December 30, 2025, and any member determined eligible for the program prior June 30, 2026 may continue to be enrolled until June 30, 2026, provided that they continue to meet all other eligibility requirements. Effective July 1, 2026, the Commonwealth must either discontinue the program, or have submitted and received approval of an amendment to the demonstration for a Part B premium subsidy design that is consistent with all applicable federal legal requirements. Should the Commonwealth decide to discontinue the program, it must follow the phase-out rules as described in STC 3.9, and all applicable statutory and regulatory requirements.
- 5.7. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under MassHealth 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 accordance with STC 8.13 and Table 9. There are two separate categories of eligibility under Family Assistance:

- a. **Family Assistance-HIV/AIDS.** As referenced in Table 3 above, for persons with HIV/AIDS whose income is above 133 percent and less than or equal to 200 percent of the FPL would be eligible for the 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 3 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 under the Title XXI State Plan if uninsured at application, and under the 1115 Demonstration if insured at application or when the CHIP allotment has been exhausted. 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.

5.8. **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.

5.9. **Former Foster Care Youth.** Individuals enrolled as "Former Foster Care Youth" (both in- and out-of-state former foster care youth) as described in Table 3 above are eligible to receive MassHealth Standard.

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



<b>Table 4: Summary of MassHealth Direct Coverage Benefits</b>				
<b>Benefits</b>	<b>Standard/ Standard ABP</b>	<b>CommonHealth</b>	<b>Family Assistance</b>	<b>CarePlus</b>
<b>EPSDT</b>	X	X		
<b>Inpatient Acute Hospital</b>	X	X	X	X
<b>Adult Day Health</b>	X	X		
<b>Adult Foster Care**</b>	X	X		
<b>Ambulance (emergency)</b>	X	X	X	X
<b>Audiologist Services</b>	X	X	X	X
<b>Behavioral Health Services (mental health and substance abuse)</b>	X	X	X	X
<b>Chapter 766 Home Assessment***</b>	X	X	X	
<b>Chiropractic Care</b>	X	X	X	X
<b>Chronic Disease and Rehabilitation Hospital Inpatient</b>	X	X	Limited	X
<b>Chronic Disease and Rehabilitation Hospital Outpatient</b>	X	X	X	X
<b>Community Health Center (includes FQHC and RHC services)</b>	X	X	X	X
<b>Day Habilitation****</b>	X	X		
<b>Dental Services</b>	X	X	X	X
<b>Diversionsary Behavioral Health Services</b>	X	X	X	X
<b>Durable Medical Equipment and Supplies</b>	X	X	X	X
<b>Early Intervention</b>	X	X	X	

<b>Table 4: Summary of MassHealth Direct Coverage Benefits</b>				
<b>Benefits</b>	<b>Standard/ Standard ABP</b>	<b>CommonHealth</b>	<b>Family Assistance</b>	<b>CarePlus</b>
<b>Family Planning</b>	X	X	X	X
<b>Group Adult Foster Care</b>	X	X		
<b>Hearing Aids</b>	X	X	X	X
<b>Home Health</b>	X	X	X	X
<b>Hospice</b>	X	X	X	X
<b>Laboratory/X- ray/ Imaging</b>	X	X	X	X
<b>Medically Necessary Non- Emergency Transport</b>	X	X		X
<b>Nurse Midwife Services</b>	X	X	X	X
<b>Nurse Practitioner Services</b>	X	X	X	X
<b>Orthotic Services</b>	X	X	X	X
<b>Outpatient Hospital</b>	X	X	X	X
<b>Outpatient Surgery</b>	X	X	X	X
<b>Oxygen and Respiratory Therapy Equipment</b>	X	X	X	X
<b>Personal Care</b>	X	X		
<b>Pharmacy</b>	X	X	X	X
<b>Physician</b>	X	X	X	X
<b>Podiatry</b>	X	X	X	X
<b>Private Duty Nursing</b>	X	X		
<b>Prosthetics</b>	X	X	X	X
<b>Rehabilitation</b>	X	X	X	X
<b>Renal Dialysis Services</b>	X	X	X	X
<b>Skilled Nursing Facility</b>	X	X	Limited	Limited

Table 4: Summary of MassHealth Direct Coverage Benefits				
Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
Speech and Hearing Services	X	X	X	X
Targeted Case Management	X	X		X
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X
Vision Care	X	X	X	X
<i>Chart Notes</i>				
<p><b>**Adult Foster Care Services:</b> 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</p>				
<p><b>*** Chapter 766 Home Assessments:</b> 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.</p>				
<p><b>**** Day Habilitation Services:</b> 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.</p>				

5.11. **Diversions Behavioral Health Services.** Diversions 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. Diversions 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 diversions 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 diversions 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. No Diversionary Behavioral Health Services under this STC 5.11 may be provided within an institution for mental disease (IMD), except when Program of Assertive Community Treatment (PACT) or Community Support Program (CSP) services are provided in an IMD as part of a beneficiary’s discharge planning from the IMD to the community.

Diversionary 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.

- a. Any MassHealth member under the demonstration who is enrolled in managed care may receive diversionary services, dependent on their clinical need for the services. Managed Care Organizations (i.e., MassHealth MCOs and Accountable Care Partnership Plans), and the Behavioral Health Prepaid Inpatient Health Plan (PIHP) may identify appropriate individuals to receive diversionary services. Managed care plans maintain a network of diversionary services and arrange, coordinate, and oversee the provision of medically necessary diversionary services, as described in Table 5. Diversionary services are included in risk-based capitation rates in accordance with 42 CFR 438.
- b. MassHealth members enrolled in fee for service (FFS) may receive Community Support Program (CSP), Program of Assertive Community Treatment, Structured Outpatient Addiction Program, and Intensive Outpatient Program services, as well as the state plan services, described in Table 5, dependent on their clinical need for the services.

<b>Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration</b>		
<b>Diversionary Behavioral Health</b>	<b>Setting</b>	<b>Description of Services</b>
Community Support Program (CSP)	Non-24-hour facility, and/or discharge planning provided in a 24 hour facility, including a facility that qualifies as an IMD	<p>All CSP services will be provided as described in this STC 5.11 under the Diversionary Behavioral Health authority through 3/31/23. Specialized CSP services will be provided as described in this STC 5.11 as of 4/1/23, under the HRSN authority, see details in Section 15.</p> <p>An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long-standing history of a psychiatric or substance use</p>

<b>Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration</b>		
<b>Diversionary Behavioral Health</b>	<b>Setting</b>	<b>Description of Services</b>
		<p>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.</p> <p>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> <p>When provided to chronically homeless individuals or individuals with justice involvement living in the community<sup>1</sup>, CSP services fall into the following domains, as applicable to the individual's needs:</p> <ul style="list-style-type: none"> <li>• Assisting Members in enhancing daily living skills; <ul style="list-style-type: none"> <li>○ Identifying and addressing barriers to attaining and maintaining community tenure</li> <li>○ Supporting members to mitigate barriers to community tenure, including coaching and connection with social services that assist them with issues such as credit history, presence of criminal record, and poor housing history</li> <li>○ Coaching members on budget strategies and/or supporting Members to connect with money</li> </ul> </li> </ul>

<sup>1</sup> Individuals with justice involvement living in the community are covered individuals released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.

**Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration**

Diversionary Behavioral Health	Setting	Description of Services
		<p>management services, including financial counselors and representative payees</p> <ul style="list-style-type: none"> <li>○ Support to gather documentation such as government identification documents, medical records</li> <li>○ Linkages to education, vocational training/services</li> <li>● Providing service coordination and linkages; <ul style="list-style-type: none"> <li>○ Referrals to healthcare providers</li> <li>○ Providers make reasonable efforts to assist Members identify and/or facilitate transportation options, including community-based transportation resources, such as public transportation and/or community- or publicly-subsidized transportation options</li> <li>○ Collaborating with state agencies, outpatient or community-based providers, Emergency Services Programs (ESPs), criminal justice entities, or other significant entities on service and discharge planning.</li> <li>○ Discharge planning that involves collaterals as appropriate. Collaterals include state agencies, community-based programs, criminal justice entities, and other non-health care community supports</li> <li>○ Provider coordinates care with Members’ primary</li> </ul> </li> </ul>

**Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration**

Diversionary Behavioral Health	Setting	Description of Services
		<p>care providers to be knowledgeable of medical conditions, to assess Members' compliance with medical treatment, and to assist with mitigating related barriers</p> <ul style="list-style-type: none"> <li>• Assisting Members with obtaining benefits, housing, and health care;               <ul style="list-style-type: none"> <li>○ Providers work with housing agencies to obtain documentation of housing status</li> <li>○ Working with Members to identify transitional supports for move-in</li> <li>○ Connecting Members to housing search assistance, and helping to coordinate search(es)</li> <li>○ Linkages to primary and preventive health services</li> <li>○ Linkages to behavioral health and substance use disorder treatment</li> <li>○ Assistance with enrolling in community benefits (Social Security benefits, SNAP, VA benefits, MassHealth, Medicare, etc.) including obtaining needed documentation and helping to complete applications and attend appointments</li> <li>○ Working with Member to identify resources for home modifications as needed</li> </ul> </li> <li>• Developing a crisis plan in the event of a psychiatric crisis;               <ul style="list-style-type: none"> <li>○ Refer the Member to outpatient provider</li> <li>○ Refer the Member to an ESP</li> </ul> </li> </ul>

**Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration**

Diversionary Behavioral Health	Setting	Description of Services
		<ul style="list-style-type: none"> <li>○ Implement other interventions such as Member’s safety plan</li> <li>○ Collaborate with providers (including ESPs) and natural supports</li> <li>● Providing prevention and intervention;               <ul style="list-style-type: none"> <li>○ Comprehensive assessment of needs (behavioral health, medical, substance use, developmental, and social history; linguistic and cultural background; mental status examination; medications and allergies; barriers to housing; diagnosis and clinical formulation supported by the clinical data gathered, rationale for treatment, and recommendations; level of functioning; justice involvement; criminogenic needs; and key providers) to identify ways to mitigate barriers to accessing clinical treatment and attaining the skills to obtain and maintain community tenure</li> <li>○ Developing a service plan/treatment plan (linkages to health, behavioral health, and substance use treatment; and addressing criminogenic needs)</li> <li>○ Assisting Members to prepare for transition to permanent supportive housing by linking Members to entities that provide transitional assistance resources. This</li> </ul> </li> </ul>



**Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration**

Diversionary Behavioral Health	Setting	Description of Services
		<p>may include referrals to houses of worship, local housing authorities and non-profit agencies. Transitional assistance includes non-recurring household set-up expenses</p> <ul style="list-style-type: none"> <li>○ Discharge planning that involves collaterals</li> <li>○ Early intervention for potential issues/behavior intervention affecting tenancy or community tenure</li> </ul> <ul style="list-style-type: none"> <li>● Fostering empowerment and recovery, including linkages to peer support and self-help groups <ul style="list-style-type: none"> <li>○ Recovery, wellness and empowerment principles and practices are incorporated in service delivery, trainings, and quality improvement activities</li> <li>○ Facilitates the use of formal and informal resources including community and natural support systems, wellness programs, vocational assistance programs, and peer and self-help supports and services</li> <li>○ Provider educates Members and their natural supports about substance use and psychiatric disorders, recovery and medications, and links with regular health services</li> </ul> </li> </ul>
Partial Hospitalization*	Non-24-hour facility	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

<b>Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration</b>		
<b>Diversionary Behavioral Health</b>	<b>Setting</b>	<b>Description of Services</b>
		therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.
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.	24-hour facility	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.
Psychiatric Day Treatment*	Non-24-hour facility	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.
Intensive Outpatient Program (IOP)*	Non-24-hour facility	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.
Structured Outpatient Addiction Program (SOAP)*	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

**Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration**

Diversionary Behavioral Health	Setting	Description of Services
		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 individuals, adolescents and adults requiring 24-hour monitoring.
Program of Assertive Community Treatment (PACT)	Non-24-hour facility, and/or discharge planning provided in a 24 hour facility, including a facility that qualifies as an IMD	<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 per day, seven days per week, 365 days per year.</p>
Emergency Services Program (to be renamed Mobile Crisis Intervention as of January 2023)*	Non-24-hour facility	Services provided through designated contracted ESPs / Mobile Crisis Intervention providers, 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.

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. The state intends to submit state plan amendments to include IOP and SOAP in the state plan on or after January 1, 2023.

\*\* 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.

## 6. OPIOID USE DISORDER/SUBSTANCE USE DISORDER

Since 2016, the Commonwealth has provided access to Substance Use Disorder (SUD) treatment services and ongoing recovery support to improve beneficiary health and increase rates of long-term recovery. During the MassHealth demonstration period, the Commonwealth seeks to continue achieving the following goals:

- Increase rates of identification, initiation, and engagement in treatment for SUD;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improve access to care for physical health conditions among beneficiaries with SUD.

6.1. **Opioid Use Disorder (OUD)/Substance Use Disorder Program (SUD).** Under this demonstration component, MassHealth members, except those in MassHealth Limited, will continue to have access to high-quality, evidence-based OUD and other SUD treatment services including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise reimbursable expenditures under section 1903 of the Act. The Commonwealth will continue to be eligible to receive FFP for Medicaid beneficiaries residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be reimbursable if the beneficiary were not residing in an IMD. The Commonwealth will continue to aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 6.5 below, to ensure short-term residential treatment stays.

The OUD/SUD benefits, as outlined in the table below, reflect a continuum of care that ensures that clients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. The American Society of Addiction Medicine (ASAM) Criteria Assessment shall continue to be used for all beneficiaries to determine placement into the appropriate level of care. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

As is currently the case, MassHealth anticipates that the Department of Public Health, Bureau of Substance Addiction 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 6: SUD Services**

<b>Service for People with SUD</b>	<b>Population</b>	<b>Setting</b>	<b>Definition of Service</b>
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 on or after 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 Services and 24-hour community-based family SUD treatment 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. 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.

**Table 6: SUD Services**

Service for People with SUD	Population	Setting	Definition of Service
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	All MassHealth members, except those in MassHealth Limited		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.
Clinical Stabilization Services	All MassHealth members, except those in MassHealth Limited	24-hour facility, including IMDs	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 individuals receive coordination of their obstetrical care.
Acute treatment services	All MassHealth members, except those in MassHealth Limited	24-hour facility, including IMDs	24-hour, seven days per 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;

Table 6: SUD Services			
Service for People with SUD	Population	Setting	Definition of Service
			individual and group counseling; psychoeducational groups; and discharge planning.  Pregnant individuals 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, and ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.
Inpatient treatment services*	All MassHealth members, except those in MassHealth Limited	Hospitals, including IMDs	Medically managed addiction treatment services that provides 24 hour nursing care and daily physician care. (ASAM Level 4)
<i>Chart Notes</i>			
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, ACO, or the behavioral health PIHP. The Commonwealth's average length of stay (ALOS) in SUD treatment for persons admitted into all DPH-licensed by or contracted ASAM Level 3.7, 3.5 and 3.1 programs during state fiscal year 2015 was 16.1 days.			
* This is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment.			

**6.2. SUD Program Requirements** The following requirements that reflect key goals and objectives of this SUD project apply to this demonstration:

- a. **Access to Critical Levels of Care for OUD and other SUDs.** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management.

- b. **Use of Evidence-based SUD-specific Patient Placement Criteria.** Providers will assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines
- c. **Patient Placement.** The state will continue to employ a utilization management approach, in accordance with state law, such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.
- d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** Residential treatment providers must align with the program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. Residential treatment providers must also be in compliance with state licensure requirements for substance use disorder treatment programs.
- e. **Standards of Care for Residential Treatment Settings.** The state will review residential treatment providers to ensure that providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.
- f. **Standards of Care for Medication Assisted Treatment.** Residential treatment providers must offer Medication Assisted Treatment (MAT) on-site or facilitate access to MAT off-site.
- g. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OD.** The state must ensure sufficient provider capacity in the critical levels of care throughout the state, including those that offer MAT.
- h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OD.** The state has implemented opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.
- i. **Improved Care Coordination and Transitions between levels of care.** The state will continue to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.



- j. **SUD Health IT Plan.** Implementation of the milestones and metrics as detailed in STC 6.3 and Attachment D.

6.3. **SUD Health Information Technology Plan (“SUD Health IT Plan”).** The SUD Health IT plan applies to all states where the health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable SUD Health IT Plan(s), to be included as Attachment D to the STCs, to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

- a. The SUD Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD Health IT Plan(s) will also be used to identify areas of health IT ecosystem improvement. The SUD Health IT Plan must include implementation milestones and projected dates for achieving them (see Attachment D), and must be aligned with the Commonwealth’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the Commonwealth’s SMI IT Health Plan.
- b. The Commonwealth must include in its Monitoring Protocol (see STC 6.5) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.
- c. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Report (see STC 16.5).
- d. As applicable, the Commonwealth should advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SUD health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
- e. Where there are opportunities at the state and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the Commonwealth should use the federally-recognized standards, barring another compelling state interest.
- f. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the Commonwealth should use the federally-recognized ISA standards, barring no other compelling state interest.
- g. Components of the SUD Health IT Plan include:

- i. The SUD Health IT Plan must describe the Commonwealth’s goals, each DY, to enhance the Commonwealth’s prescription drug monitoring program (PDMP).<sup>2</sup>
- ii. The SUD Health IT Plan must address how the Commonwealth’s PDMP will enhance ease of use for prescribers and other Commonwealth and federal stakeholders.<sup>3</sup> This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the Commonwealth will support clinicians in consulting the PDMP and reviewing the patients’ history of controlled substance prescriptions prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
- iii. The SUD Health IT Plan will, as applicable, describe the Commonwealth’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the Health IT Plan must describe current and future capabilities regarding PDMP queries—and the Commonwealth’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The Commonwealth will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
- iv. The SUD Health IT Plan will describe how the activities described in STC 6.3(a) through (c) above will support broader Commonwealth and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.<sup>4</sup>
- v. The SUD Health IT Plan will describe the Commonwealth’s current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
- vi. In developing the SUD Health IT Plan, states should use the following resources:
  1. States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).

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<sup>2</sup> Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the “opioid” epidemic and facilitate a nimble and targeted response.

<sup>3</sup> *Ibid.*

<sup>4</sup> Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

2. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6.4. **SUD Transition Period.** To avoid service disruption for beneficiaries as the Commonwealth aligns with expectations in SMDL #17-003 and these STCs, CMS is authorizing a SUD transition period until March 31, 2023. During this period, the Commonwealth can continue to claim FFP for services authorized under the demonstration. The SUD Health IT Plan must be submitted to CMS no later than 60 days after the demonstration effective date and must be approved by the end of the transition period in order for the Commonwealth to continue claiming FFP after March 31, 2023.

6.5. **SUD Monitoring Protocol.** The Commonwealth must submit a Monitoring Protocol for the SUD programs authorized by this demonstration within 150 calendar days after approval of the demonstration. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The Commonwealth must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS’s comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs as Attachment G. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the SUD Monitoring Protocol must include:

- a. An assurance of the Commonwealth’s commitment and ability to report information relevant to each of the program implementation areas listed in STC 6.2 and reporting relevant information to the Commonwealth’s SUD Health IT Plan described in STC 6.3;
- b. A description of the methods of data collection and timeframes for reporting on the Commonwealth’s progress on required measures as part of the monitoring and reporting requirements described in Section 16 of the STCs; and
- c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

6.6. **SUD Mid-Point Assessment.** The Commonwealth must contract with an independent entity to conduct an independent Mid-Point Assessment by September 30, 2025. This

timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the Commonwealth should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including SUD treatment providers), beneficiaries, community groups, and other key partners.

- a. The Commonwealth must require that the assessor provide a Mid-Point Assessment Report to the Commonwealth that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The Commonwealth must provide a copy of the report to CMS no later than 60 calendar days after September 30, 2025 and the Commonwealth must brief CMS on the report. The Commonwealth must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.
- b. For milestones and measure targets at medium to high risk of not being achieved, the Commonwealth must submit to CMS proposed modifications to the SUD Monitoring Protocol, as appropriate, for mitigating these risks. Any modifications to the Monitoring Protocol are subject to CMS approval.
- c. Elements of the Mid-Point Assessment must include at least:
  - i. An examination of progress toward meeting each milestone and timeframe, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;
  - ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
  - iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
  - iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments, or to other pertinent factors that the Commonwealth can influence that will support improvement; and
  - v. An assessment of whether the Commonwealth is on track to meet the SUD budget neutrality requirements in these STCs.

**6.7. Unallowable Expenditures Under the SUD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the Commonwealth

may not receive FFP under any expenditure authority approved under the SUD expenditure authority for any of the following:

- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

## **7. SERIOUS MENTAL ILLNESS (SMI) AND SERIOUS EMOTIONAL DISTURBANCE (SED)**

**7.1. SMI/SED Program Benefits.** FFP is available for otherwise covered Medicaid services, including inpatient psychiatric hospital services, and services authorized under this demonstration, including community crisis stabilization (CCS) services and community based acute treatment for children and adolescents (CBAT), furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) or serious emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an IMD. MassHealth beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI/SED treatment services. These SMI and SED services will range in intensity from short-term acute care in inpatient settings for SMI and SED, to ongoing chronic care for these conditions in cost effective community-based settings. CCS will be available to all MassHealth members, except those in MassHealth Limited. CBAT will be available to children and adolescents enrolled in managed care. The Commonwealth will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The Commonwealth must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration's SMI/SED programs, to be monitored pursuant to the SMI/SED Implementation Plan as outlined in STC 7.2 and STC 7.5 below.

### **7.2. SMI/SED Implementation Plan.**

- a. The Commonwealth must submit the SMI/SED Implementation Plan within 90 calendar days after approval of the SMI/SED amendment to this demonstration. If applicable, the Commonwealth must submit a revised SMI/SED Implementation Plan within 60 calendar days after receipt of CMS's comments. The Commonwealth may not claim FFP for services provided in IMDs to beneficiaries residing in IMDs primarily to receive treatment for SMI/SED under expenditure authority #15 until CMS has approved the SMI/SED Implementation Plan and the SMI/SED Financing Plan described in STC 7.2(d). After approval of the required implementation and financing plan, FFP will be available prospectively, but not retrospectively.
- b. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment F, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan, within 90 calendar days after approval of the SMI/SED amendment to this Demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this amendment to the demonstration.

Once approved, failure to progress in meeting the milestone goals agreed upon by the Commonwealth and CMS will result in a funding deferral as described in STC 7.7.

- c. At a minimum, the SMI/SED Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:
  - i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.
    1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI and SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
    2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD. Facilities providing Youth Community Crisis Stabilization and Community Based Acute Treatment for Children and Adolescents (CBAT) services must meet these requirements.<sup>5</sup> A transition period to comply with rules is permitted and described in STC 7.9.
    3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification

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<sup>5</sup> Section 2110(b)(2)(A) of the Social Security Act (the Act) excludes children residing in an IMD from being eligible for a separate CHIP at application or renewal, but as long as a child is not applying for, or renewing coverage, while a resident of an IMD, the child remains eligible for CHIP state plan services while in an IMD consistent with the requirements of 42 CFR 457.310(b)(2).

requirements as well as a national accrediting entity's accreditation requirements.

4. Use of a utilization review entity (for example, a MCO or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and, in accordance with state law, to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities.
5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues).
6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitioning to Community-Based Care.

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment).
2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who

may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available.

3. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to.
4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers).
5. Implementation of strategies to develop and/or enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

1. Establishment of a process to annually assess the availability of mental health services throughout the Commonwealth, particularly crisis stabilization services, and updates on steps taken to increase availability.
2. Commitment to implementation of the financing plan described in STC 7.2(d).
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible.
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment, Including Through Increased Integration.

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment



sooner, including through supported employment and supported education programs.

2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers.
3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

v. **Health IT Plan.** Implementation of the milestones and metrics as detailed in STC 7.4.

d. **SMI/SED Financing Plan.** As part of the SMI/SED implementation plan required by STC 7.2(a), the Commonwealth must submit, within 90 calendar days after approval of the SMI/SED amendment to this Demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment F and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan within 90 days of the approval of the SMI/SED amendment to this Demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

- i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and
- ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

7.3. **Maintenance of effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding according to the baseline figures provided by the state at the time of application. The annual MOE will be reported and monitored as part of the annual monitoring report described in STC 16.5.

7.4. **SMI/SED Health Information Technology Plan (“SMI/SED Health IT Plan”).** The SMI/SED Health IT plan applies to all states where the health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011, states must submit to CMS the applicable SMI/SED Health IT Plans, to be included as

sections of the associated Implementation Plans (see STC 7.2(c), to develop infrastructure and capabilities consistent with the requirements outlined in the SMI/SED demonstration opportunity).

- a. The SMI/SED Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plans will also be used to identify areas of health IT ecosystem improvement. The SMI/SED Health IT Plan must include implementation milestones and projected dates for achieving them (see Attachment T), and must be aligned with the Commonwealth’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the Commonwealth’s Behavioral Health (BH) IT Health Plan.
- b. The Commonwealth must include in its Monitoring Protocol (see STC 7.5) an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.
- c. The Commonwealth must monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Report (see STC 16.5).
- d. As applicable, the Commonwealth should advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the Commonwealth’s SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this SMI/SED amendment to this Demonstration.
- e. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the Commonwealth should use the federally-recognized standards, barring another compelling state interest.
- f. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the Commonwealth should use the federally-recognized ISA standards, barring no other compelling state interest.
- g. Components of the SMI/SED Health IT Plan include:
  - i. The SMI/SED Health IT Plan will describe the Commonwealth’s current and future capabilities to support providers implementing or expanding health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

- ii. In developing the SMI/SED Health IT Plan, states should use the following resources:
  1. States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).
  2. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
  3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

7.5. **SMI/SED Monitoring Protocol.** The Commonwealth must submit a Monitoring Protocol for the SMI/SED programs authorized by this demonstration within 150 calendar days after approval of the SMI/SED component (SMI amendment approved August 11, 2022). The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The Commonwealth must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS’s comments. Once approved, the SMI/SED Monitoring Protocol will be incorporated into the STCs as Attachment K. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports (as required by STC 16.5). Components of the Monitoring Protocol must include:

- a. An assurance of the Commonwealth’s commitment and ability to report information relevant to each of the program implementation areas listed in STC 7.2(c), information relevant to the Commonwealth’s financing plan described in STC 7.2(d), and information relevant to the Commonwealth’s SMI/SED Health IT plan described in STC 7.4;
- b. A description of the methods of data collection and timeframes for reporting on the Commonwealth’s progress on required measures as part of the monitoring and reporting requirements described in Section 16 of the demonstration; and
- c. A description of baselines and targets to be achieved by the end of the SMI/SED amendment to this demonstration. Where possible, baselines will be informed by Commonwealth data, and targets will be benchmarked against performance in best practice settings.

- 7.6. **Availability of FFP for the SMI/SED Services Under the SMI/SED Expenditure Authority #15.** Federal Financial Participation is only available for services provided to beneficiaries during short term stays for acute care in IMDs, including psychiatric hospitals, and CCS, and CBAT facilities. The Commonwealth may claim FFP for services furnished to beneficiaries during IMD stays of up to and including 60 days, as long as the Commonwealth shows at its SMI/SED midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMD exceed 60 days are not eligible for FFP under this demonstration. If the Commonwealth cannot show that it is meeting the 30 day ALOS requirement within one standard deviation at the SMI/SED mid-point assessment, the Commonwealth may only claim FFP for stays up to and including 45 days until such time that the Commonwealth can demonstrate that it is meeting the 30 day ALOS requirement. The Commonwealth will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days – or 45 days, as relevant.
- 7.7. **Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones.** Up to \$5,000,000 in FFP for SMI/SED services in IMDs may be deferred if the Commonwealth is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the SMI/SED Implementation Plans and the required performance measures in the Monitoring Plan agreed upon by the Commonwealth and CMS. Once CMS determines the Commonwealth has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The deferral process is not considered a final agency action, and may be appealed by the Commonwealth following the process specified in 42 CFR 430.30-48. The Commonwealth is expected to meet the milestones by the end of the first two years of the SMI/SED amendment to the demonstration.
- 7.8. **SMI/SED Mid-Point Assessment.** The Commonwealth must contract with an independent entity to conduct an independent Mid-Point Assessment by September 30, 2025; this takes the place of the SMI/SED Mid-Point Assessment originally due August 11, 2025 (established in the August 11, 2022 approval of the SMI component), whether or not the demonstration is renewed. If the demonstration is not extended or is extended for a term that ends on or before this date, then this mid-point assessment must address the entire term for which the SMI/SED Program under this demonstration was authorized. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the Commonwealth should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid-Point Assessment, the Commonwealth must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including SMI/SED treatment providers), and beneficiaries, community groups, and other key partners.

- a. The Commonwealth must require that the assessor provide a Mid-Point Assessment Report to the Commonwealth that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The Commonwealth must provide a copy of the report to CMS no later than 60 calendar days after September 30, 2025 and the Commonwealth must brief CMS on the report. The Commonwealth must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.
- b. For milestones and measure targets at medium to high risk of not being achieved, the Commonwealth must submit to CMS proposed modifications to the SMI/SED Implementation Plan, the SMI/SED Financing Plan, and the SMI/SED Monitoring Protocol, as appropriate, for mitigating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and/or Monitoring Protocol are subject to CMS approval.
- c. Elements of the Mid-Point Assessment must include at least:
  - i. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED Implementation Plan, the SMI/SED Financing Plan, if applicable, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol;
  - ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
  - iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
  - iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the Commonwealth's SMI/SED Implementation Plans and/or SMI/SED Financing Plan or to other pertinent factors that the Commonwealth can influence that will support improvement; and
  - v. An assessment of whether the Commonwealth is on track to meet the SMI/SED budget neutrality requirements in these STCs.

7.9. **Transition Period.** To avoid service disruption for beneficiaries receiving Community Crisis Stabilization (CCS) and Community Based Acute Treatment for Children and Adolescents (CBAT) in facilities that meet the definition of an IMD, as the Commonwealth aligns with expectations in SMDL #18-011, CMS is authorizing a transition period until December 31, 2023 for the state to come into alignment with the requirements and expectations as discussed in that guidance. During this period, the Commonwealth can continue to claim FFP for CCS and CBAT services authorized under the demonstration , but must ensure that facilities that meet the definition of an IMD work

to meet applicable requirements, including accreditation, under federal requirements to qualify to furnish Inpatient Psychiatric Services for Individuals under Age 21 services.

- 7.10. **Unallowable Expenditures Under the SMI/SED Expenditure Authority #15.** In addition to the other unallowable costs and caveats already outlined in these STCs, the Commonwealth may not receive FFP under expenditure authority #15 approved under this demonstration for any of the following:
- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
  - b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
  - c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
  - d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G, except as temporarily provided for in STC 7.9.

## 8. 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 insurance (ESI) 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.

- 8.1. **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 8.3-8.6. Both Medicaid and CHIP beneficiaries enroll in the managed care programs described in this demonstration. MassHealth may require Medicaid or CHIP 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 choose not 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.

However, Former Foster Care Youth (including Out of State Former Foster Care Youth as described above in Table 3) are required to enroll in Managed Care, subject to all other applicable provisions of Section 8: Delivery System.

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 9 below for additional details on Managed Care eligibility and enrollment rules.

**8.2. 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 PIHP 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.

8.3. **Managed Care Delivery Systems.** MassHealth’s Managed Care delivery systems include two categories as described above: (1) PCCM and PCCM entity delivery systems (which includes the PCC Plan (PCCM) and Primary Care ACOs (PCCM entities)); and (2) MCO-based delivery systems (which includes the MassHealth MCOs and Partnership Plans). Table 7 below provides an overview of these delivery systems.

<b>Table 7: Overview of Managed Care Delivery Systems</b>			
<b>PCCM and PCCM entity delivery systems</b>		<b>MCO-based delivery systems</b>	
PCC Plan (PCCM)	Primary Care ACOs (PCCM Entities) (a.k.a. “Model B ACOs”)	MassHealth MCOs	Partnership Plans (a.k.a. “Model A ACOs”)

8.4. **PCCM and PCCM entity delivery systems:**

- a. **The PCC Plan.** The PCC Plan is a PCCM 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. **Primary Care Clinician Payments.** MassHealth may establish 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 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. Monitoring of these benchmarks is subject to the requirements in STC 16.5.

- b. **Primary Care ACOs.** MassHealth contracts with Primary Care ACOs to serve as PCCM entities. 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 may exceed potential shared losses). Additionally, MassHealth may pay Primary Care ACOs an administrative rate for functions, consistent with 42 CFR 438.2, that will be set forth in the Primary Care ACO contracts that are submitted to CMS.
  - iv. MassHealth may make quality improvement payments to pay Primary Care ACOs in relation to quality performance. Quality performance payments would be federally matched at the 50 percent administrative matching rate.
  - v. MassHealth may also pay an enhanced case management fee, directly to providers in Primary Care ACO, per terms in Attachment O. The Commonwealth will ensure there is no duplication in payment for this enhanced case management fee.
  - vi. Primary Care ACOs may be paid for the provision of payments to certain primary care providers on behalf of the state as described in STC 8.7.
  - vii. As of April 1, 2023, Primary Care ACOs may be required to contract with Community Partners (CPs) for the provision of care coordination to certain enrollees with behavioral health or LTSS needs. Payments to CPs are permissible as an administrative cost. See STC 8.11 for further details.

MassHealth may specify the administrative rates and payment methodologies through which Primary Care ACOs pay CPs.

- viii. 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, as set forth in the applicable contracts.
- ix. MassHealth competitively procures Primary Care ACOs. Primary Care ACOs are PCCM entities under 42 CFR 438.

- c. **Other features of MassHealth’s PCCM and PCCM entity 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).

**8.5. Primary Care Payment Through the Primary Care ACOs.** The Commonwealth may prospectively pay Primary Care ACOs for certain primary care services and may require Primary Care ACOs to make prospective, per member per month (PMPM) payments that vary from state plan rates to participating primary care providers on behalf of the state. Such payments will be in lieu of fee-for-service state plan payments to participating primary care providers for certain primary care services in order to focus providers on improving clinical outcomes and reducing total cost of care for their attributed members, and to shift provider incentives away from volume. This payment meets Category 4 Population-Based Payment as described in the Alternative Payment Model (APM) Framework.<sup>6</sup>

- a. Payments by Primary Care ACOs to their participating primary care providers will be developed and calculated on a prospective per member per month (PMPM) basis, and will be based on the utilization of services of the primary care provider’s attributed population. These payments may be developed based on clinical tiers specifying service delivery expectations and other factors defined by the Commonwealth. Primary Care ACO-participating primary care providers will continue to submit claims to MassHealth for primary care services that are included within the prospective PMPM payment for data collection purposes; all claims for services covered under the payment model will be adjudicated and zero-paid. The payments to Primary Care ACOs or to providers do not need to be reconciled to actual utilization during applicable periods.
- b. The source of the non-federal share for these payments must be the Commonwealth’s general fund.
- c. The primary care payment rates and methodology paid to primary care providers participating in the Primary Care ACOs and Accountable Care Partnership Plans must be equitable. Any differences in the assumptions, methodologies, or factors

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<sup>6</sup> APM Framework: <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

used to develop the payment rates for the covered populations included in these two programs must also be based on valid payment standards that represent actual cost differences in providing the primary care services.

- d. No less than annually, the Commonwealth must submit the primary care payment rates and methodology to CMS for approval via PMDA as Attachment U, Primary Care Payment Protocol, at least 90 days prior to implementation, concurrent with the managed care contract submissions for the Primary Care ACOs that include the associated payment rates and methodology. The Commonwealth may be subject to deferrals or disallowances if it makes payments in excess of the payments approved by CMS.
- e. The primary care payment rates and methodology, submitted to CMS at least 90 days prior to implementation for review and prior approval, must include at least the following detail:
  - i. A description of the data and methodology the Commonwealth utilized to develop the primary care payment rates for Primary Care ACO-participating primary care providers, including the Commonwealth's approach to accounting for variations in factors such as, historical fee schedules, provider types, attributed members and populations, clinical care delivery tiers, and service delivery expectations.
  - ii. A description of any payment requirements or flexibilities the Commonwealth may place on Primary Care ACOs related to primary care payments, including any specific requirements related to payments to participating FQHCs and RHCs.
  - iii. Confirmation that the source of the non-federal share for such payments is the Commonwealth's general fund.
  - iv. Documentation, certified by the Commonwealth's actuary, that the primary care payment rates in the Primary Care ACOs and Accountable Care Partnership Plans are equitable.
  - v. A plan for monitoring, oversight, and program integrity efforts of the primary care payment program, including the Commonwealth's annual program integrity and oversight findings and any actions the Commonwealth has taken due to noncompliance with service or payment requirements must be included in the Annual Monitoring Report.
  - vi. Any additional information CMS deems necessary to determine these primary care payment rates and methodology are economic and efficient.
- f. MassHealth will ensure that there is no duplication of payment to primary care providers. Specifically and without limitation, MassHealth will ensure that FFS payments are not made to providers that duplicate payments, defined in this STC, made to the provider for furnishing primary care services to attributed beneficiaries.

## 8.6. MCO-based delivery systems:

- a. **MassHealth MCOs.** MCOs 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<sup>7</sup>. 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.
  - i. The State may limit disenrollment for MCO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
  - ii. MCO contracts will include requirements to use alternative payment methodologies and other arrangements described in Attachment Q, to increase accountability for cost and quality of care
  - iii. As of April 1, 2023, MCOs may be required to contract with Community Partners (CPs) for the provision of care coordination to certain enrollees with behavioral health or LTSS needs. MassHealth may specify the administrative rates and payment methodologies through which MCOs pay CPs. Payments to CPs are permissible as an administrative cost within the risk-based capitation rates paid to the MCOs. See STC 8.11 for further details.
  - iv. MassHealth MCOs are defined as MCOs under 42 CFR part 438.
- b. **Accountable Care Partnership Plans (“Partnership Plans”).** Partnership Plans are MCOs 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 paid on a fee for service basis in accordance with the State plan by MassHealth for members enrolled in Partnership Plans. 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.
  - 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

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<sup>7</sup> See Appendix C of MassHealth MCO and ACPP contracts for a discussion of services and the rate methodology.

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.

- iii. As of April 1, 2023, Partnership Plans may be required to contract with Community Partners for the provision of care coordination to certain enrollees with behavioral health or LTSS needs. MassHealth may specify the administrative rates and payment methodologies through which Partnership Plans pay CPs. Payments to CPs are permissible as an administrative cost within the risk-based capitation rates paid to the Partnership Plans. See STC 8.11 for further details.
  - iv. MassHealth will contract with Partnership Plans selectively. Partnership Plans are MCOs under 42 CFR Part 438.
- c. **State Oversight of Medical Loss Ratio (MLR):** For risk-based plans under the demonstration (i.e., MCOs, and the PIHP), the Commonwealth must submit the plan generated MLR reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov).
- i. For managed care plans that delegate risk to subcontractors, the Commonwealth's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to third-party vendors; see <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf>. The Commonwealth must submit its plan to operationalize STC 8.6(b) to CMS for review and approval, at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov), no later than April 1, 2023. The workplan must outline key deliverables and timelines to meet the requirements of STC 8.6(b).
  - ii. Effective January 1, 2024, the Commonwealth must require risk-based plans contracted with the Commonwealth to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.
  - iii. No later than January 1, 2025, the Commonwealth must require risk-based plans contracted with the Commonwealth to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities. Commonwealth.
  - iv. STC 8.6(b)(i), 8.6(b)(ii), and 8.6(b)(iii) must apply for all of the following entities:
    - 1. Risk-based plans for which the Commonwealth receives federal financial participation for associated expenditures;
    - 2. Full and partially delegated plans;

3. Other subcontractors, as applicable, that assume delegated risk from either the prime managed care plan contracted with the Commonwealth, or plans referenced in STC 8.6(b)(iv)(2); and
  4. Other subcontractors, as applicable, that assume delegated risk from entities, referenced in STC 8.6(b)(iv)(3).
- v. The Commonwealth must work with CMS to effectuate an audit of the MLR data covering all years of this 1115 demonstration renewal package. The audit must occur no sooner than April 1, 2026, and ideally later in 2027 to allow the Commonwealth time to review and finalize the calendar year 2026 MLRs.
- 8.7. **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, except in limited circumstances with MassHealth approval (e.g. Special Kids Special Care program members, geographically isolated areas), Primary Care ACOs, and Partnership Plans (both 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 Primary Care ACO may not simultaneously participate with another Primary Care ACO, or with a Partnership Plan. 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.
  - b. A primary care provider participating with a Partnership Plan may not simultaneously participate with a Primary Care ACO, or with another Partnership Plan. 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.

Where primary care provider 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).

- 8.8. **Community Partners Program.** Community Partners (CPs) are community-based organizations that provide care coordination and offer members linkages and support to community resources that facilitate a coordinated, holistic approach to care. CPs provide supports such as person-centered care coordination, assessments, care planning, navigation to social and community services, and health promotion and wellness activities to their enrolled members. Behavioral Health (BH) CPs are responsible for providing supports to certain managed care enrolled members with serious mental illness (SMI),

serious emotional disturbance (SED), and/or substance use disorder (SUD). Long Term Services and Supports (LTSS) CPs are responsible for providing supports to certain managed care enrolled members with LTSS needs including physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD). ACOs and MCOs identify members for enrollment with CPs. MassHealth may also identify members to ACOs and MCOs for enrollment with CPs. As of April 1, 2023, ACOs and MassHealth MCOs will be required to contract with CPs for the provision of CP supports and will pay CPs directly based on enrollment and quality performance. MassHealth may specify the rates and payment methodologies through which ACOs and MCOs pay CPs.

- a. Pursuant to expenditure authority, MassHealth may also provide up to \$20 million in additional payments to LTSS CPs (paid directly through the Commonwealth) to support LTSS CPs enhanced care coordination responsibilities including technology, workforce, ramp up, and operations. LTSS CPs will have substantially higher expectations than in the current demonstration increasing their scope of responsibilities to align with the current expectations of the BH CP model. These net new activities will include support of members with complex BH needs, technological integration with BH systems including psychiatric Emergency Notification Systems (ENS) and new organizational partnerships with Independent Living Centers (ILCs) and Aging Services Access Points (ASAPs), Electronic Health Record (EHR) enhancements to allow for clinical assessment, hiring and training staff for clinical assessment, clinical staffing with minimum staff to member ratios, and new expectations for hiring, training and supervision of staff with BH expertise. This funding is separate and distinct from the payment the state makes to the applicable managed care plans for CPs. The Commonwealth must ensure there is no duplication of CP funds. This funding must be claimed at the administrative match rate.

8.9. **State Directed Payments.** MassHealth may make periodic payments of the types described in Attachment Q to managed care plans, including MCOs, Partnership Plans and the Behavioral Health PIHP, and direct that these payments be made to providers in the plans' networks. Such payments will be consistent with 42 CFR 438.6(c). These STC do not constitute any direct approval of any state directed payment arrangement.

8.10. **Data Collection and Reporting.** The Beneficiary Support System 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. The state must include relevant information in its Quarterly and Annual Monitoring Reports, as described further in STC 16.6.

8.11. **Contracts.**

- a. **Managed Care Contracts.** Managed care programs outlined in these STCs (e.g., MCOs, PIHPs, PCCMs and PCCM entities) must comply with 42 CFR Part 438 unless expressly granted expenditure or waiver authority.

- b. **Capitation Rate Development.** Capitation rates for risk-based managed care plans (i.e., MCOs and PIHPs) must comply with the rate development and certification standards in 42 CFR § 438, including but not limited to 42 CFR §§ 438.4, 438.5, and 438.7.

8.12. **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 (and in cases when members voluntarily enroll in qualifying ESI), Massachusetts may provide a contribution through reimbursement or direct payment to the beneficiary, employer, or insurance plan administrator toward an individual’s share of the premium for an employer sponsored health insurance plan 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. If available and cost effective, the Commonwealth will provide premium assistance on behalf of individuals eligible for Standard (including ABP 1), CarePlus, Family Assistance, or CommonHealth coverage, to assist them in the purchase of private health insurance coverage. The Commonwealth 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 Commonwealth’s 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, Family Assistance, 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 eligible for MassHealth Standard or CommonHealth and under the age of 21 or pregnant.

8.13. **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:

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
<i>Standard/Standard ABP*</i>					
Individuals with no third party liability (TPL)	Managed Care (PCC Plan, MCO, Primary)	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up



<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
	Care ACO (PCACO) or Accountable Care Partnership Plan (ACPP)**  Certain services provided via FFS				to the first day of the third month prior to the date of application.)
Adults with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Children with TPL	Receive wrap benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with FFS wrap benefits			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Kaileigh Mulligan eligible children and children receiving title IV-E adoption assistance	Behavioral health is typically provided via BHP PIHP, although a FFS alternative must be		X		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.”

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
	available; all other services are offered via Managed Care or FFS.				Title IV-E adoption assistance - start date of adoption
Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF	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 (including Special Kids Special Care program if medically complex in the care/custody of DCF) or Accountable Care Partnership Plan in which case, behavioral health is provided through the MCO or Accountable Care Partnership Plan	X	X	X	Start date of state care/custody

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
	Certain services provided by FFS				
Provisionally eligible pregnant individuals 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 Demonstration Program without TPL	Managed Care	X			10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Home and Community-Based Waiver, under age 65	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.
<i>CommonHealth*</i>					
Individuals with no TPL	Managed Care ** (PCC Plan, MCO, PCACO, or ACPP)**  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Adults with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
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 (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with FFS benefits wrap			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>Family Assistance for HIV/AIDS*</i>					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP)  **  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with benefits wrap			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>Family Assistance for Children*</i>					

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP) ** **  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application)
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with benefits wrap				10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>CarePlus*</i>					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP) **  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)

Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs					
Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage***
Individuals with qualifying ESI	Premium assistance with benefits wrap			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>Limited</i>					
Individuals receiving emergency services only	FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Health Connector Subsidies	Premium and cost sharing assistance	X			Start date of Health Connector benefits
<i>Chart Notes</i>					
*TPL wrap could include premium payments					
** FFS until member selects or is auto-assigned to MCO, ACO or PCC Plan					
*** All retroactive eligibility is made on a FFS basis.					

## 9. COST SHARING

9.1. **Cost sharing.** Cost sharing and premiums 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 individuals. Additionally, no premium payments are required for any individual enrolled in the demonstration whose gross income is less than 150 percent of the FPL. The Commonwealth will ensure that cost sharing and premiums abide all regulatory and statutory restrictions for all state-plan eligible populations, including those receiving premium assistance for cost-effective private insurance available to beneficiaries. Please see Attachment C for a full description of cost sharing and premiums under the demonstration for MassHealth- administered programs. Attachment C will be updated to match cost sharing and premiums imposed by approved state plan amendments, as applicable.

## 10. MARKETPLACE SUBSIDIES.

- 10.1. The Commonwealth may claim as allowable expenditures under the demonstration ConnectorCare subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-operated program to provide premium and cost sharing subsidies for individuals with incomes at or below 300 percent of the FPL who purchase health insurance through the Health Connector. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid or CHIP eligible; and (2) whose income is at or below 300 percent of the FPL ; and (3) who are eligible for coverage with APTC.
- a. The state may also claim as allowable expenditures under the demonstration the payments made through its state-operated Health Safety Net (HSN) program to provide gap coverage for individuals eligible for coverage through the Health Connector with incomes at or below 300 percent of the FPL. HSN-Health Connector gap coverage is provided to eligible individuals during the time designated to select and enroll in a plan through the Health Connector. Connector gap coverage takes the form of fee-for-service payment to providers for services rendered to an individual during this Health Connector gap period.
  - b. Federal financial participation for the premium assistance, gap coverage, and cost-sharing portions of ConnectorCare subsidies for citizens and eligible qualified non-citizens will be provided through the expenditure authority corresponding to this STC. Federal financial participation is only available with respect to payments for eligible citizens or qualified non-citizens.
  - c. **Reporting for Connector Care.** The state must provide data regarding the operation of this subsidy program in the Annual Monitoring Report required per STC 16.5. This data must, at a minimum, include:
    - i. The number of individuals served by the program;
    - ii. The size of the subsidies; and
    - iii. A comparison of projected costs with actual costs.

## 11. THE SAFETY NET CARE POOL (SNCP)

- 11.1. **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 now includes the following expenditure categories:

- a. **DSH-like Pool.** Payments that offset Medicaid FFS and managed care underpayment, and uncompensated care for uninsured and underinsured (DSH – shortfall and uninsured).
- b. **UC Pool.** 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; and
- c. **DSRIP.** Final performance period of the DSRIP program, ending March 31, 2023, and close-out activities that phase down over the course of the demonstration period.
- d. **Safety Net Provider Payments (SNPP).** Close-out payments associated with the prior demonstration period and tied to DSRIP accountability to be paid to hospitals eligible during the prior demonstration period.
- e. **Public Hospital Transformation and Incentive Initiatives (PHTII).** Close-out payments associated with the prior demonstration period and tied to DSRIP accountability during the prior demonstration period to be paid to Cambridge Health Alliance.

11.2. **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 8.3, 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. **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 provider 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 to providers other than community health centers 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 11.7. The DSH Pool may include expenditures for:

- i. Public Service Hospital Safety Net Care payments to hospitals for care provided to eligible low income uninsured and underinsured patients;
- ii. Health Safety Net Trust Fund payments to hospitals and community health centers for care provided to eligible low income uninsured and underinsured patients;
- iii. Payments to Institutions for Mental Disease (IMDs) for care provided to MassHealth Members, to the extent these expenditures are not claimed under the Diversionary Behavioral Health authority described in STC 5.11, the SUD authority described in Section 6 or the SMI authority described in Section 7;
- iv. Certified public expenditures for uncompensated care provided by Department of Public Health (DPH) and Department of Mental Health (DMH) hospitals; and
- v. Safety Net Provider Payments to qualifying hospitals, as described in (2) below, and close-out Safety Net Provider Payments

b. **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.

- i. 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 2019 Center for Health Information and Analysis (CHIA) hospital cost reports.
- ii. To be eligible, the hospital must meet the following four 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; and
  4. Is not a critical access hospital with fewer than 30 beds upon issuance of the 2019 CHIA hospital cost report.
- iii. 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.

- iv. 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, a portion of Safety Net Provider Payments each year of the demonstration extension period will be tied to ACO performance measures. Twenty percent (20%) of each provider's total Safety Net Provider Payments will be at risk per demonstration year. The benchmarks for ACO performance and methodology for calculating the ACO Accountability Score and associated payment are described in Attachment N. For ACO performance that may rely on claims and/or other lagged sources of data, EOHHS may make estimated payment to participating hospitals, which will be subject to final reconciliation outlined in Attachment N.

11.3. **Uncompensated Care (UC) Pool.** Payments from this pool may be used to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to uninsured individuals as charity care by hospitals, clinics, or by other provider types, as specified at subparagraph (c) below, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association. Annual UC Pool payments are limited to \$100 million per demonstration year (total computable), as specified in STC 19.4. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form in Attachment I. The methodology used by the state to determine UC payments will ensure that payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to source of non-federal share, as specified in Attachment I. UC payments are not associated with particular individuals and are not a form of health coverage or any other benefit inuring to individuals. UC payments may employ substantively identical methodologies as payments authorized under the DSH-like Pool as further described in Attachment E, and subject to any additional limitations set forth in Attachment I.

- a. **UC Application.** To qualify for a UC Payment, a provider must submit to the Commonwealth a UC Application (or substantively equivalent report) that will collect cost and payment data on services eligible for reimbursement under the UC Pool. Data collected from the application will form the basis for UC Payments made to individual hospitals and non-hospital providers. The state must require hospitals to report data in a manner that is consistent with the Medicare Form 2552-10 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles.

Cost and payment data included on the application must be based on the Medicare 2552-10 cost report, or for non-hospital providers, a CMS-approved cost report

consistent with Medicare cost reporting principles. For hospitals not required to report charity care uncompensated costs on their cost reports, the hospital must report the required data in the tool approved by CMS and included in Attachment I. Any overpayments identified in the reconciliation process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS, except that during the reconciliation process, if a provider demonstrates that it has allowable uncompensated costs consistent with the protocol that were not reimbursed through the initial UC Payment (based on application figures), and the state has available UC Pool funding for the year in which the costs accrued, the state may provide reimbursement for those actual documented unreimbursed UC costs through a prior period of adjustment.

- i. Any provider that meets the criteria specified in Attachment I may submit a UC Application.
  1. All providers must have an executed indigent care affiliation agreement on file with the state, or be subject to a substantially similar requirement through other appropriate means (e.g., state regulation).
- ii. When submitting the UC Application, providers may request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs, resulting from changes in operations or circumstances. A provider may request that:
  1. Costs and revenue not reflected on the filed cost report, but which would be incurred for the program year, be included when calculating payment amounts; or
  2. Costs and revenue reflected on the filed cost report, but which would not be incurred for the program year, be excluded when calculating payment amounts.
  3. Adjustments described in subparagraphs (1) and (2) above cannot be considered as part of the reconciliation of a prior year payment. Such costs must be properly documented by the provider, and are subject to review by the State. Such costs are subject to reconciliation to ensure that providers actually incurred such eligible uncompensated costs.
- iii. All applicable inpatient and outpatient hospital UC payments received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue. Hospitals receiving both Safety Net Care Pool and UC Payments cannot receive total payments under the Safety Net Care Pool and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs for those services. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments. All reimbursements must be made in accordance with CMS approved Cost-Limit Protocol.

- b. **UC Payment Protocol.** The UC Payment Protocol establishes rules and guidelines for the State to claim FFP for UC Payments. The UC Payment Protocol will be appended into these STCs as Attachment I, which will be approved subsequent to this extension award. Prior to claiming FFP for the UC pool, the state must submit for CMS approval a funding and reimbursement protocol that will establish rules and guidelines for the State to claim FFP for UC Payments. The state cannot claim FFP for any UC Payments until the UC Protocol is approved by CMS. The UC Payment Protocol must include precise definitions of eligible uncompensated provider charity care costs (consistent with the Medicare cost reporting principles and revenues that must be included in the calculation of uncompensated charity care cost for the purpose of reconciling UC payments to unreimbursed charity care cost). The Protocol will also identify the allowable source documents to support costs; it will include detailed instructions regarding the calculation and documentation of eligible costs, the tool used by the State and providers to apply for UC Payments, and a timetable and reconciliation of payments against actual charity care cost documentation. This process will align the application process to the reconciliation process, as further described in Attachment I. The Protocol will contain not only allowable costs and revenues, it will also indicate the twelve (12) month period for which the costs will apply.
- c. **UC Payment Treatment.** UC Payments are considered to be Medicaid payments to providers and must be treated as Medicaid revenue when determining total title XIX funding received, in particular for any provider utilizing certified public expenditures as the non-Federal share of a Medicaid payment.
- d. **Reporting Requirements for UC Payments.** The state will submit to CMS, within ninety (90) days after the end of each Demonstration year:
  - 1. Any UC Payment applications submitted by eligible providers; and
  - 2. A chart of actual UC payments to each provider for the previous DY.

#### 11.4. Expenditure Limits under the SNCP.

- a. **Aggregate SNCP Cap.** For October 1, 2022 through December 31, 2027 (SNCP extension period), the SNCP will be subject to an aggregate cap of up to \$759.6million (total computable) added to the provider cap for the DSH-like pool described in STC 11.4(b) below, as well as the overall budget neutrality limit established in section 19 of the STCs. 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 STC 11.2(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 11.2(a) 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-like Pool has been fully expended.
- c. **Budget Neutrality Reconciliation.** The Commonwealth is bound by the budget neutrality agreement described in section 19 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 19, STC 19.1.

11.5. **Cost for Uncompensated Care following Cost Limit Protocol.** The DSH-Like pool payments support providers for furnishing uncompensated care, using definitions that generally parallel those used in traditional Disproportionate Share Hospital (DSH) funding. Massachusetts' Cost Limit Protocol ensures that payments to providers other than community health centers for uncompensated care 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. Provider incentive payments authorized through this demonstration 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 percent of the cost of providing Medicaid services, and 100 percent of uncompensated care costs as specified by the provisions of Section 1923(g) of the Act as implemented by 447.295(d).

11.6. **SNCP Additional Reporting Requirements.** All SNCP expenditures must be reported as specified in section 11, STC 11.2. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

- a. **Charts A – C of Attachment E.** The Commonwealth must submit to CMS for approval, updates to Charts A – C of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Years (SFYs) 2023-2028, 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 11.4.

- b. Before it can claim FFP, the Commonwealth must notify CMS and receive CMS approval, for any SNCP payments and expenditures outlined in Charts A-C 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 11.4. The Commonwealth must submit to CMS for approval updates to Charts A – C 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 11.4.
- c. The Commonwealth must submit to CMS for approval updates to Charts A – C 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 11.4.
- d. 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.
- e. 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 11.4.
- f. No demonstration amendment is required to update Charts A-C in Attachment E, with the exception of any new types of payments or expenditures in Charts A-C, or for any increase to the Public Service Hospital Safety Net Care payments.
- g. **DSRIP Protocol.** DSRIP reporting is required as specified in Section 12 and the approved Protocol.
- h. **UC Payments.** UC payment reporting is required as specified in STC 11.3(d).

## **12. DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP)**

- 12.1. **Delivery System Reform Incentive Program (DSRIP).** The expenditure authority authorized under this extension permits the state to use DSRIP funds remaining from the previous demonstration period. It does not increase the Commonwealth's total

expenditure authority as previously authorized. The state may claim, as authorized expenditures under the demonstration, up to \$253.2 million (total computable) over the demonstration period, for the completion of DSRIP incentive payments (including ACO Startup/Ongoing, ACO Flexible Services, CP Infrastructure and Capacity Building, and CP Care Coordination) and associated close out costs. 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 8.8(b).

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

- 12.2. **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.

12.3. **Expenditure Limits.** The Commonwealth may claim FFP for up to \$253.2 million in DSRIP expenditures.

- a. The State’s expenditure authority will be reduced based on the State’s DSRIP Accountability Score (See STC 12.16). MassHealth will reduce DSRIP payments in proportion to the reduced expenditure authority.

12.4. **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 who require BH and LTSS CP services and the timing of the final calculations required for DSRIP Accountability scoring. As such, the state may reallocate funding amounts between funding streams and Demonstration Years at its discretion. If the actual funding amounts per DSRIP funding stream and per Demonstration Year 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.

<b>Table 10: DSRIP Funding Allocation Total Computable (In Millions)</b>							
	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY31</b>	<b>DY32</b>	<b>Total</b>
<b>Total</b>	\$45.7M	\$98.6M	\$56.1M	\$52.4M	\$0.5M	\$0	\$253.2M

12.5. **DSRIP Protocol.** The DSRIP protocol is incorporated as Attachment M of these STCs, and 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, CP, and statewide investments, 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. **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.

12.6. **ACO & CP DSRIP 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.

12.7. **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 12.5-12.7 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-Contracted ACOs).

- b. **Funding Use.** MassHealth may pay ACOs under the DSRIP expenditure authority for the following:
- i. ACO startup/ongoing support
  - ii. Support for DSRIP flexible services. These services are delineated in the DSRIP Flexible Services Protocol. The protocol includes 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. The State may provide a portion of flexible services funding directly to social service organizations to help them build infrastructure and capacity to better support ACOs in delivering flexible services, subject to expenditure limits set forth in the Flexible Services Protocol. 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.
    - 7. Address medical needs and provide direct benefit and support specific outcomes that are identified in the individual waiver participant's care plan; and
    - 8. Promote the delivery of covered services in community settings;
    - 9. Decrease the need for other Medicaid services;
    - 10. Reduce the reliance on paid support; or
    - 11. Are directly related to the health and safety of the member in his/her/their home or community; or
    - 12. 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 DSRIP 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 during the quarter. If during the course of the demonstration CMS finds that flexible services provided by an ACO 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 DSRIP Flexible Services.** Flexible service dollars may not be used to fund or pay for the following:
  - 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 publicly 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 with the exception of nutrition related vouchers or nutrition prescriptions
- 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. **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 8.19).
- f. **Startup/ongoing support.** The PMPM amount for startup/ongoing funds varies for each ACO, depending on adjustments based on the following factors, as determined by MassHealth: the ACO's payer revenue mix, the ACO model and risk track selected and the number of ACO members attributed to community health centers (see DSRIP Protocol Section 4.4.1).
- g. **DSRIP Flexible services support.** The PMPM amount for DSRIP flexible services is the same for every ACO.

12.8. **Community Partners.** The following description applies to the Community Partners program under DSRIP. See STC 8.11 for information about the Community Partners program as of April 1, 2023. 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 certain supports for members over age 18 with serious mental illness (SMI), serious emotional disturbance (SED), and/or serious and persistent substance use disorder (SUD).

LTSS CPs are responsible for providing certain supports to 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. The CP may not bill MassHealth, MCOs or ACOs for activities funded through DSRIP. A BH CP may utilize DSRIP funding for the following purposes:
    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; and
    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.
  - 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; and
    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 activities funded through DSRIP. MassHealth will also ensure that there is no duplication of payment to Community Partners. 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; and
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 DSRIP Protocol Section 5.4)).
- 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.

12.9. **ACO & CP DSRIP Reporting Requirements.** The reporting requirements set forth in this STC apply to the period prior to March 31, 2023. 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 and Annual Monitoring Reports, as further described in STC 16.5.
- 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

12.10. **Stakeholder Engagement.** The State must allow for stakeholder engagement through meetings, access to web resources, and opportunities to provide feedback.

12.11. **DSRIP 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; and
  - ii. ACO Quality and Utilization Performance.
- b. **Additional DSRIP 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.
- 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

12.12. **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 minimum 18-month 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 and community mental health centers to allow primary care and behavioral health 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; and
  - 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).

12.13. **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 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. The Budget Period is January 1 through December 31, except for Budget Period 5 (January 1, 2022 - March 31, 2023). The final 2 quarters of Budget Period 5 (October 1, 2022-March 31, 2023) occur in this demonstration extension. Budget Period 5 funds for this extension period will be at-risk in accordance with the table below:

<b>Table 11: Budget Period 5 At-Risk Funds</b>	
<b>DSRIP Budget Period</b>	<b>October 1, 2022–March 31, 2023</b>
DSRIP Expenditure Authority	\$135.2M
% of Expenditure Authority At- Risk	20%
Actual Expenditure Authority At- Risk	\$27.0M

- c. **State DSRIP Accountability Score.** The State will calculate the State’s DSRIP Accountability Score. See DSRIP Protocol Section 5.2. 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
- d. 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.

- e. **Corrective Action Plan for purposes of DSRIP Accountability.** 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.
- f. **MassHealth ACO/APM Adoption Rate for purposes of DSRIP Accountability.** 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.
- g. **Reduction in State Spending Growth for purposes of DSRIP Accountability.** The State and CMS agree to a detailed methodology for calculating the State's reduction in spending growth. In general, the State is, by CY2022, accountable to a 2.1% 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 is 4.4% annually, which is the "without waiver" trend rate calculated by CMS based on the 2017 President's Budget Medicaid Baseline smoothed per capita cost trend with all populations combined (2017-2022). This trend rate was applied to the base PMPM rate in CY2017 (i.e. pre-ACO). The trend is compounded over the five Budget Periods, and the percent reduction will be determined according to the following calculation:  $\text{percent reduction} = (\text{trended PMPM} - \text{actual PMPM}) / (\text{trended PMPM})$ . Prior to CY2022, the State had target reductions smaller than 2.1% off of the trended PMPM.

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

- i. Be for the ACO-enrolled population
- ii. For the population enrolled in MCO-Contracted 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.
- h. **Gap to Goal Methodology for purposes of DSRIP Accountability.** CMS and the State agreed 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  $< (50\% * \text{Reduction Target})$ , then Measure Score = 0%
  - ii. If Actual Reduction  $\geq (\text{Reduction Target})$ , then Measure Score = 100%
  - iii. 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  $(75\% - 50\%) / (100\% - 50\%) = 50\%$
- i. **Overall Statewide Quality Performance for purposes of DSRIP Accountability.** MassHealth will annually calculate Statewide Quality performance by aggregating quality measure scores of all ACOs. Section 5.2.1.3 of the DSRIP protocol contains a detailed description of this calculation. ACO performance scores are based on preset attainment thresholds and goal benchmarks that have been agreed upon by the State and CMS as described in Section 5.3.1.2 of the DSRIP Protocol.

12.14. **Independent Assessor for purposes of DSRIP.** The state has identified 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 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 and Annual Monitoring Report requirements, outlined in STC 16.5.

Spending on the independent entities and other administrative cost associated with 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. The State may also claim FFP for expenditures related to these administrative activities using DSRIP expenditure authority.

- 12.15. **DSRIP Advisory Committee.** The state has developed and put into action a committee of stakeholders responsible for supporting the clinical performance improvement cycle of DSRIP activities. Until December 31, 2022, 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:

- Selection of additional metrics for providers that have reached baseline performance thresholds or exceeded performance targets
  - Assessing the effectiveness of cross-cutting measures to understand how aspects of one system are affecting the other. For example, are BH/SUD/LTSS performance focus areas affecting physical health outcomes?
  - 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,
  - 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 percent 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.

### 13. WORKFORCE INITIATIVES

To support workforce recruitment and retention to promote the increased availability of certain health care practitioners to serve Medicaid and demonstration beneficiaries, the Commonwealth shall implement student loan repayment and family nurse practitioner residency programs. The aim of these programs is to address shortages in qualified providers serving MassHealth members.

13.1. **Behavioral Health Student Loan Repayment.** The Commonwealth will make available the following student loan repayment programs:

- a. Up to \$300,000, per practitioner, for psychiatrists and nurse practitioners with prescribing privileges who make a 4-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 40% MassHealth and/or uninsured members.
- b. Up to \$50,000, per practitioner, for licensed behavioral health clinicians or masters-prepared clinicians (clinicians who have completed masters-level training but do not yet have the necessary licensure to practice independently) intending to obtain behavioral health practitioner licensure within one year of the award who make a 4-year commitment to practice full-time in a community-based setting serving at least 40 percent MassHealth and/or uninsured patients. If the clinicians do not receive licensure within one year of the award, they are ineligible for awards, and funding provided to them must be recouped with the federal share returned to CMS.

13.2. **Primary Care Student Loan Repayment.** The Commonwealth will make available up to \$100,000 for primary care physicians, and up to \$50,000 for advanced practice registered nurses, pediatric clinical nurse specialists, nurse practitioners, and physician assistants, per practitioner, who make a four-year full-time service commitment in a community-based setting serving at least 40 percent MassHealth and/or uninsured patients.

- 13.3. **Family Nurse Practitioner (FNP) Residency Grant Program.** The Commonwealth will provide up to \$105,000 per residency slot to allow Community Health Centers (CHCs) to support up to 10 FNP residency slots per year for four years. Awards may be made only to CHCs whose patient populations are at least 40 percent of MassHealth beneficiaries. Eligible recipient organizations must demonstrate significant residency training experience and infrastructure, and must align programs with established standards for FNP residency training programs to meet a baseline of quality and standardization.
- 13.4. **Additional Terms and Operations of Student Loan Repayment and FNP Residency Programs.** For the demonstration behavioral health student and primary care student loan repayment programs, and the FNP residency grant program, the following shall apply:
- a. Loan repayments and residency payments may be made directly only to the student loan servicer (or CHC in the case of the FNP Residency Program) by either the Commonwealth or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.
    - i. For both program types, MassHealth will first pay the managing vendor(s), if any, the funds, so that it can then in turn make payments to either the loan servicers or the CHCs sponsoring the FNP residency programs.
    - ii. For the Student Loan Repayment Program, for each individual round of awarded practitioners, the managing vendor will make payments in two equal installments during the first two years of the four-year service obligations.
  - b. For each yearly issuance of funding for the Family Nurse Practitioner residency grant program, the managing vendor will make a single payment to each CHC covering one year's residency slot costs. MassHealth will ensure that the amount of the award does not exceed the cost of operating the slot at the CHC; if the award exceeds the cost of the residency slot, the award will be reduced so that it matches the cost of the slot.
  - c. The Commonwealth may have multiple rounds/cohorts of disbursements (i.e., awards to new individuals each year), so long as it does not expend beyond the applicable authorized level of funding for each program over the course of the demonstration or demonstration year, as applicable.
  - d. The Commonwealth shall have a process for ensuring that practitioners meet the qualifying service commitment. If the service commitment is not met, except in extraordinary circumstances as determined by the Commonwealth (e.g., disability or death), the Commonwealth shall recoup any student loan payments made on the behalf of practitioners. In the case of recoupment, the Commonwealth shall return federal financial participation in those student loan payments to CMS.
  - e. Specific to student loan repayments, the Commonwealth may only pay for each provider an amount up to the student loan amount owed by the provider. It may not pay an amount that exceeds an individual provider's student loan. Provider

applicants may be eligible for different amounts of loan repayment based on their discipline and credentialing level, as determined by the Commonwealth. Only the student loan for educational costs associated with the course of study that led to the highest degree earned as a prerequisite to obtaining the relevant clinical credential may qualify for reimbursement under one of the student loan repayment programs.

- 13.5. For Residency Programs, the Commonwealth may only claim FFP for expenditures associated with residency slots that are filled by qualifying providers. In the event that an individual residency slot is not filled for the entirety of a year, the slot payment is pro-rated for the portion of the year that the residency slot was occupied. If the payment is made at the start of the year and the slot becomes unfilled mid-year, MassHealth will provide for recoupment and return of FFP if the slot is not re-filled within one month.
- 13.6. MassHealth may claim expenditures associated with the implementation of the Workforce Investment program, which are matchable as administrative expenditures, until no later than July 1, 2031, so long as the Commonwealth adheres with federal timely filing requirements. The expenditures will continue to be claimed on the CMS 64 on the specified waiver lines if the date where claims are made go beyond the demonstration period as part of this extension period. Allowable administrative expenditures under this authority include the specific costs of student loan repayments and residency slot payments, as well as the costs for monitoring the service commitments of providers for the repayment programs, as applicable. However, no payments for student loans or residency slots may be made following the demonstration period's expiration (December 31, 2027); any claimed expenditures after this date through July 1, 2031 must be only to pay close-out administrative costs of operating the program and monitoring service commitments.
- 13.7. Across all the student loan repayment and residency programs, the Commonwealth will define application criteria and eligibility, and then select awardees through a competitive process that will allow the State to evaluate the applicants relative to the criteria established. MassHealth may prioritize clinicians with cultural and linguistic competence that is likely to reflect and respond to the needs of the MassHealth population. The criteria must follow federal civil rights law and not impermissibly discriminate based on race, ethnicity, national origin, or any other federally protected classes or characteristics.

13.8. The funding table below shows the maximum amount of funding for each workforce initiative (including 15% administrative costs) by demonstration year.

<b>Table 12: Workforce Funding by Initiative (in Millions)</b>						
	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY32</b>	<b>Total</b>
Behavioral Health Student Loan Repayment	\$2.50M	\$5.00M	\$5.00M	\$5.00M	\$2.50M	\$20.00M
Primary Care Student Loan Repayment	\$2.30M	\$4.60M	\$4.60M	\$4.60M	\$2.30M	\$18.40M
Nurse Practitioner Residency	\$1.21M	\$1.21M	\$1.21M	\$1.21M	\$0M	\$4.84M
<b>Total</b>	<b>\$6.01M</b>	<b>\$10.81M</b>	<b>\$10.81M</b>	<b>\$10.81M</b>	<b>\$4.80M</b>	<b>\$43.24M</b>

#### **14. HOSPITAL QUALITY AND EQUITY INITIATIVE**

A key goal of the Commonwealth in this extension period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs and health disparities demonstrated by variation in quality performance. The MassHealth section 1115 demonstration includes expenditure authority for the Hospital Quality and Equity Initiative, which includes two components of the Commonwealth’s statewide strategy to advance health quality and equity: specifically, the health quality and equity incentive programs for private acute hospitals and Cambridge Health Alliance (CHA).

14.1. **Description.** As specified in Table 13 below, CMS will authorize up to \$400 million (total computable) annually (except DY27-28) in expenditure authority for participating private acute hospitals to improve health care quality and equity within the Commonwealth, and up to \$90 million (total computable) annually (except DY 27) in expenditure authority for Cambridge Health Alliance to improve health care quality and equity and develop interventions for both its Medicaid population and the uninsured individuals it serves. As part of this initiative, participating hospitals can earn a performance-based incentive payment for meeting data collection requirements, reporting expectations, and achieving quality and equity improvement standards that demonstrate improvement in health care quality and equity. The Commonwealth and participating hospitals will use the data to assess and address areas for improvement in health care quality and equity outcomes, which may include identification of disparities in health care delivery. The Commonwealth will require participating hospitals to conduct a Needs Assessment (defined in the Health Quality and Equity Initiative Implementation Plan) reflecting the healthcare needs of beneficiaries within the state. Participating hospitals may use existing community health needs assessments to inform this Needs Assessment. As part of this program, participating hospitals will also build organizational/workforce competence to improve quality and health outcomes and reduce disparities, and enhance their ability to provide accessible and culturally appropriate services.



- a. In this program, the Commonwealth will pay hospitals solely based on their achievement on goals and corresponding progress as measured by performance on identified metrics as further described in STCs 14.3, 14.4, and 14.5; no direct funding is available for implementation, such as systems or infrastructure build-out, or for reimbursement of provider costs incurred in implementing the program.
- b. Unexpended incentive payment amounts are forfeited and not recoverable. Authorized expenditure amounts for one performance year cannot be combined, carried, shifted, or otherwise transferred across performance years in any circumstances; however, earned incentive payment based on one performance year may be paid in a subsequent performance year against the expenditure limit for the performance year on which the incentive payment is based, as necessary pursuant to operational processes to determine the final incentive payment amount.

<b>Table 13: Annual Expenditure Limits (in millions, total computable)</b>						
	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>
Private Acute Hospitals	\$80M	\$320M	\$400M	\$400M	\$400M	\$400M
CHA	\$22.5M	\$90M	\$90M	\$90M	\$90M	\$90M
Performance Years (PY)	PY 1		PY 2	PY 3	PY 4	PY 5

**14.2. Overview of Targeted Domains for Improvement.** The Commonwealth and participating hospitals will pursue performance improvements in the domains specified below, as part of the Hospital Quality and Equity Initiative. Details of each domain, including performance metrics, associated interventions (including assurance of compliance with the parameters on the scope of interventions noted in STC 14.12), and reporting expectations, are described further in STCs 14.3-14.5 and will be included within the Hospital Quality and Equity Initiative Implementation Plan that will be an attachment to these STCs.

- a. Domain 1: Demographic and Health-Related Social Needs Data

MassHealth and its participating hospitals will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the Commonwealth’s data requirements as described in the Hospital Quality and Equity Initiative Implementation Plan. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, primary language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element. Details about the demographic data submission process must be described in the Hospital Quality and Equity Initiative Implementation Plan.

b. Domain 2: Equitable Access and Quality

MassHealth and its participating hospitals will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access; access for individuals with disabilities and/or limited English proficiency; access to preventive, perinatal, and pediatric care services; access to care for chronic diseases and behavioral health; and care coordination, as specified in the Hospital Quality and Equity Initiative Implementation Plan.

c. Domain 3: Capacity and Collaboration

MassHealth and its participating hospitals will be assessed on improvements in metrics such as provider and workforce capacity and collaboration between health system partners to improve quality and reduce health care disparities.

**14.3. Demographic and Health-Related Social Needs Data Collection Domain Goals**

- a. MassHealth will submit to CMS an assessment of beneficiary-reported demographic and health-related social needs data adequacy and completeness for purposes of the Hospital Quality and Equity Initiative by July 1, 2023.
- b. MassHealth and its participating hospitals will be incentivized through annual milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data by the end of PY3 (DY30), meaning that the Commonwealth must require participating hospitals to collect and submit data to the Commonwealth in a consistent format for at least 80 percent of beneficiaries who received care at participating hospitals as further defined in the Hospital Quality and Equity Initiative Implementation Plan.
- c. MassHealth and its participating hospitals will be incentivized through annual milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including at least primary language, disability status, sexual orientation and gender identity) by the end of PY5 (DY32), meaning that the Commonwealth must require participating hospitals to collect and submit data to the Commonwealth in a consistent format for at least 80 percent of beneficiaries who received care at Massachusetts participating hospitals as further defined in the Hospital Quality and Equity Initiative Implementation Plan.
- d. MassHealth and its participating hospitals will be incentivized to meaningfully improve rates of health-related social needs screenings from the baseline period by the end of PY5 (DY 32). To meet this goal, hospitals must not only conduct screenings of beneficiaries, but establish the capacity to track and report on screenings and referrals. CMS and the Commonwealth will agree to the specific annual goal through the Hospital Quality and Equity Initiative Implementation Plan, based on a background assessment of current hospital capacity on these aspects, focusing on aggressive but achievable improvement.

- e. For the purposes of measuring beneficiary-reported data completeness demographic and health-related social needs screening data, beneficiaries who affirmatively decline to provide a response (for example, by indicating in their response “refuse to respond” or “don’t know” or other applicable but consistent value) shall be considered to have reported for purpose of data completeness.

#### 14.4. **Equitable Quality and Access Domain Goals**

- a. MassHealth and its participating hospitals will be incentivized for performance on metrics such as those related to access to care (including for individuals with limited English proficiency and/or disability), preventive, perinatal, and pediatric care, care for chronic diseases, behavioral health, care coordination, and/or patient experience. Subject to CMS approval and informed by the Needs Assessments, the Commonwealth will select a subset of measures from the following priority areas, at least three relevant measures from CMS’s Health Equity Measure Slate for hospital performance and at least seven for statewide performance:
  - i. maternal health (except as inapplicable if a hospital has a non-birthing hospital status);
  - ii. care coordination;
  - iii. care for acute and/or chronic conditions;
  - iv. patient experience of and/or access to care.
- b. Metric performance expectations shall be specified further in the Hospital Quality and Equity Initiative Implementation Plan and shall include, at a minimum:
  - i. reporting on access and quality metric performance, including stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health-related social needs; and/or defined by other individual- or community-level markers or indices of social risk;
  - ii. developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics (including those identified in STC 14.2(b)(i) that account for clinical and social risk factors found through analysis to be associated with lower performance on such metrics and/or other appropriate individual- or community-level markers or indices of social vulnerability. Consistent with 42 CFR 440.262, such interventions may serve to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of sex (including sexual orientation and gender identity), and ensure that all beneficiaries regardless of their demographic characteristics have access to covered services that are delivered in a manner that meets their unique needs. The interventions must also comply with the limits described in Section 14.11.

- iii. Improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics (including but not limited to those metrics outlined in STC 14.2(b)).
  - 1. For example, the Commonwealth may stratify health quality metric performance on a quantile basis within and/or between hospitals and provide incentive payments for improving the achievement of the lower-performing quantiles.
  - 2. For example, the Commonwealth may stratify health quality metric performance based on geographic or community-level markers of identified social risks and provide incentive payments for improving the achievement of metric performance among those members who reside in or are associated with these geographies/communities.
  - 3. For example, the Commonwealth may stratify health quality metric performance by demographic factors. However, if it chooses to do so, the Commonwealth must do so using a combination of multiple demographic and clinical factors and provide incentive payments for reducing the disparity between achievement of low performing and high performing groups among these stratifications. Such an incentive design as detailed in the Hospital Quality and Equity Implementation Plan must be calculated to reward performance on reducing disparities through increasing metric performance for lower-performing groups, and not where the disparity shrinks because of lower performance for previously higher-performing groups.
- c. For up to the first 3 performance years, performance will be based on expectations described in STCs 14.4(b)(i) and 14.4(b)(ii). For at least the last two performance years, performance will also be based on expectations described in STC 14.4(b)(iii), thus allowing adequate time to mitigate the lack of available and complete stratified data within the Commonwealth that would support the determination of benchmarks or baselines for tracking performance improvement on these dimensions at the time of initial initiative approval.

The measures and additional information on performance expectations and incentive payments will be further specified in the Hospital Quality and Equity Initiative Implementation Plan.

#### **14.5. Capacity and Collaboration Domain Goals.**

- a. MassHealth and its participating hospitals will be incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain may relate to provider cultural competence and achievement of externally validated equity standards. The measures will ultimately be reviewed and approved by CMS, and the approved measures incorporated into the Hospital Quality and Equity Initiative Implementation Plan.

- b. MassHealth and its participating hospitals will be expected to meet a target of 80 percent of hospitals achieving rigorous standards regarding service capacity, access, and delivery of culturally and linguistically appropriate care by the end of PY3 (DY 30), as established by a national quality or accreditation organization.

#### **14.6. Performance Assessment Methodology.**

- a. MassHealth will implement a performance assessment methodology that should encourage all participating hospitals to improve, including high-performing hospitals where there may be reduced opportunity for improvement as compared to other participating hospitals. This methodology should be consistent across measures and detailed in the Hospital Quality and Equity Initiative Implementation Plan.
  - i. For metrics described in STC 14.3 and 14.5, MassHealth must set performance targets (or benchmarks) and reward participating hospitals for improvement and/or achievement on the established benchmarks based on aggregate performance.
  - ii. For metrics described in STC 14.4, MassHealth must set performance targets (or benchmarks) and reward hospitals for improvement and achievement for the established benchmarks based on aggregate performance and stratified performance as described in STC 14.4(b)(iii), including by reducing observed performance disparities through improvement (and not through reduced performance for certain groups or quantiles).
- b. If a measure benchmark cannot be established by July 1, 2025 using Massachusetts-derived data, the impacted measure must be replaced by the Commonwealth, choosing a CMS-approved measure that is already widely used within Massachusetts (or for which reliable data to establish a valid benchmark are readily available). The Commonwealth will then establish a benchmark, using the alternative data, using the same methodology included in the approved Hospital Quality and Equity Initiative Implementation Plan unless modifications are required to accommodate differences between the intended data and the alternative data that will be used.
- c. The Commonwealth may use imputed data prior to full data collection to support disparities assessment only; payment to participating hospitals for completeness of demographic and health-related social needs data cannot be based on imputed data for either the benchmark or the performance period data, nor may imputed data be used in the calculation of stratified metrics that may form the basis for incentivize payment.

#### **14.7. Expenditure Authority Allocation Across Domains.**

- a. The expenditure authority (total computable) for the private acute hospitals in the Hospital Quality and Equity Initiative will be allocated by domains according to the following, across all performance years:

<b>Table 14: Expenditure Authority Annual Allocation by Domain</b>			
	<b>Domain 1: Demographic and Health-Related Social Needs Data Collection</b>	<b>Domain 2: Equitable Access and Quality</b>	<b>Domain 3: Capacity and Collaboration</b>
% of Annual Limit	25 percent	50 percent	25 percent
Annual Amount (\$)	\$100M	\$200M	\$100M

- b. Within each domain, individual subdomains and measures may be weighted evenly or differently, reflecting agreed upon MassHealth and CMS priorities, or the anticipated difficulty in implementing interventions that are expected to lead to improvements in the measures. Such weighting will be specified within the Hospital Quality and Equity Initiative Implementation Plan, subject to CMS approval.
- c. The Commonwealth may vary the incentive payment amount each participating hospital is eligible to earn, with safety net hospitals as identified by the Commonwealth eligible to earn a relatively larger incentive amount than non-safety net hospitals.

**14.8. Hospital Quality and Equity Initiative Implementation Plan.** The Commonwealth must submit a proposed Hospital Quality and Equity Initiative Implementation Plan describing activities to occur during PY 1 (DY27 and DY28) for CMS approval. FFP will be available retroactively to the beginning of the demonstration approval period for approved elements of the Hospital Quality and Equity Initiative Implementation Plan, should the state make qualifying expenditures prior to the Plan’s approval. The Commonwealth is at risk for all expenditures until the Hospital Quality and Equity Initiative Implementation Plan is approved. Six months prior to the beginning of PY 2, the Commonwealth shall submit an addendum to the Implementation Plan to address the remaining performance years occurring in DY 29 through DY32 for CMS review and approval. No FFP is available starting DY 29 until the addendum is approved by CMS. The Commonwealth may submit additional annual addenda for CMS review and approval in PY2, PY3, and PY4 to reflect new data collected and reported under this initiative delineating new and emerging needs and learnings identified from the data, and other programmatic changes or stakeholder input. The Hospital Quality and Equity Initiative Implementation Plan will be appended to these STC as Attachment J. The Hospital Quality and Equity Initiative Implementation Plan must include the following information:

- a. Description of the statewide approach to advance healthcare quality and equity, including the relationship between state accountability metrics and the interventions at the health system level. For example, how the state will use metrics and health outcomes data to inform future interventions toward improving overall quality of care, which in turn may also address equity goals.

- b. The Commonwealth will also discuss how its analysis (including Needs Assessment), which will identify areas for improvement across Domains, led to the selection of the measures and interventions within the Hospital Quality and Equity Implementation Plan. The analysis and/or Needs Assessment may be updated in subsequent years through PY4 to reflect baseline health disparity data collected during the initial years of the Hospital Quality and Equity Initiative.
- c. Summarized approach of how the participating hospitals are expected to achieve the performance goals outlined, which will have been developed in collaboration with the health systems/providers.
- d. Conceptual framework that provides an overview of the initiatives, clinical strategies, staffing/HR changes, operational changes, systems changes, and other actions that will be undertaken by the hospitals using Hospital Quality and Equity Initiative payments.
- e. An overview of the Commonwealth's intended approach to a corrective action plan process in the event that providers are not on track to meet the expectations or objectives of the program, such as if providers are not on track to achieve defined performance targets in relation to metrics identified in the Hospital Quality and Equity Implementation Plan.
- f. Selected measures and their technical specifications for the Hospital Quality and Equity Initiative . The Commonwealth must have written permission from measure stewards to use their measures, as applicable. Validated and tested measures from nationally recognized measure stewards will be considered for use in this program; if such measures are not available to address program goals, additional measures may be selected or developed, subject to CMS approval. In the event that a measure is retired by a measure steward for any reason, the Commonwealth must replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within Massachusetts (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the findings from analysis and/or Needs Assessment.
- g. Information about how the Commonwealth and its hospitals will identify beneficiaries with unmet HRSN needs or at risk of experiencing unmet HRSN, as well as a description of the beneficiary eligibility for HRSN services criteria, implementation settings, any screening tools selected, and rescreening approach and frequency, as applicable.
- h. Information about how beneficiaries will be linked to services to address unmet health-related social needs, whether through social needs case management or alternative approaches, as applicable. The implementation plan should also describe how the Commonwealth will ensure that screening and services related to the demonstration are provided to beneficiaries in ways that are culturally appropriate and/or trauma informed.

14.9. **State and Hospital Risk for Health Quality and Equity.** Funding for the Hospital Quality and Equity Initiative will be at risk for each performance year, according to the following framework:

- a. Statewide accountability is applied prior to calculations of hospital accountability, so any reductions from statewide accountability apply to the global amount of funding from which hospital payments may be made, subject to the hospital accountability calculations described in STC 14.9(b) below.
  - i. The components of statewide accountability calculations include the following:
    1. Achievement of or improvement towards performance goals on the following measures across both Cambridge Health Alliance and participating hospitals in the Hospital Quality and Equity Initiative:
      - a. A selection of measures established for hospitals as described in STC 14.3, 14.4, and 14.5.
      - b. A selection of metrics agreed upon by CMS and the Commonwealth from the draft CMS Health Equity Measure Slate for DY27 and DY28, and the final CMS Health Equity Measure Slate for remaining performance years, upon its release; at least three of these agreed-upon metrics may be included in measures established for hospitals as described in 14.9(a)(i)(1)(a).
    2. Maternal Morbidity Measure (to be specified by CMS).
  - ii. Each statewide accountability component will be assigned a weight for each performance year in the Implementation Plan, such that the sum of the component weights is 100 percent each year. State performance in each component will be multiplied by the associated weight, and then summed together to create an aggregate score, which will be the State's Accountability Score. The state will report its Accountability Score to CMS once it is available, with supporting documentation showing the calculation of the score, and the score will then be used by the State and CMS to determine whether the Commonwealth's Hospital Quality and Equity Initiative expenditure authority will be reduced for the relevant demonstration year. The maximum amount of funding at risk for statewide accountability is described in the table immediately below, and the actual amount of any reduction for a fiscal year will be determined according to a methodology agreed upon by the state and CMS in the Hospital Quality and Equity Initiative Implementation Plan.



<b>Table 15: Funding At-Risk by Demonstration Year</b>					
	<b>DY 27-28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>
Funding at risk for statewide achievement	5 percent	15 percent	20 percent	25 percent	25 percent
At-risk assigned by Performance years	PY 1	PY 2	PY 3	PY 4	PY 5

- b. Participating hospital performance is assessed individually by hospital and by domain and measure to determine whether the hospital has met the established targets for incentive payments. Each participating hospital must receive a domain-specific score, which are then weighted according to the methodology that is defined in the Implementation Plan. The aggregate score will be used to calculate the participating hospital’s earned incentive payment.
  - c. Unearned payments to participating hospitals and expenditure limit reductions for the Commonwealth are forfeited and cannot be earned back in subsequent demonstration years. However, an earned incentive payment based on one performance year may be paid in a subsequent performance year against the expenditure limit for the performance year on which the incentive payment is based, as necessary pursuant to following operational processes to determine the final earned incentive payment amount.
- 14.10. **CMS Health Equity Measure Slate and Statewide Accountability.** MassHealth will incorporate into demonstration monitoring a selection of metrics agreed upon by CMS and the Commonwealth from the draft CMS Health Equity Measure Slate for DY27/DY28 and the final CMS’s Health Equity Measure Slate upon its release, anticipated within 2023. The Health Equity Measure Slate will reflect CMS priorities and align with other CMS initiatives. MassHealth will be required to include reporting on applicable measures included within the CMS Health Equity Measure Slate, along with the reporting otherwise discussed within these STCs. The Commonwealth and CMS will agree on at least seven of these measures to be introduced as part of statewide accountability calculations; the measures chosen should be chosen from across each priority area category as provided in STC 14.4(a). Measures from the CMS Health Equity Measure Slate will not be required to be implemented as part of hospital accountability (i.e., three domains described in STCs 14.2-14.5).
- 14.11. **Limitations on Interventions.** The Commonwealth must ensure that the Commonwealth and its participating hospitals implement clinically appropriate interventions that are broadly accessible irrespective of race, ethnicity, national origin, religion, sex, or gender; and the Commonwealth shall ensure interventions are delivered in a culturally and linguistically competent manner. Interventions may be based upon health status and health needs, geography, and other factors not listed in the previous sentence only as relevant to the specific measure (e.g., current or past pregnancy status for maternal health measures). The Commonwealth must ensure compliance with Federal anti-discrimination statutes consistent with STC 3.1.

- 14.12. **State Oversight of Programs.** The Commonwealth must demonstrate ongoing performance oversight of health systems and participating hospitals receiving the Hospital Quality and Equity Initiative payments, including performance monitoring, a corrective action plan process, and a process for ensuring compliance with all applicable requirements, including those specified in STC 14.11. The Commonwealth is required to report findings from its performance assessments and any corrective action plans to CMS in its Quarterly and Annual Monitoring Reports, per STC 16.5.
- 14.13. **Claiming processes for Hospital Quality and Equity Initiative.** The Commonwealth is required to report expenditures for the program on the CMS 64 as prescribed within these STCs and follow applicable timely filing rules.
- a. The Commonwealth will incur administrative costs related to implementing and overseeing the Hospital Quality and Equity Initiative for the entirety of the demonstration period, but also related administrative closeout costs that may be claimed for up to two years following the conclusion of Performance Year 5.
  - b. The Commonwealth may only distribute incentive payments associated Performance Years 1-5. Nothing in this STC restricts the Commonwealth from seeking an extension of the Hospital Quality and Equity Initiative expenditure authority.
- 14.14. **Independent Assessor for the Hospital Quality and Equity Initiative.**
- a. The state will identify independent entities with expertise in delivery system improvement to assist with Hospital Quality and Equity Initiative administration, oversight, and monitoring as may be appropriate, including the identification and engagement of an independent assessor. The Commonwealth must ensure that the independent assessor, in collaboration with other entities identified by the state as needed, will review proposals, progress reports and other related documents, to ensure compliance with the approved STCs, the Hospital Quality and Equity Initiative Implementation Plan, and any applicable Protocols. The Commonwealth must ensure that the independent assessor makes recommendations to the Commonwealth for program improvement. The independent assessor (or another independent entity identified by the Commonwealth) will also assist the Commonwealth with compiling data for progress reports, other ongoing reviews of the Hospital Quality and Equity Initiative Implementation Plan, and any applicable protocols, and assist with continuous quality improvement activities.
  - b. Spending on the independent entities and other administrative costs associated with the Hospital Quality and Equity Initiative fund is classified as a state administrative activity. The Commonwealth must ensure that all administrative expenditures for the independent entities are proper and efficient for the administration of the program.
- 14.15. **Provider Rate Increase Expectations.** As a condition of the Hospital Quality and Equity Initiative expenditure authority, Massachusetts must comply with the provider rate increase requirements in Section 21 of the STCs.

14.16. **Cambridge Health Alliance Hospital Quality and Equity Initiative Design and Goals.** CMS will authorize up to \$90 million (total computable) a year (except DY 27) for Cambridge Health Alliance (CHA) to implement a program that addresses health quality and equity for its patients, subject to the limitations outlined in STC 14.11 incorporating responsibility for both Medicaid beneficiaries and the uninsured. See table 16 in STC 14.17 for the annual expenditure authority limits and allocations for hospital performance (described in STC 14.18(a)) and ambulatory performance (described in STC 14.18(b)).

14.17. **Cambridge Health Alliance Hospital Quality and Equity Initiative Measurement.**

- a. 70 percent of the incentive payment for CHA is allocated to CHA’s performance on the Hospital Quality and Equity Initiative domains, which will be described within the Hospital Quality and Equity Initiative Implementation Plan. CHA is held to an aligned improvement methodology, measure selection, and benchmarking methodology for Medicaid beneficiaries as established in STC 14.6 for private acute hospitals. However, in addition to the Medicaid population, CHA will also be held responsible for the served uninsured population within its service area, which will be measured separately. Recognizing adaptation necessary for an uninsured population, the specific applicable domain elements, weighting, measurement, and performance assessment methodology, and attribution methodology for the uninsured population will be described within the CHA-specific Hospital Quality and Equity Initiative Implementation Plan Addendum.
- b. 30 percent of the incentive payment for CHA is allocated to CHA’s reporting and/or performance on ambulatory quality measures for the served uninsured population (e.g., controlling high blood pressure, HbA1c control) and payment may be based on both overall improvement and disparities reduction on those measures. Details of the methodology and measures will be described within a CHA-specific addendum to the Hospital Quality and Equity Implementation Plan. In general, Massachusetts will calculate a total performance score based on CHA’s performance on the approved measures. The total performance score will be used to determine the earned incentive payment.
- c. To determine the total earned incentive payment, the Commonwealth will sum the payment earned from CHA’s performance described in STC 14.17(a) with payment earned in STC 14.17(b).

<b>Table 16: CHA Expenditure Authority Allotments (total computable)</b>						
	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY30</b>	<b>DY 31</b>	<b>DY32</b>
Hospital performance	\$15.75M	\$63M	\$63M	\$63M	\$63M	\$63M
Ambulatory performance	\$6.75M	\$27M	\$27M	\$27M	\$27M	\$27M
Total Annual Limit	\$22.5M	\$90M	\$90M	\$90M	\$90M	\$90M

- 14.18. **CHA Hospital Quality and Equity Initiative Implementation Plan.** The Implementation Plan for CHA’s Hospital Quality and Equity Initiative will be an addendum to the Hospital Quality and Equity Initiative Implementation Plan as defined in STC 14.8 (following the same timeframe for submission and revision as described in that STC), and must address the same content expectations specified in STC 14.8 related to 14.17(a) for the hospital-based Medicaid population, with adaptations necessary for the inclusion of the uninsured individuals served by CHA. The parameters for 14.17(b) will be included in the CHA-specific addendum to the Hospital Quality and Equity Initiative Implementation Plan. To the extent MassHealth intends to make any changes to the CHA program’s operation, it must submit the proposed change to the Hospital Quality and Equity Initiative Implementation Plan to CMS and receive approval prior to implementation of any changes. Updates to technical specifications shall not require CMS approval insofar as the updates do not alter the intention of measure, but must be documented in Monitoring Reports and/or the Implementation Plan, as appropriate. FFP cannot be claimed until the protocol is approved by CMS, but FFP may be claimed retroactively to the date of the initiative’s approval, for approved elements of the Hospital Quality and Equity Initiative Implementation Plan.
- 14.19. **Statewide Accountability and Cambridge Health Alliance.** Cambridge Health Alliance’s performance for Medicaid beneficiaries on the Hospital Quality and Equity Initiative will be an input into statewide accountability calculation, as described in STC 14.9. In the event that statewide accountability calculations lead to a reduction in expenditure authority for the Hospital Quality and Equity Initiative for a demonstration year, a proportionate reduction will be made to the CHA-specific program’s expenditure authority.
- 14.20. **Budget Neutrality Treatment for Hospital Quality and Equity Initiative.** The expenditure authority for the Hospital Quality and Equity Initiative must be supported out of budget neutrality savings.
- 14.21. **Federal Matching Rate for Hospital Quality and Equity Initiative.** All expenditures for the Hospital Quality and Equity Initiative must be claimed as administrative on the applicable CMS 64.10 waiver form(s).
- 14.22. **Exclusion from Uncompensated Care Calculations.** Incentive payments under this authority 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, or the uncompensated care protocol.
- 14.23. **Hospital Quality and Equity Initiative Advisory Committee.** The Commonwealth will develop and convene a committee of stakeholders (Committee) who will be responsible for supporting the clinical performance improvement cycle of Hospital Quality and Equity Initiative activities. The Committee will serve as an advisory group offering expertise in health care quality measurement, equity measurement, quality and equity improvement, and clinical, demographic, and health-related social needs data used in performance improvement initiatives, quality, and best practices. Final decision-making authority over

the demonstration will be retained by the Commonwealth (and CMS, as applicable), although the Commonwealth will consider all Committee recommendations .

## 15. HEALTH-RELATED SOCIAL NEEDS

Over the life of the MassHealth demonstration, the Commonwealth has taken steps to offer programs and services (e.g., Flexible Services and the Community Support Program) that address health-related social needs (HRSN) for individuals meeting certain clinical and risk-based needs criteria. This section of the STCs establishes a framework for ongoing HRSN services and new services authorized through expenditure authority in order for the Commonwealth and CMS to better evaluate the effects of HRSN on the Medicaid population.

15.1. **HRSN Services Glide Path.** Given that MassHealth currently operates the Flexible Services Program, which is being modified through this framework, CMS will permit the Commonwealth until the beginning of DY 30 to come into compliance with the terms of this section within STC 15.7 through STC 15.9, and 15.13(b) for HRSN Flexible Services. Expectations for CSP-JI are addressed by STC 15.1(d) below. No other flexibility is provided.

- a. **HRSN Flexible Service Transition into Managed Care Delivery Systems.** By no later than January 1, 2025, Massachusetts will include coverage for HRSN Flexible Services into managed care delivery systems and comply with all Federal requirements, including those outlined in 42 CFR 438, and those outlined within Section 15 of the STCs. In order to demonstrate the Commonwealth is prepared to implement HRSN flexible services in managed care delivery systems, Massachusetts must complete key action steps within CMS's required timelines outlined below. In no event, shall this time- limited expenditure authority for this glide path extend beyond December 31, 2024. CMS reserves the right to ask for additional supporting documentation related to managed care implementation.
  - i. If the Commonwealth faces unforeseen circumstances in meeting a required timeline for a key action step, it may formally request an extension to one of the required timelines specified in STC 15.1(a)(ii)-(vii). below, subject to CMS review and approval. The Commonwealth's extension request must include the required components outlined below and be submitted to CMS no later than 60 days prior to the required timeline associated with a key action step. Additionally, with an extension request, the Commonwealth must: (1) provide a description of the unforeseen circumstance impacting the Commonwealth's ability to meet a key action step within the required timeline; (2) propose a new timeline for meeting the required action step, including a description of why this requested new timeline is reasonable and appropriate; and (3) submit a Corrective Action Plan detailing the activities the Commonwealth will undertake to ensure no further delays in completing key action steps within the required timelines. In no event, shall the expenditure authority for this glidepath extend beyond December 31, 2024. CMS reserves the right to ask for additional supporting documentation or

request a revised timeline related to the Commonwealth's extension request. An approved extension becomes a component of the 1115 and CMS will publish the extension, including all components outlined above, as an Attachment to the 1115.

- ii. By July 1, 2023, the Commonwealth must submit to CMS for review and approval a complete implementation plan outlining key action items and required timelines to implement HRSN flexible services into managed care delivery systems, including but not limited to the following key topics: (1) beneficiary rights and protections; (2) operations, data and system management; (3) payment/capitation rate development; (4) provider enrollment, service delivery and network adequacy.
- iii. By April 1, 2024, the Commonwealth must notify CMS if it intends to utilize a state directed payment(s) to direct the expenditures of its risk-based managed care plans related to HRSN flexible services, such as by requiring a minimum fee schedule or other payment arrangement, beginning January 1, 2025.
- iv. By July 1, 2024, the Commonwealth must submit a complete preprint(s) for the calendar year 2025 rating period if CMS determines that prior approval by CMS is required for any state directed payment(s), in accordance with 42 CFR 438.6(c).
- v. By August 1, 2024, the Commonwealth must submit draft managed care plan contract actions that incorporate HRSN flexible services in compliance with Federal requirements, including but not limited to, those outlined the framework described in the STCs and 42 CFR 438.
- vi. By October 1, 2024, the Commonwealth must submit calendar year 2025 rate certifications for all Medicaid managed care programs that incorporate HRSN flexible services into the risk-based capitation rates for MCOs and PIHPs that provide HRSN. The rate certifications must include all necessary documentation outlined in the Medicaid Managed Care Rate Development Guide. The Primary Care ACOs may provide payment to providers for HRSN services consistent with the fee-for-service rates reviewed and approved by CMS.
- vii. By October 1, 2024, the Commonwealth must submit the related executed managed care plan contract actions that incorporate HRSN flexible services in compliance with Federal requirements, including but not limited to, those outlined the framework described in the STCs and 42 CFR 438.
- viii. By October 31, 2024, the Commonwealth must submit documentation of its completed readiness review consistent with the requirements outlined in 42 CFR 438.66(d).

- b. **Flexible Services Transition to HRSN Fee-For-Service Framework.** For fee-for-service delivery systems, the Commonwealth must submit HRSN Flexible Service

rates for CMS review and approval, following the expectations described in the HRSN Implementation Plan section below, by July 1, 2024. Following December 31, 2024, the Commonwealth must comply with all of the applicable requirements identified within Section 15 of the STCs.

- c. The Commonwealth may submit an amendment at a future date in order to request any necessary changes to authorities or these STC to reflect its intended operational design for the program, but must comport with this framework and applicable regulations and statute.
- d. **CSP HRSN Services Transition.** CSP for individuals with justice involvement (CSP-JI) Services will meet the requirements of this STC 15 as of April 1, 2023. Prior to April 1, 2023, CSP-JI will operate under the BH Diversionary Services construct, per STC 5.11.

15.2. **Health- Related Social Needs (HRSN) Services.** The Commonwealth may claim FFP for expenditures for certain evidence-based and allowable HRSN services identified in Attachment P and this STC, subject to the restrictions described below, including Section 21 of these STCs. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX or Title XXI, but consistent with Medicaid demonstration objectives that enable the Commonwealth to continue to increase the efficiency and quality of care. The Commonwealth is required to align clinical and health-related social needs criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the Commonwealth or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the Commonwealth be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. Additional detail on covered services must be submitted to CMS for approval, outlining the name and description of each proposed HRSN service, the criteria for defining a medically appropriate population for each service, and the process by which that criteria will be applied, including care plan requirements or other documented processes as outlined in STC 15.6 and Attachment P.

15.3. **Allowable HRSN services.** The Commonwealth may cover the following HRSN services:

- a. Housing supports, including:
  - i. Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention.
  - ii. Housing transition navigation services.
  - iii. One-time transition and moving costs (e.g., security deposit, first-month's rent, utilities activation fees and payments in arrears, movers, relocation

expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture).

- iv. Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification.
  - v. Medically necessary air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units as needed for medical treatment.
  - vi. Medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.
- b. Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees. This category includes the services authorized in the Community Support Program for justice involved individuals.
- c. Nutrition Supports
- i. Nutrition counseling and education, including on healthy meal preparation.
  - ii. Up to 3 meals a day delivered in the home, or private residence, for up to 6 months. Additional meal support is permitted when provided to the household of a child identified as high risk or pregnant individual, as defined in the risk and needs-based criteria, and in accordance with the Flexible Service Program requirements.
  - iii. Medically-tailored or nutritionally-appropriate food prescriptions (e.g., fruit and vegetable prescriptions, protein box), delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months.
  - iv. Cooking supplies that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs (e.g., pots and pans, utensils, refrigerator).
- d. Transportation to HRSN services for tenancy supports as described in 15.3(a) above and nutrition supports as described in 15.3(c) above.
- 15.4. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:
- a. Construction costs (bricks and mortar) or capital investments.
  - b. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months.
  - c. Research grants and expenditures not related to monitoring and evaluation.



- d. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting.
- e. Services provided to individuals who are not lawfully present in the United States or are undocumented.
- f. Expenditures that supplant services and activities funded by other state and federal governmental entities.
- g. School-based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education and/or state or the local education agency.
- h. Any other projects or activities not specifically approved by CMS as qualifying for coverage as a HRSN item or service under this demonstration.

15.5. **Covered Populations.** Expenditures for HRSN services may be made for the targeted populations specified below. To receive HRSN services, individuals in the target populations must have a documented medical need for the services and the services must be determined medically appropriate, as described in the HRSN Services section in STC 15.5, for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's HRSN service plan or medical record. Additional detail on targeted populations, including the clinical and other health-related social needs criteria, is outlined in Attachment P.

- a. **Flexible Services Program.** The Flexible Services Program targets MassHealth ACO-enrolled members ages 0 to 64, including individuals up to 12 months post-partum and their child(ren), who meet at least one of the health needs-based criteria and at least one risk factor defined by the Commonwealth in Attachment P. The Flexible Services program addresses the health-related social needs of eligible individuals in the areas of housing and nutrition by providing access to tenancy preservation and nutrition sustaining supports.
- b. **Specialized Community Support Programs (Specialized CSPs).** MassHealth members, except MassHealth Limited members, who meet certain criteria related to behavioral health needs are eligible to receive specialized CSP services. Specialized CSP services are outreach and supportive services to enable beneficiaries to use clinical treatment services and other supports, as described below. The CSP provider does not provide clinical treatment services. Specialized CSPs may also provide support for transition between service settings, including connecting with the member just prior to discharge from an inpatient or 24-hour diversionary setting and supporting them through the transition to accessing outpatient and community-based services and supports. Services will vary with respect to hours, type and intensity of services depending on the changing needs of the beneficiary. The following Specialized CSPs will target populations in need of specialized supports.

- i. **CSP for Homeless Individuals (HI).** CSP for Homeless Individuals (HI) is a more intensive form of CSP for members who are experiencing homelessness. Specialized services include assistance from specialized professionals who assist members in searching for housing opportunities, transitioning into community based housing, sustaining tenancy, and meeting their health needs.
- ii. **CSP for Individuals with Justice Involvement (JI).** CSP for Individuals with Justice Involvement targets beneficiaries with justice involvement living in the community in need of specialized services to improve and maintain health while transitioning back to the community and to promote successful community tenure. Individuals with justice involvement living in the community are defined as covered individuals released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.
- iii. **CSP Tenancy Preservation Program (TPP).** CSP-TPP is a specialized form of CSP that works directly with members with behavioral health needs who are facing eviction as a result of behavior related to their condition (rather than strictly non-payment of rent), in order to preserve tenancy.

15.6. **Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications.** The Commonwealth must complete and submit to CMS for approval a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services, in accordance with STC 15.1. This Protocol must include a list of the services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, and provider qualification criteria for each service. The Commonwealth must submit this Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 calendar days of the approval of the 1115 demonstration extension. The Commonwealth must resubmit an updated Protocol, as required by CMS feedback on the initial submission. The Commonwealth may not claim FFP for HRSN service provision or HRSN infrastructure expenditures until CMS approves the Protocol, except as otherwise provided herein. Once approved, the Commonwealth can claim FFP for HRSN services and HRSN infrastructure retrospectively to the beginning of the extension approval date. Once approved, the Protocol will be appended to the STCs as Attachment P.

15.7. **Service Delivery.** Consistent with the managed care contract and guidance:

- a. Terms applicable to all HRSN Services.
  - i. Any applicable HRSN 1115 services that are delivered by managed care plans must be included in the managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and (r).

- ii. HRSN 1115 services may be paid on a fee-for-service basis when provided by the Commonwealth. HRSN 1115 services, when provided by a managed care plan, must be paid as outlined below. The Commonwealth must also comply with STC 15 for all HRSN services.
  - iii. When HRSN (i.e., HRSN services defined in STC 15.3 for the covered populations outlined in STC 15.5) is included in risk-based capitation rates, HRSN services should be reported in the MLR reporting as incurred claims. Managed care plans should not report HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates.
    - 1. The Commonwealth must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 18 months prior to the implementation of HRSN services in risk-based capitation rates. The Commonwealth may submit this process to CMS at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov). This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The Commonwealth's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.
- b. Terms applicable to Specialized CSP HRSN Services
- i. Specialized CSP HRSN services will be available through the fee-for-service and managed care delivery systems.
  - ii. Specialized CSP HRSN services, pursuant to STC 15, when provided by MassHealth MCOs, BH PIHP, and Accountable Care Partnership Plans, must be included within the risk-based capitation rates, and must be submitted to CMS for review and approval in accordance with 42 CFR 438.4(b) and 438.7(a).
- c. Terms applicable to Flexible Services HRSN Services
- i. Flexible Services HRSN Services will only be available to enrollees of Primary Care ACOs and Accountable Care Partnership Plans.
  - ii. Primary Care ACOs, and Accountable Care Partnership Plans provide HRSN Flexible Services authorized under this demonstration through contracted network providers, as further described in STC 15.7.
  - iii. The Commonwealth may allow Primary Care ACOs and Accountable Care Partnership Plans to offer the Flexible Services HRSN services or settings statewide or in some or all geographic areas in which the plan operates.
  - iv. The Commonwealth must require that each Primary Care ACOs and Accountable Care Partnership Plans report to the state Medicaid agency, the geographic areas in which it intends to offer the Flexible services HRSN

services and any sub-area limitations on the availability of the service. Primary Care ACOs and Accountable Care Partnership Plans must receive state approval and provide public notice of any such limitations on each Flexible service including specifying such limitations in the enrollee handbook.

- v. HRSN Flexible Services, pursuant to STC 15.4(a), will be paid as follows, as of 2025:
  1. The Primary Care ACOs (PCCM entities) may provide payment to providers for Flexible Services, consistent with the fee-for-service rates reviewed and approved by CMS.
  2. For Accountable Care Partnership Plans, it is permissible for Flexible Services HRSN Services to be provided as a non-risk payment. For a non-risk payment, the MCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR § 447.362 and may be reimbursed by the Commonwealth at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR § 447.362 is the fee-for-service authorized in this demonstration for Flexible Services paid on a fee-for-service basis by MassHealth. If the Commonwealth chooses instead to incorporate the Flexible Services HRSN Services into the risk-based capitation rates it must comply with all applicable Federal requirements, including but not limited to 42 CFR §§ 438.4, 438.5 and 438.7.
- vi. MassHealth may offer Primary Care ACOs and Accountable Care Partnership Plans the option to newly offer Flexible Services HRSN services or change their election from time to time and may make or change such election pursuant to the terms of their contract with the Commonwealth. Any change to the coverage of Flexible Services HRSN services requires an amendment to the Commonwealth's contracts with the Primary Care ACOs and Accountable Partnership Plans that requires CMS review and approval in accordance with 42 CFR 438.3(a) and (r). Additionally, when Flexible Services HRSN services are included in risk-based capitation rates for the Accountable Care Partnership Plans, the Commonwealth's actuary must evaluate if a rate amendment is necessary to ensure actuarially sound capitation rates in accordance with 42 CFR 438.4. The Commonwealth or managed care plan must also provide adequate notice to beneficiaries.
- vii. MassHealth may permit Primary Care ACOs and Accountable Care Partnership Plans to discontinue offering Flexible Services HRSN services with notice to the state Medicaid agency, and beneficiaries, at the Commonwealth's discretion. When a managed care plan ceases to offer Flexible Services HRSN service to its enrollees, the Commonwealth or the plan, as directed by the Commonwealth, must develop a transition of care

policy to ensure enrollee protections as well as minimal disruption of care and adequate access to state plan services and settings. The Commonwealth must also modify the corresponding managed care contracts and submit the modified contracts to CMS as required in 42 CFR 438.3(a). Additionally, the Commonwealth must adjust payment as needed to either remove the non-risk payment if the HRSN is reimbursed in that manner, or if the HRSN is included within the risk-based capitation rate it should be revised, as needed, to remove utilization and cost of the HRSN from capitation rates as required in § 438.7(a) and § 438.7(c)(2).

#### 15.8. **Contracted Providers.**

- a. Specialized CSP HRSN Services, applicable as of April 1, 2023
  - i. MassHealth, MassHealth MCOs, BH PIHP, and Accountable Care Partnership Plans will contract with specialized CSP service providers (“Contracted Providers”) to deliver the specialized CSP HRSN services authorized under the demonstration.
  - ii. MassHealth, MassHealth MCOs, BH PIHP and Accountable Care Partnership Plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the specialized CSP services being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable, based on the services being furnished or activities being performed by the staff.
- b. Flexible Services HRSN Services, applicable as of January 1, 2025
  - i. MassHealth, Primary Care ACOs, and/or Accountable Care Partnership Plans may contract with HRSN service providers (“Contracted Providers”) to deliver the Flexible Services HRSN services authorized under the demonstration.
  - ii. MassHealth, Primary Care ACOs, and/or Accountable Care Partnership Plans should establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the Flexible Services HRSN services being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable, based on the services furnished or activities being performed by the staff.
  - iii. Any state direction on the payment arrangement for Flexible Services HRSN that constitutes a state directed payment must satisfy the requirements in 42 CFR 438.6(c).

15.9. **Provider Network Capacity.** As of April 1, 2023, the Commonwealth must require MassHealth MCOs, BH PIHP and/or Accountable Care Partnership Plans to ensure the

Specialized CSP HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the specialized CSP HRSN services, in accordance with the MassHealth MCOs, BH PIHP and/or Accountable Care Partnership Plans contracts and other state Medicaid agency guidance.

As of January 1, 2025, the Commonwealth must require Primary Care ACOs and Accountable Care Partnership Plans to ensure the Flexible Services HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the Flexible Services HRSN services, in accordance with the Primary Care ACOs' and Accountable Care Partnership Plans' contracts and other state Medicaid agency guidance.

The Commonwealth must provide comparable protections and network adequacy as described within this STC to beneficiaries provided HRSN within fee-for-service delivery systems as of January 1, 2025.

- 15.10. **Compliance with Federal Requirements.** The Commonwealth shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.
- 15.11. **Person Centered Plan.** As of January 1, 2025, the Commonwealth shall ensure there is a person-centered service plan for each individual receiving HRSN services that is person-centered, identifies the member's needs and individualized strategies and interventions for meeting those needs, and is developed in consultation with the member and member's chosen support network, as appropriate. The service plan is reviewed, and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
- 15.12. **Conflict of Interest.** The Commonwealth shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The Commonwealth also agrees that appropriate separation of service planning and service provision functions are incorporated into the Commonwealth's conflict of interest policies.
- 15.13. **Medicaid Beneficiary Protections.** As part of the Commonwealth's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the Commonwealth must provide documentation including, but not limited to:
  - a. Beneficiary and plan protections, including but not limited to:
    - i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.

- ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.
  - iii. Medicaid beneficiaries who are offered or utilize an HRSN retain all rights and protections afforded under part 438.
  - iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested those services, or have received these services in the past.
  - v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.
- b. Managed care plans must timely submit any related data requested by the Commonwealth or CMS, including, but not limited to:
- i. Data to evaluate the utilization and effectiveness of the HRSN services.
  - ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and/or supplemental reporting on health outcomes and any disparities. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.
  - iii. Any data necessary to monitor appeals and grievances for beneficiaries.
  - iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.
  - v. Any data determined necessary by the Commonwealth or CMS to monitor and oversee the HRSN initiatives.
- c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:
- i. The managed care plans must submit timely and accurate encounter data to the Commonwealth for beneficiaries eligible for HRSN services. The Commonwealth must seek CMS approval on what is considered appropriate and reasonable timeframe for plan submission of encounter data. When possible, this encounter data must include data necessary for the Commonwealth to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the Commonwealth.

- ii. Any additional information requested by CMS, the Commonwealth or a legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the Commonwealth, CMS, or a legally authorized independent entity.
- iii. The Commonwealth must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on its progress in building and sustaining its partnership with existing housing and nutrition agencies to utilize their expertise and existing housing and nutrition resources and avoiding duplication of efforts.
- iv. Any additional information determined reasonable, appropriate and necessary by CMS.

15.14. **Maintenance of Effort (MOE).** The Commonwealth must maintain level state funding for social services related to housing transitions supports and nutrition supports for the duration of the demonstration. Within 90 days of demonstration approval, the Commonwealth will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will determine baseline spending on these services throughout the Commonwealth. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 16.6, including any justifications necessary to describe the findings.

15.15. **Partnerships with State and Local Entities.** The Commonwealth must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care program, local housing authorities, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The Commonwealth will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and other supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly and Annual Monitoring described in STC 16.6, the Commonwealth will provide the status of the Commonwealth's fulfillment of its plan and progress relative to timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the Commonwealth's plan is fully implemented then the Commonwealth may conclude its status updates in the Monitoring Reports.

15.16. **HRSN Implementation Plan.** The Commonwealth is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The Implementation Plan can be updated as initiatives are changed or added. CMS will provide a template to support this reporting that the Commonwealth will be required to use to help structure the information provided and prompt the Commonwealth



for information CMS would find helpful in approving the Implementation Plan. The Commonwealth must submit a partial Implementation Plan within 90 calendar days after approval of this demonstration, in accordance with STC 15.1. A complete Implementation Plan is due on July 1, 2023, per the terms in this STC and STC 15.1. The Commonwealth must submit further clarifications or revisions to information submitted in the Implementation Plan if required by CMS feedback within 60 calendar days after receipt of CMS's comments. Once approved, the Implementation Plan will be appended as Attachment T, and, once appended, may be altered only with CMS approval.

At a minimum, the Implementation Plan must provide a description of the Commonwealth's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

The Implementation Plan must include information on, but not limited to, the following:

- a. To the extent the information is not already provided in the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications (per STC 9.6), the Implementation Plan must add any outstanding details or updates on:
  - i. Process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.
  - ii. Process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.
    1. Plan to identify specific diagnosis or procedure codes (e.g., ICD-10, CPT, HCPCS codes) that the Commonwealth will use to operationalize the criteria;
    2. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and other stakeholders;
- b. Process for developing care plans based on assessment of need:
  - i. Plan to initiate care plans and referrals (with feedback to the referring provider or entity that the referral has been completed and information about any referred services furnished) to social services and community providers based on outcomes of the screening.

- ii. Information about (1) how and on what timeline beneficiaries will be linked to services to address unmet social needs, and (2) how and when beneficiaries will receive follow up with a care plan, through social needs case management or alternative approaches, as applicable, the timeframe in which beneficiaries will be linked to services, the approach to follow-up, who will conduct the linkage and follow-up, and the approach to developing care plans, if applicable.
  - iii. Description of how the Commonwealth will ensure that screening and services related to the demonstration are provided to beneficiaries in ways that are culturally appropriate and/or trauma informed.
- c. Medicaid services to which beneficiaries could be referred.
- d. Plans for technical assistance, quality improvement, and sustainability planning.
- e. Plan for establishing and/or improving data sharing and partnerships with an array of health and social system stakeholders to the extent those entities are vital to provide needed data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.
- f. Information about key partnerships, capacity building for community partners, and how the Commonwealth will solicit and incorporate input from impacted groups, such as community partners, health care delivery system partners, and beneficiaries.
- g. Information technology infrastructure to support data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision. A plan for tracking and improving upon the share of Medicaid beneficiaries who are eligible and enrolled in SNAP and WIC, relative to the number eligible.
- h. Implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout that can facilitate robust evaluation designs if these implementation strategies are culturally appropriate.
- i. Information as required per STC 15.14 (MOE).
- j. Documentation of existing partnerships with state and local entities (e.g., Department of Housing and Urban Development, Continuum of Care program, local housing authority, SNAP state agency) and plan to ensure that pathways to non-Medicaid funding sources of housing and other supports are available upon the conclusion of temporary Medicaid reimbursement.
- k. Information as required per STC 15.15 (Partnerships with State and Local Entities).

- l. All rate/payment methodologies for authorized HRSN services outlined in the STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to fee-for-service payment as well as non-risk payments, capitation rates and PCCM entity payment in managed care delivery systems, as part of the Implementation Plan at least 60 days prior to implementation. The Commonwealth must submit all documentation requested by CMS, including but not limited to: the payment rate methodology as well as other documentation and supporting information (e.g., Commonwealth responses to Medicaid non-federal share financing questions). The Commonwealth must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting fee-for-service payment rates.
- m. Alignment with other state initiatives.

Failure to submit a HRSN Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the HRSN services initiative under this demonstration.

#### **15.17. HRSN Infrastructure Investments: Social Service Organization (SSO) Integration Fund**

- a. Up to \$8 million (total computable) in expenditure authority will be made available for the first 4 years of the demonstration, in order for the Commonwealth to support the development and implementation of HRSN services. Funding will be available for the following activities, subject to the exclusions in STC 15.4:
  - i. Technology – e.g., electronic referral systems, shared data platforms, EHR adaptations or data bridges, screening and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems.
  - ii. Developing business or operational practices to support delivery of Flexible Services – e.g., developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.
  - iii. Workforce development – e.g., cultural competency training, trauma-informed training, Community Health Worker (CHW) certification, training staff on new policies and procedures.
  - iv. Outreach and education – e.g., design and production of outreach and education materials, translation, obtaining community input.
- b. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The Commonwealth must ensure there is no duplication of funds. HRSN infrastructure funding must be claimed at the applicable administrative match rate.

- c. To the extent the Commonwealth requests any additional Social Service Organization Infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS’s consideration.
  - d. The Commonwealth may not claim any FFP for Social Service Organization Infrastructure funding until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications is approved. Once approved, the Commonwealth can claim FFP for HRSN Social Service Organization Infrastructure funding retrospectively to the beginning of the extension approval date.
- 15.18. **Provider Rate Increase Expectations.** As a condition of the HRSN and Hospital Quality and Equity Initiative expenditure authority, Massachusetts must comply with the provider rate increase requirements in Section 21 of the STCs.

## 16. MONITORING AND REPORTING REQUIREMENTS

- 16.1. **Submission of Post-approval Deliverables.** The Commonwealth shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs (“deliverables”). The Commonwealth shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.
- 16.2. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to be not consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The Commonwealth does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the Commonwealth materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due, if the Commonwealth has not submitted a written request to CMS for approval of an extension as described in subsection (b) below, or 2) 30 calendar days after CMS has notified the Commonwealth in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the Commonwealth providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the Commonwealth may submit to CMS 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

Commonwealth has taken to address such issue, and the Commonwealth's anticipated date of submission. Should CMS agree in writing to the Commonwealth's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the Commonwealth fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the Commonwealth.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the Commonwealth submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outline in these STCs, the deferral(s) will be released.

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 will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

**16.3. Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate section 1115 demonstration reporting and analytics functions, the Commonwealth shall work with CMS to:

- a. revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.
- b. ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the Commonwealth; and
- c. submit all deliverables to the appropriate system as directed by CMS.

**16.4. Monitoring Protocol for Other Policies.** The Commonwealth must submit to CMS a Monitoring Protocol addressing components of the demonstration not covered by the SUD and SMI/SED Monitoring Protocols (e.g., hospital health equity framework, workforce development initiatives, continuous eligibility, premiums, and waivers of retroactive eligibility). The Commonwealth must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Once approved, the Monitoring Protocol for Other Policies will be incorporated in the STCs as Attachment W. In addition, the Commonwealth must submit an updated or a separate Monitoring Protocol for any

amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol will affirm the Commonwealth's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the Commonwealth will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 16.5(b)), the Commonwealth is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the Commonwealth's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the Commonwealth's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the Commonwealth's HRSN initiatives authorized through this demonstration, the Monitoring Protocol requires specifying selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines. CMS underscores the importance of the Commonwealth's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers. The Monitoring Protocol must also outline the Commonwealth's planned approaches and parameters to track performance relative to the goals and milestones, as provided in the Implementation Plan, for the HRSN infrastructure investments.

Furthermore, for HRSN initiatives, the Commonwealth must describe in the Monitoring Protocol its plans and methods to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics, as applicable. These sources may include, but are not limited to (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or housing assistance), (3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable), and (4) social needs screening results from electronic health records, health plans, or other partner agencies as applicable. Across data sources, the Commonwealth must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

For the qualitative elements (e.g., operational updates as described in STC 16.5(a) below), CMS will provide the Commonwealth with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the Commonwealth's Quarterly and Annual Monitoring Reports.

- 16.5. **Quarterly and Annual Monitoring Reports.** The Commonwealth must submit three Quarterly Reports and one Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 days following the end of each demonstration quarter. The Annual Report (including the fourth quarter information) is due no later than 90 days following the end of the DY. The Commonwealth must submit a revised Monitoring Report within 60 days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 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. The Quarterly and Annual Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.
- a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The Commonwealth must also share findings and updates on other demonstration components, including (but not limited to): primary care payment oversight activities (e.g., auditing of PCPs); the volume and nature of beneficiary support system contacts and the resolution of such contacts; findings from ACO and CP quarterly operation reports; HRSN infrastructure investments, and findings from performance assessments and corrective action plans related to oversight of health systems and providers receiving health equity incentive funding. The reports must 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. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
  - b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the Commonwealth is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and must cover all key policies under this demonstration. Metrics in the Commonwealth's Monitoring Reports must cover key policies under this demonstration, including but not limited to SUD, SMI/SED, the hospital health quality framework, continuous eligibility, workforce development initiatives, HRSN demonstration component, premiums, and

waivers of retroactive eligibility. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

The Commonwealth's metrics reporting must cover categories to include, but not limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, enrollment by premium payment status, unpaid medical bills at time of application, and quality of care and health outcomes. The Commonwealth must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration component—to the extent feasible—to identify existing inequities and track progress towards reducing inequities. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the Commonwealth's Medicaid population, including the narrowing of any identified disparities.

In addition to the SUD and SMI/SED metrics, for each of the demonstration components listed below, the Commonwealth should report metrics related (but not limited) to:

- i. For the Hospital Quality and Equity Initiative, in coordination with CMS and in alignment with a critical set of health equity measures CMS is finalizing, the Commonwealth's reporting of quality of care and health outcomes metrics must represent a critical set of health equity-focused measures from CMS's upcoming guidance on Health Equity Measure Slate.
- ii. For the workforce initiatives component, the Commonwealth must monitor, for example, the numbers of students (primary care and behavioral health) and family nurse practitioners supported through the loan repayment and residency grant programs under the demonstration, provider tenure, the demographic makeup of providers.
- iii. For the HRSN initiatives, in addition to reporting on the metrics described above, the Commonwealth must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the Commonwealth or partner entities assisting in the administration of the demonstration and social services organizations. Specifically, in the context of the HRSN initiatives, the Commonwealth's enrollment and renewal metrics must capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-



parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible.

In addition, if the Commonwealth, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the Commonwealth must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics.

- iv. In addition to the enrollment and renewal metrics that support tracking Medicaid churn, systematic monitoring of the continuous eligibility policy must—at a minimum—capture data on utilization of preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.
- v. To monitor premiums and premium assistance policies, the Commonwealth must report metrics including (but not limited to) the number of beneficiaries subject to these policies, enrollment continuity and disenrollment rates, and third-party payment. 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.
- vi. For the waiver of retroactive eligibility, the Commonwealth must report the number of beneficiaries who indicated they had unpaid medical bills at the time of application, and information about beneficiaries who experienced a gap in coverage.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

- c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The Commonwealth 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 Commonwealth must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

- d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. The Commonwealth shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

16.6. **Monitoring Calls.** CMS will convene periodic conference calls with the Commonwealth.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, the status of investment submissions, and progress on evaluation activities.
- 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 Commonwealth and CMS will jointly develop the agenda for the calls.

16.7. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the Commonwealth to submit a correction action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change, inconsistent with state targets and goals, as applicable, and the Commonwealth has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

## 17. EVALUATION OF THE DEMONSTRATION

17.1. **Independent Evaluator.** The Commonwealth must use 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 an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the Commonwealth may request, and CMS may agree to changes in the methodology in appropriate circumstances.

17.2. **Cooperation with Federal Evaluators and Learning Collaboration.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or

any component of the demonstration, the Commonwealth 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 Commonwealth 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 Commonwealth under 42 CFR 431.420(f) to support federal evaluation. This may also include the Commonwealth's participation—including representation from the Commonwealth's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The Commonwealth may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 16.2.

- 17.3. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft 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 report 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, or if the estimates appear to be excessive.
- 17.4. **Draft Evaluation Design.** The Commonwealth must submit, for CMS comment and approval, a draft Evaluation Design for this demonstration approval period no later than 180 calendar days after the approval date of the demonstration. The Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to): (1) Attachment A (Preparing the Evaluation Design) of these STCs, and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the Commonwealth is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The Commonwealth is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must

include a timeline for key evaluation activities, including the deliverables outlined in STCs 17.7 and 17.8.

For any amendment to the demonstration, the Commonwealth will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the Commonwealth may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the Commonwealth's Interim (as applicable) and Summative Evaluation Reports, described below.

- 17.5. **Evaluation Design Approval and Updates.** The Commonwealth must submit a revised Evaluation Design within 60 days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment S of these STCs. Per 42 CFR 431.424(c), the Commonwealth will publish the approved Evaluation Design to its Medicaid website within 30 days of CMS approval. Once CMS approves the Evaluation Design, if the Commonwealth wishes to make changes, the Commonwealth must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the Commonwealth may include updates to the Evaluation Design in Monitoring Reports.
- 17.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the Commonwealth intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the Commonwealth undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of

and experience with the various demonstration policy components including premiums and the waiver of retroactive eligibility, beneficiary experiences with access to and quality of care, as well as changes in incidence of beneficiary medical debt. The Commonwealth is also strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the Commonwealth’s crafting and selection of testable hypotheses and research questions for the demonstration’s outcome and impact evaluations and provide context for interpreting the findings. To the extent feasible, the Commonwealth must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration’s various policies might support reducing such disparities.

As part of its evaluation efforts, the Commonwealth must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The Commonwealth must analyze the budgetary effects of the HRSN services, and the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the Commonwealth must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration’s effects on the fiscal sustainability of the Commonwealth’s Medicaid program.

The Commonwealth must develop evaluation questions and hypotheses related to each demonstration component. Examples include, but are not limited to:

- a. **SUD Treatments.** Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include (but are not limited to): initiation and engagement with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.
- b. **SMI Services.** Hypotheses for the SMI program must include an assessment of the objectives of the SMI component of this 1115 demonstration. Examples include (but are not limited to): utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination.
- c. **Hospital Quality and Equity Initiative.** The Commonwealth’s evaluation efforts must also include developing thoughtful hypotheses and research questions to assess

the effectiveness of the Hospital Quality and Equity Initiative in ensuring provision of consistent high-quality care to all beneficiaries, and must provide evidence of the Commonwealth's efforts to collect stratified data for selected performance measures. The evaluation of the Initiative must also include robust analyses that help demonstrate whether the Commonwealth is succeeding in improving the quality and completeness of reporting on stratified data elements.

- d. **Workforce Development.** The Commonwealth must evaluate whether the targeted loan repayment and residency grant programs, and any other authorized workforce initiatives under the demonstration, improve access to covered services for Medicaid beneficiaries. To that end, the Commonwealth must investigate—to the extent feasible—the effects of the workforce initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention, especially in the concentration areas such as primary care, behavioral health and family practice. Because these initiatives may affect a small number of providers, the Commonwealth is strongly encouraged to use a mixed-methods approach that would incorporate qualitative data sources, including interviews and/or focus groups with participating providers, and beneficiary experience surveys.
- e. **HRSN.** Evaluation hypotheses for the HRSN initiatives in the demonstration must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include an analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. In alignment with the demonstration's objectives to improve outcomes for the Commonwealth's overall beneficiary populations eligible for the HRSN initiatives, the Commonwealth must also include research questions and hypotheses focused on understanding the impact of HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing, nutrition and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must

include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. It is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

- f. **Continuous Eligibility.** For the continuous eligibility policy, the Commonwealth must evaluate the impact of the program on all relevant populations appropriately tailored for the specific time span of eligibility. For example, the Commonwealth must evaluate how the continuous eligibility policy affects coverage, enrollment, and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled and re-enroll within 12 months), as well as population-specific appropriate measures of service utilization and health outcomes. The Commonwealth must also evaluate the effectiveness of the continuous eligibility authority. For example, for the Commonwealth's populations of focus under the demonstration's continuous eligibility policy, to the extent feasible, the Commonwealth may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the Commonwealth's administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the Commonwealth may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.
- g. **Premiums and Premium Assistance.** The Commonwealth must include hypotheses including (but not limited to): beneficiary access to and utilization of preventive, primary, specialist, and emergency services; enrollment continuity, number and frequency of coverage gaps, and disenrollment rates; and beneficiary experiences with care.
- h. **Waiver of Retroactive Eligibility.** Hypotheses for the waiver of retroactive eligibility must include an assessment of the outcomes of the retroactive eligibility component of this section 1115 demonstration. Examples include (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, health status, and beneficiary medical debt, which can be assessed through a beneficiary survey or using data obtained from credit bureaus.
- i. **Delivery System Reform.** The following are among the hypotheses to be considered in development of the Evaluation Design and will be included in the design as appropriate:
  - i. the formation of new partnerships and collaborations within the delivery system;
  - ii. the increased acceptance of TCOC risk-based payments among MassHealth providers;

- iii. improvements in the member experience of care, particularly through increased member engagement in the primary care setting or closer coordination among providers; more robust EHR and other infrastructure capabilities and interconnectivity among providers; increased coordination across silos of care (e.g., physical health, behavioral health, LTSS, social supports);
- iv. maintenance or improvement of clinical quality; and
- v. the enhancement of safety net providers' capacity to serve Medicaid and uninsured patients in the Commonwealth.

17.7. **Interim Evaluation Report.** The Commonwealth must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report should be posted to the Commonwealth's website with the application for public comment.

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
- b. For demonstration authority or any components within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the Commonwealth.
- c. If the Commonwealth is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or 1 year prior to the end of the demonstration, whichever is sooner. If the Commonwealth is not requesting an extension for a demonstration, an Interim Evaluation report is due 1 year prior to the end of the demonstration.
- d. The Commonwealth must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the Commonwealth must post the final Interim Evaluation Report to the Commonwealth's Medicaid website within 30 calendar days.
- e. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

17.8. **Summative Evaluation Report.** The Commonwealth must submit a draft Summative Evaluation Report for the demonstration's approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.



- a. The Commonwealth must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
  - b. The final Summative Evaluation Report must be posted to the Commonwealth's Medicaid website within 30 calendar days of approval by CMS.
- 17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the Commonwealth to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 17.10. **State Presentations for CMS.** CMS reserves the right to request that the Commonwealth present and participate in a discussion with CMS on the Evaluation Design, Interim Evaluation Report, and/or Summative Evaluation report. Presentations may be conducted remotely.
- 17.11. **Close Out Report.** Within 120 calendar days after the expiration of the demonstration, the Commonwealth must submit a draft Close Out Report to CMS for comments.
- a. The Close Out Report must comply with the most current Guidance from CMS.
  - b. In consultation with CMS, and per guidance from CMS, the Commonwealth will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close Out Report. Depending on the timeline of the phase-out during the demonstration approval period, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 15.6 and 15.7, respectively.
  - c. The Commonwealth will present to and participate in a discussion with CMS on the Close Out Report.
  - d. The Commonwealth must take into consideration CMS's comments for incorporation into the final Close Out Report.
  - e. A revised Close Out Report is due to CMS no later than 30 days after receipt of CMS's comments, if any.

- f. A delay in submitting the draft or final versions of the Close Out Report could subject the Commonwealth to penalties described above.
- 17.12. **Public Access.** The Commonwealth shall post the final documents (e.g., Implementation Plans, Monitoring Protocols, monitoring reports, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the Commonwealth’s Medicaid website within 30 days of approval by CMS.
- 17.13. **Additional Presentations and Publications.** For a period of 12 months following the CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings including in related publications (including, for example, journal articles), by the Commonwealth, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

## 18. GENERAL FINANCIAL REQUIREMENTS

- 18.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.
- 18.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The Commonwealth will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The Commonwealth will 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 federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the Commonwealth’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the Commonwealth shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the Commonwealth, and include the reconciling adjustment in the finalization of the grant award to the Commonwealth.
- 18.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible

state and/or local funds that, unless permitted by law, are not other federal funds. The Commonwealth further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

- a. If requested, the Commonwealth must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
- b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the Commonwealth must address CMS's concerns within the time frames allotted by CMS.
- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

**18.4. State Certification of Funding Conditions.** As a condition of demonstration approval, the Commonwealth certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the Commonwealth must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
- b. To the extent the Commonwealth utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the Commonwealth must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the Commonwealth identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).
- c. The Commonwealth may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are

transferred by units of government within the Commonwealth. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the Commonwealth any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. 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.
- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the Commonwealth's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

**18.5. Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the Commonwealth attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

**18.6. Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the Commonwealth attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).
- c. If the health care-related tax is either not broad-based or not uniform, the Commonwealth has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

- e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

18.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the Commonwealth must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 16.2. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the Commonwealth, or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;
- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the Commonwealth will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

18.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 19:

- 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. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration

extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

- 18.9. **Program Integrity.** The Commonwealth must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The Commonwealth must also ensure that the Commonwealth and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.
- 18.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

<b>Table 17: Master MEG Chart</b>					
<b>MEG</b>	<b>Which BN Test Applies?</b>	<b>WOW Per Capita</b>	<b>WOW Aggregate</b>	<b>WW</b>	<b>Brief Description</b>
Base Families	Main	X		X	Eligible non-disabled individuals enrolled in MassHealth Standard (including those enrolled in Temporary Assistance for Needy Families), as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only).
Base Disabled	Main	X		X	Eligible individuals with disabilities enrolled in MassHealth Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only).
1902(r)(2) Children	Main	X		X	Medicaid expansion children and pregnant individuals who are enrolled in MassHealth Standard, as well as eligible children and pregnant individuals enrolled in MassHealth Limited (emergency services only).
1902(r)(2) Disabled	Main	X		X	Eligible individuals with disabilities enrolled in MassHealth 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).
BCCDP	Main	X		X	Individuals eligible under the Breast and Cervical Cancer Demonstration Program who are enrolled in MassHealth Standard.

Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
CommonHealth	Hypo 1	X		X	Higher income working adults and children with disabilities enrolled in CommonHealth.
e-Family Assistance	Main			X	Eligible children receiving premium assistance or direct coverage through 300 percent of the FPL enrolled in Family Assistance.
e-HIV/FA	Main			X	Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance.
SNCP-DSRIP	Main			X	Expenditures for Delivery System Reform Payments (DSRIP). This should be inclusive of SNCP-DSRIP-ACO, SNCP-DSRIP-CP, SNCP-DSRIP-SWI, SNCP-DSRIP-Operations.
SNCP-PHTII	Main			X	Expenditures authorized under the Public Hospital Transformation and Incentives Initiative
SNCP-DSH-HSNTF	Main			X	Expenditures authorized under the Health Safety Net program as referenced on Attachment E item 4.
SNCP-DSH-IMD	Main			X	Expenditures authorized under the SNCP for IMD services, as referenced on Attachment E item 5, excluding expenditures reported under STC 13.2(f)
SNCP-DSH-CPE	Main			X	Expenditures for State owned non-acute hospitals operated by the Department of Public Health and the Department of Mental Health, as referenced on Attachment E items 6 and 7.



Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
SNCP-UCC	Main			X	Expenditures authorized under the Uncompensated Care Pool.
SNCP-OTHER	Main			X	All other expenditures authorized under the SNCP, including Public Services Hospital Safety Net Care Payments as referenced on Attachment E item 1
SNCP - Safety Net Provider Payments	Main			X	Expenditures for Safety Net Provider Payments, as referenced on Attachment E item 8
New Adult Group	Hypo 2	X		X	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.
Marketplace Subsidies	Hypo 3	X		X	Expenditures for premium and cost sharing subsidies and Connector gap coverage under the demonstration.
Provisional Eligibility	Main			X	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority consistent with STC 4.7.
EAEDC	Main			X	Expenditures for health care related costs for individuals receiving Emergency Aid to Elders, Disabled and Children.
End of Month Coverage	Main			X	Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.
FFCY	Hypo 4	X		X	Expenditures for those individuals enrolled as “Out-of-state Former Foster Care Youth,” who are youth under age 26 who were in foster care under the

Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
					responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18 (or a higher age at which the state's or Tribe's foster care assistance ends), and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.
SUD	Hypo 5	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table 6 of Section 6.
SMI IMD Services	Hypo 6	X		X	Expenditures for costs of medical assistance provided to Base Disabled, Base Families, CommonHealth, eHIV/FA, 1902(r)(2) Disabled, 1902(r)(2) BCCDP, and New Adult Group individuals while they are a patient in an IMD for SMI treatment that could be covered, were it not for the IMD prohibition under the state plan as described in Expenditure Authority #15.
Medicare Savings Program (MSP) Expansion	Main			X	All expenditures for MSP benefits as described in Expenditure Authority #17 for MassHealth members eligible for Medicare cost sharing assistance through the Commonwealth's MSP income limit expansion, without applying an asset test (i.e., MassHealth income limit between 133 percent FPL and 165 percent FPL).

<b>Table 17: Master MEG Chart</b>					
<b>MEG</b>	<b>Which BN Test Applies?</b>	<b>WOW Per Capita</b>	<b>WOW Aggregate</b>	<b>WW</b>	<b>Brief Description</b>
Diversionsary BH	Main			X	All expenditures for Diversionsary BH Services
CP Enhanced Care Coordination	Main			X	Report all expenditures for payments directly to LTSS CPs to support LTSS CPs care coordination responsibilities.
Hospital Quality and Equity Initiative	Main			X	All expenditures authorized through the Hospital Quality and Equity Initiative.
Workforce Initiative	Main			X	All expenditures for student loan repayment and residency programs.
HRSN Services	Capped Hypo		X	X	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	Capped Hypo		X	X	All infrastructure expenditures for certain HRSN initiatives.
Flexible Services: Transportation	Main			X	All expenditures for the transportation benefit under the Flexible Services Program.
Flexible Services: Cooking Supplies	Main			X	Report all expenditures for the cooking supplies under the Flexible Services Program.
CE Formerly Incarcerated/ Base Families	Hypo 7	X		X	All expenditures for Formerly Incarcerated individuals who are defined as Base Families during the Continuous Eligibility period.
CE Formerly Incarcerated/ Base Disabled	Hypo 7	X		X	All expenditures for Formerly Incarcerated individuals who are defined as Base Disabled during the Continuous Eligibility period.
CE Homeless/Base Families	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as Base Families during the Continuous Eligibility period.

<b>Table 17: Master MEG Chart</b>					
<b>MEG</b>	<b>Which BN Test Applies?</b>	<b>WOW Per Capita</b>	<b>WOW Aggregate</b>	<b>WW</b>	<b>Brief Description</b>
CE Homeless/Base Disabled	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as Base Disabled during the Continuous Eligibility period.
CE Homeless/1902(r)2 Children	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as 1902(r)2 Children during the Continuous Eligibility period.
CE Homeless/1902(r)2 Disabled	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as 1902(r)2 Disabled during the Continuous Eligibility period.
CE Homeless/1902(r)2 BCCDP	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

- 18.11. **Reporting Expenditures and Member Months.** The Commonwealth must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00030/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the Commonwealth also must report member months of eligibility for specified MEGs.
- a. **Cost Settlements.** The Commonwealth will report any cost settlements attributable to the demonstration 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), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
  - b. **Premiums and Cost Sharing Collected by the State.** The Commonwealth will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the Commonwealth's compliance with the budget neutrality limits.
  - c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the Commonwealth must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The Commonwealth must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must

be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

- d. **Administrative Costs.** The Commonwealth will 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. Unless indicated otherwise on the MEG Charts and in the STCs in section 19, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
  - e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 16, the Commonwealth must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration 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 months per person, for a total of four eligible member months. The Commonwealth must submit a statement accompanying the annual report certifying the accuracy of this information.
  - f. **Budget Neutrality Specifications Manual.** The Commonwealth will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the Commonwealth will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the Commonwealth compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.
- 18.12. **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 MEG, the 1902(r)(2) Children EG, the CommonHealth MEG 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 MEGs under the title XIX demonstration apply:

- a. **Base Families XXI RO, 1902(r)(2) RO, CommonHealth XXI, and Fam Assist XXI:** 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 18.11 (Reporting Expenditures and Member Months).
- 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 MEGs will:
  - i. Count toward the budget neutrality expenditure limit calculated under section 19, STC 19.3 (Calculation of the Budget Neutrality Limits and How They are Applied); and
  - ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 19.3, 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 MEG will be considered expenditures subject to the budget neutrality agreement as defined in STC 19.3. 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.

**Table 18: MEG Detail for Expenditure and Member Month Reporting**

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
<b>Base Families</b>	Report all medical assistance expenditures for eligible non-disabled individuals enrolled in MassHealth Standard (including those receiving Temporary Assistance for Needy Families) and eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>Base Disabled</b>	Report all medical assistance expenditures for eligible individuals with disabilities enrolled in MassHealth Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27



<b>1902(r)(2) Children</b>	Report all medical assistance expenditures for Medicaid expansion children and pregnant individuals who are enrolled in MassHealth Standard, as well as eligible children and pregnant individuals enrolled in MassHealth Limited (emergency services only).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>1902(r)(2) Disabled</b>	Report all medical assistance expenditures for eligible individuals with disabilities enrolled in MassHealth 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).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>BCCDP</b>	Report all medical assistance expenditures for individuals eligible under the Breast and Cervical Cancer Demonstration Program who are enrolled in MassHealth Standard.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27

<b>CommonHealth</b>	Report all medical assistance expenditures for higher income working adults and children with disabilities enrolled in CommonHealth.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>e-Family Assistance</b>	Report all medical assistance expenditures for eligible children receiving premium assistance or direct coverage through 300 percent of the FPL enrolled in Family Assistance.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	7/1/97	12/31/27
<b>e-HIV/FA</b>	Report all medical assistance expenditures for Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>SNCP-DSRIP</b>	Report expenditures for Delivery System Reform Payments (DSRIP). This should be inclusive of SNCP-DSRIP-ACO, SNCP-DSRIP-CP, SNCP-		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	7/1/17	12/31/27

	DSRIP-SWI, SNCP-DSRIP-Operations.							
<b>SNCP-PHTII</b>	Report expenditures authorized under the Public Hospital Transformation and Incentives Initiative		Follow standard CMS-64.9 Category of Service Definition	Date of service/Date of payment	MAP	N	7/1/17	06/30/2024
<b>SNCP-DSH-HSNTF</b>	Report expenditures authorized under the Health Safety Net program as referenced on Attachment E item 4.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP-DSH-IMD</b>	Report expenditures authorized under the SNCP for IMD services, as referenced on Attachment E item 5, excluding expenditures reported under STC 13.2(f)		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP-DSH-CPE</b>	Report expenditures for State owned non-acute hospitals operated by the Department of Public Health and the Department of Mental Health, as referenced on Attachment E items 6 and 7.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27

<b>SNCP-UCC</b>	Report expenditures authorized under the Uncompensated Care Pool.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP-OTHER</b>	Report all other expenditures authorized under the SNCP, including Public Services Hospital Safety Net Care Payments , as referenced on Attachment E item 1.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP - Safety Net Provider Payments</b>	Report expenditures authorized under the SNCP as referenced on Attachment E item 8.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	10/1/22	12/31/27
<b>New Adult Group</b>	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.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>Marketplace Subsidies</b>	Report expenditures for premium and cost sharing subsidies and Connector gap coverage under the demonstration.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	7/1/17	12/31/27

<b>Provisional Eligibility</b>	Report expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority consistent with STC 4.7.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>EAEDC</b>	Report all medical assistance expenditures for health care related costs for individuals receiving Emergency Aid to Elders, Disabled and Children.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>End of Month Coverage</b>	Report all medical assistance expenditures for beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>FFCY</b>	Report all medical assistance expenditures for those individuals enrolled as “Out-of-state Former Foster Care Youth,” who are youth under age 26 who were in foster care under the responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27

	(or a higher age at which the state's or Tribe's foster care assistance ends), and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.							
<b>SUD</b>	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table 6 of Section 6.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>SMI IMD Services</b>	Report all medical assistance expenditures for costs of medical assistance provided to Base Disabled, Base Families, CommonHealth, eHIV/FA, 1902(r)(2) Disabled, 1902(r)(2) BCCDP, and New Adult Group individuals while they are a patient in an IMD for SMI treatment that could be covered, were it not for the IMD		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	8/11/22	12/31/27

	prohibition under the state plan as described in Expenditure Authority #15.							
<b>Medicare Savings Program (MSP) Expansion</b>	Report all medical assistance expenditures for MSP benefits as described in Expenditure Authority #17 for MassHealth members eligible for Medicare cost sharing assistance through the Commonwealth's MSP income limit expansion, without applying an asset test (i.e., MassHealth income limit between 133 percent FPL and 165 percent FPL).		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	8/11/22	12/31/27
<b>Diversionsary BH</b>	All expenditures for Diversionsary BH Services		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	10/1/22	12/31/27
<b>CP Enhanced Care Coordination</b>	Report all expenditures for payments directly to LTSS CPs to support LTSS CPs care coordination responsibilities.		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/22	12/31/27
<b>Hospital Quality and</b>	Report all expenditures for the Hospital		Follow standard	Date of payment	ADM	N	10/1/22	12/31/27

<b>Equity Initiative</b>	Quality and Equity Initiative.		CMS 64.10- Category of Service Definitions					
<b>Workforce Initiative</b>	Report all expenditures for student loan repayment and residency programs.		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/22	12/31/27
<b>HRSN Services</b>	Report all expenditures for approved HRSN initiatives.		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service/Date of payment	MAP/ADM	N	10/1/22	12/31/27
<b>HRSN Infrastructure</b>	Report all infrastructure expenditures for approved HRSN initiatives.		Follow standard CMS 64.10 Category of Service Definitions	Date of service/Date of payment	ADM	N	10/1/22	12/31/27
<b>Flexible Services: Transportation</b>	Report all expenditures for the transportation benefit under the Flexible Services Program.		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service/Date of payment	MAP/ADM	N	10/1/22	12/31/27
<b>Flexible Services: Cooking Supplies</b>	Report all expenditures for the cooking supplies benefit under the Flexible Services Program.		Follow standard CMS 64.10 Category of	Date of service/Date of payment	ADM	N	10/1/22	12/31/27



			Service Definitions					
<b>CE Formerly Incarcerated/ Base Families</b>	All expenditures for Formerly Incarcerated individuals who are defined as Base Families during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Formerly Incarcerated/ Base Disabled</b>	All expenditures for Formerly Incarcerated individuals who are defined as Base Disabled during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/Base Families</b>	All expenditures for Homeless individuals who are defined as Base Families during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/Base Disabled</b>	All expenditures for Homeless individuals who are defined as Base Disabled during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/ 1902(r)2 Children</b>	All expenditures for Homeless individuals who are defined as 1902(r)2 Children		Follow standard CMS-64.9 Category of	Date of service	MAP	Y	10/1/22	12/31/27

	during the Continuous Eligibility period.		Service Definitions					
<b>CE Homeless/ 1902(r)2 Disabled</b>	All expenditures for Homeless individuals who are defined as 1902(r)2 Disabled during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/ 1902(r)2 BCCDP</b>	All expenditures for Homeless individuals who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>ADM</b>	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/22	12/31/27

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group

- 18.13. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

<b>Table 19: Demonstration Years</b>		
Demonstration Year 27	October 1, 2022 to December 31, 2022	3 months
Demonstration Year 28	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 29	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 30	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 31	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 32	January 1, 2027 to December 31, 2027	12 months

- 18.14. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the Commonwealth conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the Commonwealth’s regular Title XIX FMAP rate. Should state data indicate that there is an estimate more accurate than 2.6 percent by which to adjust claiming for individuals defined in 42 CFR 433.204(a)(1), CMS will work with the Commonwealth to update this percentage to the more accurate figure, as supported by the Commonwealth’s proposed methodology and data. CMS anticipates no increase in enrollment among individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) that are experiencing homelessness for the continuous eligibility period; therefore, no change in FMAP claiming is required for the homeless population.
- 18.15. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 18.14 above. The Commonwealth must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the Commonwealth’s regular Title XIX FMAP rate.
- 18.16. **Budget Neutrality Monitoring Tool.** The Commonwealth must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s actual expenditures to the budget

neutrality expenditure limits described in section 19. CMS will provide technical assistance, upon request.<sup>8</sup>

- 18.17. **Claiming Period.** The Commonwealth will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the Commonwealth will 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.
- 18.18. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
  - b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such 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 STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance

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<sup>8</sup> Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

- 18.19. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 18.19.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
  - b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
    - i. Provider rate increases that are anticipated to further strengthen access to care;
    - ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
    - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
    - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

- v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
  - vi. High cost innovative medical treatments that states are required to cover; or,
  - vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
- i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and
  - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state’s Medicaid expenditures that are unrelated to the demonstration and/or outside the state’s control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

## 19. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

19.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, if applicable, as described below. CMS’s assessment of the state’s compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

19.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 17, Master MEG Chart and Table 18, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

- 19.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 19.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government’s Medicaid costs would likely have been absent the demonstration, and that federal Medicaid “savings” have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as “WOW Only” or “Both” are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as “Both.”

**Table 20: Main Budget Neutrality Test**

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Base Families	PC	Both	2019	4.80%	\$451.74	\$465.17	\$487.50	\$510.90	\$535.42	\$561.12
Base Disabled	PC	Both	2019	4.80%	\$1,315.34	\$1,354.45	\$1,419.47	\$1,487.60	\$1,559.01	\$1,633.84
1902(r)(2) Children	PC	Both	2019	4.80%	\$460.97	\$474.68	\$497.46	\$521.34	\$546.36	\$572.59
1902(r)(2) Disabled	PC	Both	2019	4.80%	\$586.71	\$604.16	\$633.16	\$663.55	\$695.40	\$728.78
BCCDP	PC	Both	2019	5.50%	\$2,125.26	\$2,197.58	\$2,318.45	\$2,445.96	\$2,580.49	\$2,722.42
e-Family Assistance	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
e-HIV/FA	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					



**Table 20: Main Budget Neutrality Test**

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SNCP-DSRIP	Agg	WW Only	2019	N/A	\$45,662,216	\$98,564,491	\$56,119,944	\$52,380,944	\$502,625	-
SNCP-PHTII	Agg	WW Only	2019	N/A	-	\$6,350,000	-	-	-	-
SNCP-DSH-HSNTF	Agg	WW Only	2019	N/A	\$56,705,632	\$236,000,000	\$236,000,000	\$236,000,000	\$236,000,000	\$236,000,000
SNCP-DSH-IMD	Agg	WW Only	2019	N/A	\$8,085,662	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000
SNCP-DSH-CPE	Agg	WW Only	2019	N/A	\$38,996,798	\$156,000,000	\$165,000,000	\$165,000,000	\$165,000,000	\$165,000,000
SNCP-UCC	Agg	WW Only	2019	N/A	-	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000
SNCP-OTHER	Agg	WW Only	2019	N/A	\$5,000,000	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000

**Table 20: Main Budget Neutrality Test**

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SNCP - Safety Net Provider Payments	Agg	WW Only	2019	N/A	\$74,750,000	\$316,025,039	\$329,380,000	\$299,000,000	\$299,000,000	\$299,000,000
Provisional Eligibility	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
EAEDC	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
End of Month Coverage	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
Medicare Savings Program (MSP) Expansion	N/A	WW only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
Diversionsary BH	N/A	WW only		N/A	The Commonwealth must have savings to offset these expenditures.					
CP Enhanced Care Coordination	Agg	WW only		N/A	-	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000

**Table 20: Main Budget Neutrality Test**

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Hospital Quality and Equity Initiative	Agg	WW only		N/A	\$102,500,000	\$410,000,000	\$490,000,000	\$490,000,000	\$490,000,000	\$490,000,000
Workforce Initiative	Agg	WW only		N/A	-	\$6,010,000	\$10,810,000	\$10,810,000	\$10,810,000	\$4,800,000
Flexible Services: Transportation	N/A	WW only		N/A	The Commonwealth must have savings to offset these expenditures.					
Flexible Services: Cooking Supplies	N/A	WW only		N/A	The Commonwealth must have savings to offset these expenditures.					
DSH Diversion^	Agg	WOW only		N/A	\$186,963,000	\$750,656,445	\$761,916,292	\$773,345,036	\$784,945,212	\$796,719,390

\*PC = Per Capita, Agg = Aggregate

^The annual DSH allotment is set by federal regulation. The figures in this table are only estimates.

19.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

19.6. **Hypothetical Budget Neutrality Test 1: CommonHealth** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 21: Hypothetical Budget Neutrality Test 1										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Common Health	PC	Both	2019	4.80%	\$510.23	\$525.40	\$550.62	\$577.05	\$604.75	\$633.78

19.7. **Hypothetical Budget Neutrality Test 2: New Adult Group** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are

designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 22: Hypothetical Budget Neutrality Test 2										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
New Adult Group	PC	Both	2019	5.50%	\$694.88	\$718.53	\$758.05	\$799.74	\$843.72	\$890.13

19.8. **Hypothetical Budget Neutrality Test 3: Marketplace Subsidies.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 23: Hypothetical Budget Neutrality Test 3										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Marketplace Subsidies	PC	Both	2019	5.60%	\$170.96	\$176.88	\$186.79	\$197.25	\$208.29	\$219.96

19.9. **Hypothetical Budget Neutrality Test 4: FFCY.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 24: Hypothetical Budget Neutrality Test 4										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
FFCY	PC	Both	2021	5.50%	\$408.64	\$422.55	\$445.79	\$470.30	\$496.17	\$523.46

19.10. **Hypothetical Budget Neutrality Test 5: SUD.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 25: Hypothetical Budget Neutrality Test 5										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SUD	PC	Both	2019	5.60%	\$9,844.88	\$10,185.92	\$10,756.33	\$11,358.69	\$11,994.77	\$12,666.48

19.11. **Hypothetical Budget Neutrality Test 6: SMI IMD Services** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 26: Hypothetical Budget Neutrality Test 6										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SMI IMD Services	PC	Both	2019	5.60%	\$4,167.70	\$4,312.08	\$4,553.55	\$4,808.55	\$5,077.83	\$5,362.19

19.12. **Hypothetical Budget Neutrality Test 7: Continuous Eligibility.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

<b>Table 27: Hypothetical Budget Neutrality Test 7</b>										
<b>MEG</b>	<b>PC or Agg</b>	<b>WOW Only, WW Only, or Both</b>	<b>Base Year</b>	<b>Trend Rate</b>	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>
CE Formerly Incarcerated/ Base Families	PC	Both	2023	4.80%	-	\$465.17	\$487.50	\$510.90	\$535.42	\$561.12
CE Formerly Incarcerated/ Base Disabled	PC	Both	2023	4.80%	-	\$1,354.45	\$1,419.47	\$1,487.60	\$1,559.01	\$1,633.84
CE Homeless/ Base Families	PC	Both	2023	4.80%	-	\$465.17	\$487.50	\$510.90	\$535.42	\$561.12



**Table 27: Hypothetical Budget Neutrality Test 7**

<b>MEG</b>	<b>PC or Agg</b>	<b>WOW Only, WW Only, or Both</b>	<b>Base Year</b>	<b>Trend Rate</b>	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>
CE Homeless/ Base Disabled	PC	Both	2023	4.80%	-	\$1,354.45	\$1,419.47	\$1,487.60	\$1,559.01	\$1,633.84
CE Homeless/ 1902(r)2 Children	PC	Both	2023	4.80%	-	\$474.68	\$497.46	\$521.34	\$546.36	\$572.59
CE Homeless/ 1902(r)2 Disabled	PC	Both	2023	4.80%	-	\$604.16	\$633.16	\$663.55	\$695.40	\$728.78
CE Homeless/ 1902(r)2 BCCDP	PC	Both	2023	5.50%	-	\$2,197.58	\$2,318.45	\$2,445.96	\$2,580.49	\$2,722.42

- 19.13. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 15), CMS considers these expenditures to be “capped hypothetical” expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state’s expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test’s expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state’s capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.
- 19.14. **Capped Hypothetical Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

**Table 28: Capped Hypothetical Budget Neutrality Test**

MEG	Agg	WOW Only, WW Only, or Both	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
HRSN Services	Agg	Both	-	\$71,903,277	\$124,899,764	\$163,699,764	\$163,699,764	\$163,699,764
HRSN Infrastructure	Agg	Both	-	\$4,000,000	\$3,000,000	\$1,000,000	-	-

- 19.15. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, 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. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 19.16. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from October 1, 2022 to December 31, 2027. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (July 1, 2012 to June 30, 2022). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. 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.
- 19.17. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 19.16, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is \$18,699,799,972.

19.18. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

<b>Table 29: Budget Neutrality Test Corrective Action Plan Calculation</b>		
<b>Demonstration Year</b>	<b>Cumulative Target Definition</b>	<b>Percentage</b>
DY 27 through DY 28	Cumulative budget neutrality limit plus:	2.0 percent
DY 27 through DY 29	Cumulative budget neutrality limit plus:	1.5 percent
DY 27 through DY 30	Cumulative budget neutrality limit plus:	1.0 percent
DY 27 through DY 31	Cumulative budget neutrality limit plus:	0.5 percent
DY 27 through DY 32	Cumulative budget neutrality limit plus:	0.0 percent

**20. MONITORING ALLOTMENT NEUTRALITY**

20.1. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS 64 reporting instructions as outlined in section 2115 of the State Medicaid Manual.
- b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for the title XXI funded Medicaid expansion population (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and the title XXI funded separate CHIP population (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 and CMS-64.21U waiver forms for each title XXI demonstration population.
- c. **Premiums.** Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver and the CMS-64.21U Waiver forms (specifically lines 1A through 1D as applicable) for each title XXI demonstration

population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

- d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS-64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

20.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for the title XXI funded separate CHIP population and CMS-37 for the title XXI funded Medicaid expansion population. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

- a. CMS will 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 report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the title XXI funded separate CHIP population and report demonstration expenditures for the title XXI funded Medicaid expansion population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS-64.21UP Waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

20.3. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

20.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 18.12 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or

reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

- 20.5. **Exhaustion of Title XXI Allotment for CHIP Populations.** If the state has exhausted title XXI funds, expenditures for the title XXI funded CHIP populations described in STC 18.12, and as approved within the CHIP state plan, may be claimed as title XIX expenditures. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the CHIP populations. The state shall report demonstration expenditures for these individuals on the Forms CMS 64.9W and/or CMS 64.9P W.

## 21. PROVIDER RATE INCREASE REQUIREMENTS

- 21.1. The provider payment rate increase requirements described hereafter are a condition for both the Hospital Quality and Equity Initiative and HRSN expenditure authorities, as referenced in expenditure authorities #25 and #22, respectively.

As a condition of approval and ongoing provision of FFP for the Hospital Quality and Equity Initiative and HRSN expenditures over this demonstration period of performance, DY 27 through DY 32, the Commonwealth will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the Commonwealth's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of service is below 80 percent.

The Commonwealth may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC.

The Commonwealth will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section 21, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other Commonwealth and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the Commonwealth's definition of behavioral health care services.

No later than 90 days of the demonstration effective date, and if the Commonwealth makes fee for service payments, the Commonwealth must establish and report to CMS the Commonwealth's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

- a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the Commonwealth and the service category as noted in the following sources:
  - i. for primary care and obstetric care services in Zuckerman, *et al.* 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); AND
  - ii. for behavioral health services (the category called, ‘Psychotherapy’ in Clemans-Cope, *et al.* 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3)); OR
- b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:
  - i. Service codes must be representative of each service category as defined in STC 21.4;
  - ii. Medicaid and Medicare data must be from the same year and not older than 2019.
  - iii. The Commonwealth’s methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

21.2. To establish the Commonwealth’s ratio for each service category identified in STC 21.4 as it pertains to managed care plans’ provider payment rates in the Commonwealth, the Commonwealth must provide to CMS either:

- a. The average fee-for-service ratio as provided in STC 21.5(a), if the Commonwealth and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the Commonwealth pay providers based on state plan fee-for-service payment rate schedules); OR
- b. The data and methodology for any or all of the service categories as provided in STC 21.5(b) using Medicaid managed care provider payment rate and utilization data.

21.3. In determining the ratios required under STC 21.5 and 21.6, the Commonwealth may not incorporate fee-for-service supplemental payments that the Commonwealth made or plans



to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

- 21.4. If the Commonwealth is required to increase provider payment rates for managed care plans per STC 21.2 and 21.6, the Commonwealth must:
  - a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and
  - b. Ensure that the entirety of a two percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.
- 21.5. For the entirety of DY 30 through DY 32, the provider payment rate increase for each service in a service category for which the average ratio is less than 80 percent will be no lower than the highest rate in DY 28 for that service plus a two percentage point increase relative to the rate for the same or comparable Medicare service code rate in the same year, and such rate will be in effect on the first day of DY 30. A required payment rate increase shall apply to all services in a service category as defined under STC 21.4.
- 21.6. If the Commonwealth uses a managed care delivery system for any of the service categories defined in STC 21.4, for the beginning of the first rating period, as defined in 42 CFR 438.2(a), that starts in each demonstration year from DY 30 through DY 32, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 28 plus a two percentage point increase. The payment increase shall apply to all services in a service category as defined under STC 21.4.
- 21.7. If the Commonwealth has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the Commonwealth from implementing a required payment rate increase by the first day of DY 30 (or, as applicable, the first day of the first rating period that starts in DY 30), the Commonwealth will provide an alternative effective date and rationale for CMS review and approval.
- 21.8. Massachusetts will provide the information to document the payment rate ratio required under STC 21.5 and 21.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.
- 21.9. For demonstration years following the first year of provider payment rate increases, if any, Massachusetts will provide an annual attestation within the Commonwealth's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.
- 21.10. No later than 90 days following the demonstration effective date, the Commonwealth will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to

PMDA, along with a description of the Commonwealth’s methodology and the Commonwealth’s supporting data for establishing ratios for each of the three service categories in accordance with STC 21.5 and 21.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment V:

<b>Massachusetts Hospital Quality and Equity Initiative Related Provider Payment Increase Assessment – Attestation Table</b>		
The reported data and attestations pertain to Hospital Quality and Equity Initiative related provider payment increase requirements for the demonstration period of performance DY 27 thru DY 32		
<b>Category of Service</b>	<b>Medicaid Fee-for-Service to Medicare Fee-for-service Ratio</b>	<b>Medicaid Managed Care to Medicare Fee-for-service Ratio</b>
Primary Care Services	<i>[insert percent, or N/A if state does not make Medicaid fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 21.5(a) or STC 21.5(b)]</i>	<i>[insert approach, either ratio derived under STC 21.6(a) or STC 21.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>
Obstetric Care Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 21.5(a) or STC 5(b) ]</i>	<i>[insert approach, either ratio derived under STC 21.6(a) or STC 21.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>
Behavioral Health Care Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]</i>

	<p>[insert approach, either ratio derived under STC 21.5(a) or STC 21.5(b)]</p>	<p>[insert approach, either ratio derived under STC 21.6(a) or STC 21.6(b)]; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio ]</p>
<p>In accordance with STCs 21.1 through 21.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the Commonwealth’s Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on [insert date] and will not be lower than the highest rate for that service code in DY 28 plus a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least [insert date].</p> <p>For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the Commonwealth agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the Commonwealth’s definition.</p> <p>The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the Commonwealth’s definition of the category, except the behavioral health codes do not have to include inpatient care services.</p> <p>For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 21.6(b) will be based on Medicaid managed care provider payment rate and utilization data.</p> <p>[Select the applicable effective date, must check either a. or b. below]</p> <p><input type="checkbox"/> a. The effective date of the rate increases is the first day of DY [3, provide the actual year] and will be at least sustained, if not higher, through DY [5, provide the actual year]</p> <p><input type="checkbox"/> b. Massachusetts has a biennial legislative session that requires provider payment approval and the timing of that session precludes the Commonwealth from implementing the payment increase on the first day of DY [3, provide the actual year]. Massachusetts will effectuate the rate increases no later than the CMS approved date of [insert date], and will sustain these rates, if not made higher, through DY [5, provide the accrual year].</p>		

Massachusetts [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the Hospital Quality and Equity Initiative STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

Massachusetts [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the Hospital Quality and Equity Initiative STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 21.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than [*insert date*]

If the Commonwealth utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 21.8, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.

Massachusetts further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 21.

I, [*insert name of SMD or CFO(or equivalent position)*] [*insert title*], attest that the above information is complete and accurate.

[*Provide signature* \_\_\_\_\_] [*Provide date* \_\_\_\_\_]  
[*Provide printed name of signator* \_\_\_\_\_]

## 22. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

The Commonwealth 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.

<b>Date – Specific</b>	<b>Deliverable</b>	<b>STC/Section Reference</b>
180 calendar days from demonstration approval date	Draft Evaluation Design	STC 17.4
Within 60 days of receipt of CMS comments	Revised Evaluation Design	STC 17.5
One year prior to demonstration expiration or with extension application	Draft Interim Evaluation Report	STC 17.7
Within 60 days of receipt of CMS comments	Revised Interim Evaluation Report	STC 17.7
Within 18 months after the expiration of this demonstration period	Draft Summative Evaluation Report	STC 17.8
Within 60 days of receipt of CMS comments	Revised Summative Evaluation Report	STC 17.8
Within 120 days after the end of the demonstration	Draft Close Out Report	STC 17.11
Within 30 days after receipt of CMS comments	Revised Close Out Report	STC 17.11
90 calendar days after approval of this demonstration	Continuous Eligibility Implementation Plan	STC 4.13
90 calendar days after approval date of SMI/SED amendment to this Demonstration	SMI/SED Implementation Plan (including Health IT Plans and Financing Plan)	STC 7.15(a)
60 calendar days after receipt of CMS comments on SMI/SED Implementation Plans	Revised SMI/SED Implementation Plans (including Health IT Plans and Financing Plan)	STC 7.15(a)
150 calendar days after approval date of SMI/SED amendment to this Demonstration	SMI/SED Monitoring Protocol	STC 7.5
60 calendar days after receipt of CMS comments on SMI/SED Monitoring Protocol	Revised SMI/SED Monitoring Protocol	STC 7.5
No later than 60 calendar days after September 30, 2024	SMI/SED Mid-Point Assessment	STC 7.8
150 calendar days after approval of the demonstration	SUD Monitoring Protocol	STC 6.7

<b>Date – Specific</b>	<b>Deliverable</b>	<b>STC/Section Reference</b>
60 calendar days after receipt of CMS comments on SUD Monitoring Protocol	Revised SUD Monitoring Protocol	STC 6.7
No later than 60 calendar days after September 30, 2025	SUD Mid-Point Assessment	STC 6.8
No later than 60 days after demonstration effective date	SUD HIT Plan	STC 6.7
Prior to claiming UC FFP	UC Payment Protocol	STC 10.3
Prior to claiming FFP	Hospital Quality and Equity Implementation Plan	STC 14.8
No later than 90 days after demonstration effective date (prior to claiming FFP)	Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning and Provider Qualifications	STC 15.5
90 calendar days after demonstration effective date	HRSN Implementation Plan	STC 15.12
60 calendar days after receipt of CMS comments on HRSN Implementation Plan	Revised HRSN Implementation Plan	STC 15.12
No later than 90 days prior to the effective date	Primary Care Payment Protocol	STC 8.5
No later than 90 days after demonstration effective date	Provider Payment Rate Increase Assessment Attestation Table	STC 21.14
No later than 90 days of the demonstration effective date	Average Medicaid to Medicare fee-for-service provider rate ratio	STCs 21.5 and 21.12
<i>Annually</i>		
90 days after the end of each DY	Annual Monitoring Report (including Q4 monitoring information and budget neutrality)	STC 16.5
30 days of the receipt of CMS comments	Revised Annual Monitoring Report	STC 16.5
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 14, 15
No later than 90 days after the end of each DY	Report of actual UC payments	Section 11

Date – Specific	Deliverable	STC/Section Reference
By December 31 of each DY	Report of projected UC payments	Section 11
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 14, 15
Updated at least annually	Update to Primary Care Payment Protocol	STC 8.5
<i>Quarterly</i>		
60 days following the end of the quarter	Quarterly Monitoring Reports, including metrics described in STC 16.5	STC 16.5
30 days following the end of the quarter	Quarterly Expenditure Reports	Section 13
60 days following the end of the quarter, except for Q4 which is submitted with Annual Report	Quarterly Budget Neutrality Report	Section 14

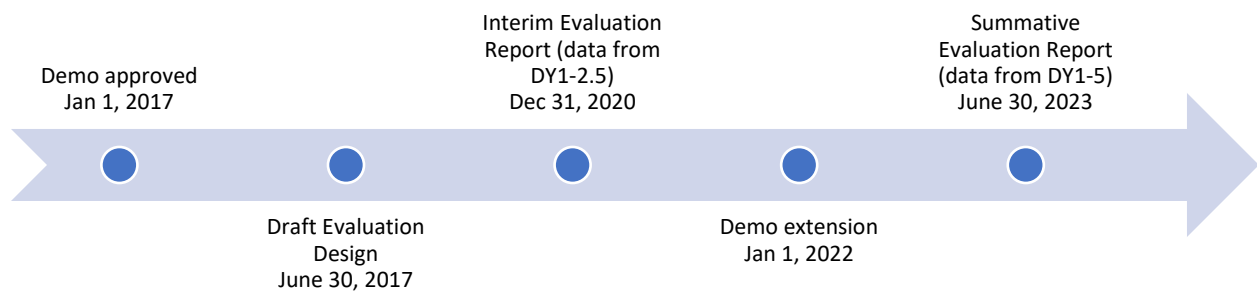
## ATTACHMENT A Preparing the Evaluation Design

### Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

### Submission Timelines

There is a specified timeline for the state’s submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state’s website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



### Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations.



The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

**A. General Background Information** – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

**B. Evaluation Questions and Hypotheses** – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship

between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrrvs.pdf>.

1. **Methodology** – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and

Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
  - a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
  - b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
  - c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
  - d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

**Table A. Example Design Table for the Evaluation of the Demonstration**

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
<b>Hypothesis 1</b>				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
<b>Hypothesis 2</b>				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

**D. Methodological Limitations** – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
  - a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
  - b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
  - a. Operating smoothly without administrative changes;

- b. No or minimal appeals and grievances;
- c. No state issues with CMS-64 reporting or budget neutrality; and
- d. No Corrective Action Plans for the demonstration.

#### **E. Attachments**

- 1) **Independent 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, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a “No Conflict of Interest” statement signed by the independent evaluator.
- 2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and 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 draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
- 3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

## ATTACHMENT B

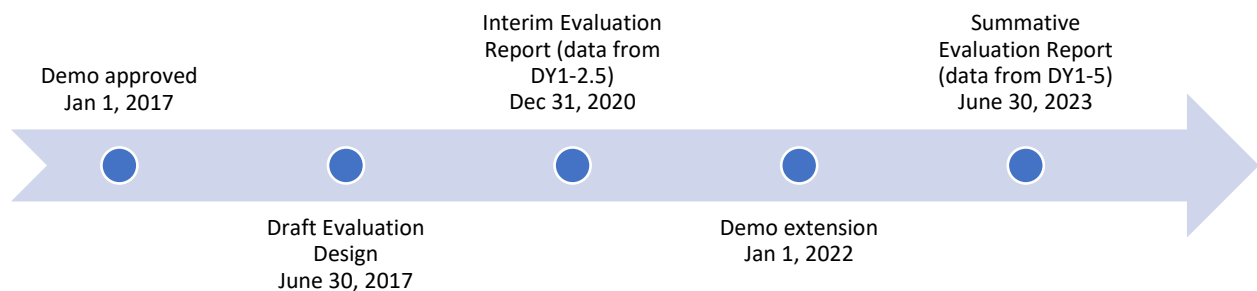
### Preparing the Interim and Summative Evaluation Reports

#### Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

#### Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverable's timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



#### Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request,

and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

### **Intent of this Attachment**

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

### **Required Core Components of Interim and Summative Evaluation Reports**

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

- A. The format for the Interim and Summative Evaluation reports is as follows: Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

**B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

**C. Evaluation Questions and Hypotheses** – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

**D. Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.



This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

- 1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
- 2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
- 3) *Evaluation Period* – Describe the time periods for which data will be collected.
- 4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
- 5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
- 6) *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
- 7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

**E. Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

**F. Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

**G. Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
  - a. If the state did not fully achieve its intended goals, why not?
  - b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

**H. Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration

with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

**I. Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

a. **Attachment(s)**

- 1) Evaluation Design: Provide the CMS-approved Evaluation Design

## ATTACHMENT C 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 Federal Poverty Level (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 4.3.

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.

<b>Demonstration Program</b>	<b>Premiums (only for persons with family income above 150 percent of the FPL)</b>	<b>Co-payments</b>
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
MassHealth Family Assistance: Direct Coverage	\$12 per child, \$36 max per family group	Children only-no copayments.

<b>Breast and Cervical Cancer Treatment Program Premium Schedule</b>	
<b>Percent of FPL</b>	<b>Premium Cost</b>
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

<b>CommonHealth Full Premium Schedule</b>		
<b>Base Premium</b>	<b>Additional Premium Cost</b>	<b>Range of Premium Cost</b>
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

<b>CommonHealth Full Premium Schedule</b>		
<b>Base Premium</b>	<b>Additional Premium Cost</b>	<b>Range of Premium Cost</b>
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

<b>CommonHealth Supplemental Premium Schedule</b>	
<b>% of FPL</b>	<b>Premium requirement</b>
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
Above 600% to 800%	75% per above
Above 800% to 1000%	80% above
Above 1000%	85% above

<b>Small Business Employee Premium Assistance* (effective January 1, 2014)</b>	<b>% of FPL</b>	<b>Premium Requirement for Individual</b>	<b>Premium Requirement for Couples</b>
<b>Small Business Employee Premium Assistance*</b> 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**  
**SUD HIT Plan (Reserved)**

**ATTACHMENT E**  
**Safety Net Care Pool Payments (Reserved)**

**ATTACHMENT F**  
**SMI/SED Implementation Plan (Reserved)**



**ATTACHMENT G**  
**SUD Monitoring Protocol (Reserved)**

**ATTACHMENT H**  
**Safety Net Care Pool Uncompensated Care Cost Limit Protocol (Reserved)**

**ATTACHMENT I**  
**Uncompensated Care Payment Protocol (Reserved)**

**ATTACHMENT J**  
**Hospital Quality and Equity Initiative Implementation Plan (Reserved)**

**ATTACHMENT K**  
**SMI/SED Monitoring Protocol (Reserved)**

**ATTACHMENT L**  
**Accountable Care Organization (ACO) Payment Methodology (Reserved)**

**Attachment M**

**Massachusetts Delivery System Reform Incentive Payment (DSRIP) Protocol**

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## Section 1. DSRIP Overview and Goals

### 1.1 MassHealth Medicaid Section 1115 Demonstration

The DSRIP Protocol provides additional detail to the State's DSRIP proposal, beyond those set forth in the Section 1115 Demonstration and Special Terms and Conditions (STCs). The DSRIP Protocol applies during the demonstration Approval Period (July 1, 2017 - June 30, 2022).

### 1.2 Overview - Delivery System Reform Incentive Payment Program (DSRIP)

In accordance with STC 60(e) and as set forth in this document, the State may allocate DSRIP funds to four purposes: (1) Accountable Care Organization (ACO) funding, which supports the implementation of three ACO models, including transitional funding for certain safety net hospitals; (2) Community Partners (CP) funding, which supports the formation and payment of Behavioral Health (BH) and Long Term Services and Supports (LTSS) CPs and funding for Community Service Agencies (CSAs); (3) Statewide Investments, which are initiatives related to statewide infrastructure and workforce capacity to support successful reform implementation; and (4) State Operations and Implementation, which includes the State's oversight of the DSRIP program.

### 1.3 Goals of DSRIP Program

Massachusetts' DSRIP program provides an opportunity for the State to emphasize value in care delivery, better meet members' needs through more integrated and coordinated care, and moderate the cost trend while maintaining the clinical quality of care. The State's DSRIP goals are to (1) implement 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) improve integration among physical health, behavioral health, long-term services and supports and health-related social services; and (3) sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals.

### 1.4 DSRIP Funding Streams

To accomplish the goals of the DSRIP program, Massachusetts plans to launch and support with DSRIP funding the following initiatives:

- **Accountable Care Organizations** – Generally provider-led health systems or organizations with an explicit focus on integration of physical health, behavioral health, long term services and supports and health-related social service needs. ACOs will be financially accountable for the cost and quality of their members' care.
- **Community Partners / Community Service Agencies (CSAs)** – Community-based BH and LTSS organizations who support eligible members with BH and LTSS needs.
- **Statewide Investments** – Set of direct state investments in scalable infrastructure and workforce capacity.

Additionally, the State will utilize DSRIP funding to support Statewide Operations and Implementation, including oversight, of the DSRIP program.

Exhibit 1 shows anticipated amounts of funding per DSRIP funding stream by demonstration year as well as the overall anticipated percentage of funding distributed to each stream in total. Please see Section 4.7 for discussion of situations in which funding may be shifted between funding streams or carried forward from one demonstration year to the next.

EXHIBIT 1 – DSRIP Anticipated Funding Streams By Demonstration Year (\$M)

Funding Stream	Demo Y1	DY2	DY3	DY4	DY5	Total	% of Total*
ACOs	\$329.2M	\$289.9M	\$229.4M	\$152.0M	\$65.1M	<b>\$1,065.6M</b>	<b>59%</b>
Community Partners (including CSAs)	\$57.0M	\$95.9M	\$132.2M	\$133.6M	\$128.0M	<b>\$546.6M</b>	<b>30%</b>
Statewide Investments	\$24.2M	\$24.6M	\$23.8M	\$24.8M	\$17.4M	<b>\$114.8M</b>	<b>6%</b>
State Operations and Implementation	\$14.6M	\$14.6M	\$14.6M	\$14.6M	\$14.6M	<b>\$73.0M</b>	<b>4%</b>
<b>Total:</b>	<b>\$425.0M</b>	<b>\$425.0M</b>	<b>\$400.0M</b>	<b>\$325.0M</b>	<b>\$225.0M</b>	<b>\$1,800.0M</b>	

\*Percentages do not sum to 100% due to rounding

### 1.4.1 Accountable Care Organizations

To achieve Massachusetts’ DSRIP goals as described above, the State intends to launch a new Accountable Care Organization program. Massachusetts has designed three ACO payment models that respond to the diversity of the State’s delivery system, and intends to select ACOs across all three models through a competitive procurement. Massachusetts intends to contract with ACOs across all three ACO models starting in 2017.

Massachusetts’ three ACO models are:

- **Accountable Care Partnership Plan (a Partnership Plan):** either a MCO with a separate, designated ACO partner, or a single, integrated entity that meets the requirements of both. Partnership Plans are vertically integrated between the health plan and ACO delivery system, and take accountability for the cost and quality of care under prospective capitation
- **Primary Care Accountable Care Organization:** a provider-led health care system or other provider-based organization, contracting directly with MassHealth, with savings and risk shared retrospectively
- **MCO-Administered ACO:** a provider-led health care system or other provider-based organization that contracts with MCOs and takes financial accountability for shared savings and risk as part of MCO networks

### 1.4.2 Community Partners and CSAs

Community Partners will provide support to eligible members with complex BH and LTSS needs, including linkages to community resources, allowing providers to deliver comprehensive care for the whole person and improvement in member health outcomes. Community Partners (CPs) will receive DSRIP funds for care coordination activities, as well as to support infrastructure and workforce capacity building. CPs will be required to partner with the ACOs and MCOs. ACOs and MCOs will similarly be required to partner with both BH and LTSS CPs. The goals of Community Partners include:

- Creating explicit opportunities for ACOs and MCOs to leverage existing community-based expertise and capabilities to best support members with LTSS and BH needs
- Breaking down existing silos in the care delivery system across BH, LTSS and physical health
- Ensuring care is person-centered, and avoiding over-medicalization of care for members with LTSS needs

- Preserving conflict-free principles including consideration of care options for members and limitations on self-referrals
- Making investments in community-based infrastructure within an overall framework of performance accountability
- Requiring ACOs, MCOs and Community Partners to formalize how they work together, e.g., for care coordination and performance management

Massachusetts will selectively procure two types of Community Partners:

- **Behavioral Health Community Partners (BH CPs):** BH CPs will support eligible adult members with a diagnosis of Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD) as well as adult members who exhibit SMI and SUD needs, but have not been diagnosed, as defined by the State.
- **LTSS Community Partners (LTSS CPs):** LTSS CPs will support eligible members ages three and older with complex LTSS needs, which may include members with physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD) and others, as defined by the State.

**Community Service Agencies (CSAs):** Additionally, existing provider entities, known as Community Service Agencies (CSAs) currently provide State Plan intensive care coordination services to eligible MassHealth members under 21 years of age with Serious Emotional Disturbances (SED). These CSAs will be eligible to receive DSRIP funds for infrastructure and workforce capacity building. CSAs will not receive DSRIP funds as payment for the provision of Massachusetts State Plan services.

### 1.4.3 Statewide Investments

Statewide Investments are part of the State’s strategy to efficiently scale up statewide infrastructure and workforce capacity, and will play a key role in moving Massachusetts towards achievement of its care delivery and payment reform goals. Massachusetts will utilize DSRIP funds to invest in the following eight high priority initiatives:

1. Student loan repayment program
2. Primary care integration models and retention program
3. Expanded support of residency slots at community health centers
4. Workforce professional development grant program
5. Technical assistance to ACOs and CPs (scalable, state-procured approach)
6. Alternative payment methods preparation fund
7. Enhanced diversionary behavioral health services
8. Improved accessibility for people with disabilities or for whom English is not a primary language

These eight initiatives are further detailed in Section 4.6.

### 1.4.4 State Operations and Implementation

The State will allocate a portion of DSRIP funding to support robust operations, implementation and oversight of the DSRIP program (see Section 6 for detail). An integrated team of state administrative staff will implement and oversee general and day-to-day administration of ACOs, CPs and Statewide Investments programs to ensure success and movement towards state goals. This team will manage several

contracted vendors that support key aspects of program implementation. In addition, several independent entities will support the State’s oversight of the DSRIP program, including the DSRIP Steering Committee, DSRIP Advisory Committee on Quality, Independent Assessor and Independent Evaluator (see Sections 3.4.1.2 and 6.4 for further details on each). The State Operations and Implementation funding stream will support these personnel/fringe and contractual costs.

## **Section 2. Delivery System Models**

Please see Appendix A for discussion of Delivery System Models, including a description of the procurement process for ACOs and CPs, as well as a high-level description of selection criteria for these entities.

## **Section 3. Participation Plans, Budgets, and Budget Narratives**

In order to receive DSRIP funding, each ACO, CP and CSA will be required to submit for the State’s approval: (1) a Participation Plan for the five-year demonstration period; and (2) a Budget and Budget Narrative for each annual budget period. These documents will detail how ACOs, CPs and CSAs will use DSRIP funding. The Participation Plan will cover the five years of the demonstration period. There will be two Participation Plans submitted – (1) “Preliminary Participation Plan” – providing an initial five-year plan and (2) “Full Participation Plan” – submitted to provide a revised five-year plan based on refined estimates of projected funding amounts. The State will use its review and approval processes of these documents to align with ACOs, CPs and CSAs on initiatives, goals and investments and to hold ACOs, CPs and CSAs accountable to the State’s delivery system reform goals. The State will also use these documents to report to CMS, as requested.

Because the DSRIP Participation Plans are based around the ACOs’, CPs’ and CSAs’ budget periods, this section begins by explaining the DSRIP budget periods that will apply to these entities. The section then discusses the details of the Preliminary Participations Plans, Full Participation Plans, Budgets and Budget Narratives that ACOs, CPs and CSAs will submit to the State, including what information will be included in each. The Section then details the State’s review and approval process for each of these documents.

### **3.1 DSRIP Budget Periods**

#### **3.1.1 ACO Budget Periods**

The State’s 1115 demonstration aligns with the State’s fiscal year (July 1 to June 30). Performance years (PYs) for the State’s ACO Program (i.e., the time periods which the State will use to calculate cost and quality accountability for ACOs) align with the calendar year (January 1 to December 31), and are thus offset from the State’s demonstration years by 6 months.

The State will disburse DSRIP funding to ACOs using six “Budget Periods” (BPs) that align with ACO performance years. The State anticipates that the first BP, the “Preparation Budget Period,” will begin on July 1, 2017 or when contracts between the State and the ACOs are executed (whichever is later) and end December 31, 2017. ACOs will therefore have completed their contracting with the State prior to the start of the Preparation Budget Period. During this Preparation Budget Period, ACOs will have the opportunity to make investments and arrangements necessary to succeed as an ACO. Moving to a Total Cost of Care (TCOC) model is a significant undertaking that requires preparation and investment such as training staff, purchasing appropriate infrastructure, and setting up electronic, secure communications. The Preparation Budget Period will allow for such actions to occur. Investments may include, but are not limited to: health information technology, performance management infrastructure, network development/contracting, project management, and care coordination/management investment.

During this Preparation Budget Period, the State will work with ACOs to ensure they are ready for the responsibilities of the full TCOC model (e.g., enrolling members, taking financial risk, receiving data supports) including holding regular meetings with ACOs, performing a structured “readiness review” process similar to the one the State undertakes for its MCOs, and providing preliminary data supports. Additionally, ACOs will be required to submit Budgets and Budget Narratives that lay out their plans and goals for DSRIP funding. The State will review and approve such plans, requesting additional information where necessary.

Budget Periods 1-5 (BP 1-5) will each last for one full calendar year, with Budget Period 1 beginning January 1, 2018 and ending December 31, 2018, etc. Please see Exhibit 2 for the schedule of the DSRIP ACO Budget Periods.

**EXHIBIT 2 – Schedule of DSRIP ACO Budget Periods**

CY2017		CY2018				CY2019				CY2020				CY2021				CY2022			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
State Demonstration Y1		Demo Y2				Demo Y3				Demo Y4				Demo Y5							
		ACO Performance Y1				ACO PY 2				ACO PY 3				ACO PY 4				ACO PY 5			
Prep Budget Period		Budget Period 1				BP 2				BP 3				BP 4				BP 5			

The budget period approach will not change the amount of funding that an ACO receives for a given demonstration year. Specifically, the Preparation Budget Period funds will be sourced from demonstration year 1 funds. Budget Period 1 funds will be sourced from demonstration year 1 and 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 sourced only from demonstration year 5 funds.

**3.1.2 Community Partner and CSA Budget Periods**

The State’s 1115 demonstration years align with the State’s fiscal year (July 1 to June 30). Performance years for the State’s CP program (i.e., the time periods the State will use to calculate accountability for CPs) align with the calendar year (January 1 to December 31), with the exception of Performance Year 1, which is six months from July 1, 2018 to December 31, 2018. CP performance years are thus generally offset from the State’s demonstration years by six months.

The State will disburse DSRIP funding to CPs and CSAs using six “Budget Periods” (BPs) that align with CP and CSA Performance Years. The first BP, the “Preparation Budget Period” will begin when contracts between the State and the CPs and CSAs are executed (anticipated October/November 2017) and end May 31, 2018. During the Preparation Budget Period, CPs will utilize infrastructure dollars to invest in technology, workforce development, business startup costs and/or operational infrastructure. During the Preparation Budget Period, CSAs will utilize infrastructure dollars to invest in technology, workforce development and/or operational infrastructure.

CP and CSA Budget Period 1 will be seven months from June 1, 2018 to December 31, 2018. The remaining four budget periods (BP 2-5) will each last for one full calendar year, with Budget Period 2 beginning January 1, 2019 and ending December 31, 2019, etc. If the State changes the schedule for CP and CSA performance years, the State may adjust the CP and CSA Budget Periods to align with the performance years. Please see Exhibit 3 for the anticipated schedule of the DSRIP CP and CSA Budget Periods.



EXHIBIT 3 – Schedule of DSRIP CP/CSAs Budget Periods

CY2017		CY2018				CY2019				CY2020				CY2021				CY2022			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
State Demonstration Y1		Demo Y2				Demo Y3				Demo Y4				Demo Y5							
		CP Performance Y1 (6 mo.)		CP PY 2				CP PY 3				CP PY 4				CP PY 5					
Prep Budget Period		Budget Period 1 (7 mo.)		BP 2				BP 3				BP 4				BP 5					

This budget period approach will not change the amount of funding that a CP or CSA receives for a given demonstration year. Specifically, the Preparation Budget Period funds will be sourced from demonstration year 1 funds. Budget Period 1 funds will be sourced from demonstration year 1 and 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 sourced only from demonstration year 5 funds.

**3.1.3 Funding Adjustments for Budget Period 5 and Close-Out Activities**

The second half of Budget Period 5 (July 1, 2022 to December 31, 2022), as well as the time period during which DSRIP close-out activities will occur, falls outside of the approved demonstration period (July 1, 2017 to June 30, 2022). To account for this, the following programmatic and administrative close-out payments will be attributed to the relevant Budget Periods:

**Programmatic Payments**

- ACO Startup/Ongoing payments (see Section 4.4.1)
- ACO DSTI Glide Path payments (see Section 4.4.3)
- ACO Flexible Services payments (see Section 4.2.2)
- CP and CSA Infrastructure and Capacity Building payments (see Sections 4.5.2, 4.5.5, and 4.5.7)
- CP Care Coordination payments (see Sections 4.5.1 and 4.5.4)
- CP Outcomes-Based Payments (see Sections 4.5.3 and 4.5.6)
- ACO, CP, and CSA Earned At-Risk payments (see Section 5.1.2)
- ACO, CP, and CSA Performance Remediation Plan payments (see Sections 5.3.4.2 and 5.4.6.1)

The ACO Startup/Ongoing, DSTI Glide Path, and CP/CSA Infrastructure and Capacity Building payments attributed to the first half of BP5 will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had \$100 total of non-at-risk startup/ongoing funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 (\$50 each), as opposed to \$25 attributed across each of the four quarters of BP5 (see Section 4.4.1 for more specific funding details). Similarly, if a CP had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total amount would be attributed to the first half of BP5 (see Section 4.5.2 for more specific funding details).

For ACO flexible services funding, during the first half of BP5, the State will pay out the full BP5 flexible services funding prospectively, based on the ACO’s approved BP5 flexible services budgets. ACOs will still need to submit their flexible services documentation and claims during BP5. If the ACOs do not use all of their flexible services allocation in BP5, or if the ACOs make expenditures that are deemed unacceptable by the State, then the ACOs will have to return the appropriate amount of flexible services funding to the State. See Section 4.2.2 for more specific funding details.

The State pays CPs for care coordination supports provided on a monthly basis, based on qualifying activities submitted by the CPs. The CPs have a limited time period from the delivery of care coordination supports to submit a qualifying activity for payment, as determined by the State. All payments associated with qualifying activities submitted during this allowable time period will be attributed to the budget period during which the supports were provided. For example, payments associated with care coordination supports provided in June 2022 will be attributed to BP5, as long as the qualifying activities are submitted during the allowable time period.

BH CP outcomes-based payments (see Section 4.5.3) and LTSS CP outcomes-based payments (see Section 4.5.6), which are tied to performance in specific budget period, starting with Budget Period 3, will be attributed to that budget period.

ACO, CP, and CSA earned at-risk payments (see Section 5.1.2) and performance remediation plan payments (see Sections 5.3.4.2 and 5.4.6.1), which are tied to performance in a specific budget period, will be attributed to that budget period.

### **Administrative Close-Out Activities**

- Work of Independent Assessor (see Section 6.2.2)
- Work of Independent Evaluator (see Section 6.4.2)
- Work of Member Experience Survey vendor (see Section 5.5.3)
- Work of Statewide Investments vendor (see Section 4.6)

The Independent Assessor, Independent Evaluator, member experience survey vendor, and the Statewide Investments vendors all will perform DSRIP close-out activities occurring after the demonstration period. Associated payments will be attributed to either the relevant budget period or to the first half of Budget Period 5, as determined by the State. For example, if the member experience survey vendor is fielding a survey to assess BP4 member experience, then the associated payments for those activities will be attributed to BP4. As another example, payments to the Statewide Investments vendor administering close-out activities for the student loan repayment program will be attributed to the first half of BP5.

## **3.2 Participation Plans**

### **3.2.1 Preliminary Participation Plans**

Preliminary Participation Plans document ACOs', CPs' and CSAs' plans for DSRIP expenditure. For the Preparation Budget Period and the first quarterly payment of Budget Period 1, the State will not disburse DSRIP funds to an ACO, CP or CSA that does not have a state-approved Preliminary Participation Plan. The State may withhold DSRIP funds from an ACO, CP or CSA if there are outstanding State requests for amendments to its Preliminary Participation Plan.

#### **3.2.1.1 ACOs**

Each ACO will submit for the State's approval a Preliminary Participation Plan with its response to the ACO procurement. Once approved, the State may request amendments to the Preliminary Participation Plan as necessary. At a minimum, this Preliminary Participation Plan will include information such as:

- The ACO's five-year business plan, including the ACO's goals and identified challenges under the ACO contract with MassHealth

- The ACO’s planned investments and spending plan, including specific investments or programs the ACO anticipates supporting with DSRIP funds. Such investments and programs may include but are not limited to:
  - Care coordination or care management programs, including any programs to manage high-risk populations or other population health initiatives and including the ACO’s transitional care management program
  - Efforts to address members’ health-related social needs, including expanding community linkages between the ACO and providers, Community Partners or other social service organizations, and including any spending on allowable flexible services to address health-related social needs
  - Ensuring appropriate workforce capacity and professional development opportunities to meet increased expectations for care coordination, management and integration
  - Investments in the ACO’s and providers’ data and analytics capabilities
  - Programs to shift service volume or capital away from avoidable inpatient care toward outpatient, community-based primary and preventive care, or from institutional care towards community-based LTSS, including capital investments to downsize or repurpose inpatient or institutional capacity<sup>1</sup>, investments in expanding outpatient and community capacity and costs associated with piloting new care delivery models, such as those involving alternate settings of care and the use of telehealth or home-based services
  - Investments in improved linguistic and cultural competency of care, including hiring translators and providers fluent in members’ preferred languages
  - Other investments or programs identified and proposed by the ACO that align with other requirements that MassHealth will have of the ACO

### **3.2.1.2 Community Partners/CSAs**

Each CP and CSA will submit for the State’s approval a Preliminary Participation Plan with their procurement responses and requests for funding respectively. Once approved, the State may request amendments to Preliminary Participation Plans as necessary. The Preliminary Participation Plan may include:

- Executive Summary: This section will summarize the CP’s or CSA’s DSRIP Participation Plan and describe the CP’s or CSA’s five-year business plan, goals and identified challenges.
- Partnerships: This section will list providers with which the CP or CSA will partner and describe these relationships and how they will align with the CP’s or CSA’s proposed investments and programs, as well as the CP’s or CSA’s core goals, such as improving the quality of member care.
- Member and Community Population: This section will include a description of the CP’s or CSA’s member population and surrounding communities, regions and service areas covered and how the CP or CSA will both promote the health and well-being of these individuals, and also actively initiate and maintain engagement with them.
- Narrative: The narrative will describe
  - The CP’s Care Model (CPs only):
    - Proposed staffing models

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<sup>1</sup> Payments will be made to support providers’ reform efforts that focus on the goals of reducing hospitalization and promotion of preventative care in the community, not directly to offset revenue from reduced hospital utilization.

- Proposed outreach and engagement strategies
- Proposed process for assessment and person-centered care planning
- Proposed process for managing transitions of care
- Proposed methods for how the CP will address members' health and wellness issues
- Proposed methods for how CP will connect the member to community resources and social services
- Proposed methods and processes for how the CP will enable continuous quality and member experience improvement
- The CP's or CSA's investment plan:
  - Identifying specific investments or programs that the CP or CSA will support with DSRIP funds
  - Estimating the amount and structure (e.g., one-time vs. annual) of costs associated with each investment or program
  - Explaining how each investment or program will support the CP's or CSA's core goals, such as improving the quality of member care and ensuring integration of care across different settings of care
  - Specifying goals, internal evaluation, measurement or performance management strategies the CP or CSA will apply to these investments or programs to demonstrate effectiveness and inform subsequent revisions to the Participation Plan
  - Examples of domains for potential CP or CSA investments or programs include but are not limited to:
    - Workforce capacity development
    - Data and analytics
    - HIT
    - Performance management capabilities
    - Contracting/networking development
    - Project management capabilities
    - Care coordination and community linkages
- Implementation of care model requirements
  - Spending Categories and Amounts: This section will include the CP's or CSA's anticipated spend over the five years in broad based funding categories.
  - Timeline: This section will include a five-year timeline for the CP's or CSA's proposed investments and programs.
  - Sustainability: This section will describe the CP's or CSA's plan to sustainably fund proposed investments and programs after the five-year period. This section may include information about other funding opportunities available to the CP or CSA, as well as information about any tools,

resources or processes that the CP or CSA intends to develop using DSRIP funding and continue using after the end of the DSRIP investment.

- Metrics and Measures: This section will describe the CP's or CSA's plan to report on the various DSRIP accountability metrics set forth in Appendix D.

### 3.2.2 Full Participation Plans

Full Participation Plans build on the information contained in Preliminary Participation Plans. For all DSRIP payments except the Preparation Budget Period and the first quarter's payments for Budget Period 1, the State will not disburse DSRIP funds to an ACO, CP or CSA that does not have a state-approved Full Participation Plan. The State may withhold DSRIP funds from an ACO, CP or CSA if there are outstanding State requests for amendments to its Full Participation Plans.

#### 3.2.2.1 ACOs

Once each ACO is notified of (1) its anticipated amount of Budget Period 1 funds, and (2) its tentative amount of Budget Period 2 through 5 funds, the ACO will submit a Full Participation Plan (see section 3.4.2 for timeline). The Full Participation Plan will expand on the information submitted with the Preliminary Participation Plan, and will include information such as:

- The ACO's five-year business plan, including the ACO's goals and identified challenges under the ACO contract with MassHealth
- The providers and organizations with which the ACO is partnering or plans to partner, the governance structure and a description of how these partnerships will support the ACO's planned activities and proposed investments
- A population and community needs assessment
- The ACO's planned investments and spending plan, including specific investments or programs the ACO anticipates supporting with DSRIP funds. Such investments and programs may include but are not limited to:
  - Care coordination or care management programs, including any programs to manage high-risk populations or other population health initiatives and including the ACO's transitional care management program
  - Efforts to address members' health-related social needs, including expanding community linkages between the ACO and providers, Community Partners or other social service organizations, and including any spending on allowable flexible services to address health-related social needs
  - Ensuring appropriate workforce capacity and professional development opportunities to meet increased expectations for care coordination, management and integration
  - Investments in the ACO's and providers' data and analytics capabilities
  - Programs to shift service volume or capital away from avoidable inpatient care toward outpatient, community-based primary and preventive care or from institutional care towards community-based LTSS, including capital investments to downsize or repurpose inpatient or institutional capacity, investments in expanding outpatient and community capacity and costs associated with piloting new care delivery models, such as those involving alternate settings of care and the use of telehealth or home-based services
  - Investments in improved linguistic and cultural competency of care, including hiring

translators and providers fluent in members' preferred languages

- Other investments or programs identified and proposed by the ACO that align with other requirements that MassHealth will have of the ACO
- Estimates of the amount and structure (e.g., one-time vs. annual) of costs associated with each investment or program identified in the ACO's Participation Plan
- Descriptions of how each investment or program will support the ACO's performance
- Specific goals, evaluation plans, measurable outcomes and performance management strategies the ACO will apply to each investment or program
- A five-year timeline of the ACO's proposed investments and programs
- A description of the ACO's plan to sustainably fund proposed investments and programs over the five-year period as DSRIP funding levels decrease
- Descriptions of how the ACO will fulfill its contract requirements, including:
  - Investments, value-based payment arrangements and performance management for its primary care providers
  - Care delivery improvement and care management strategies
  - Relationships with other providers, state agencies and other entities involved in the care of its members
  - Relationships with CPs
  - Activities to ensure the ACO's compliance with contract management, reporting and administrative requirements described in the ACO contract
- A plan to increase the ACO's capabilities to share information among providers involved in care of its members. Such plan will include, at a minimum:
  - The ACO's current event notification capabilities and procedures to ensure that the ACO's primary care providers are aware of members' inpatient admissions and emergency department visits
  - The ACO's self-assessed gaps in such capabilities and procedures, and how the ACO plans to address such gaps
  - A description of the ACO's plans, if any, to increase the use of EHR technologies certified by the Office of the National Coordinator (ONC)
  - A description of how the ACO plans to ensure the ACO's providers consistently use the statewide health information exchange to send or receive legally and clinically appropriate patient clinical information and support transitions of care
- Attestations to ensure non-duplication of funding

### **3.2.2.2 Community Partners**

Once the CP or CSA is notified of (1) the amount of Budget Period 1 funds, and (2) the tentative amount of Budget Period 2 through 5 funds, the CP or CSA will be required to submit a Full Participation Plan. The Full Participation Plan will expand on the information submitted within the Preliminary Participation Plan and will reflect the new information available to CPs or CSAs about their anticipated funding amounts (see section 3.4.3 for timeline). Examples of additional detail that CPs and CSAs will be contractually required to provide include:

- The community-based organizations and providers with which the CP or CSA is partnering or plans to partner, the CSA or CP consortium governance structure and a description of how these partnerships will support the CP's or CSA's planned activities and proposed investments
- Descriptions of specific investments or programs the CP or CSA will support with DSRIP funds, including cost estimates, measures, goals and performance management and sustainability plans in the following areas:
  - Relationships with state agencies, community-based organizations, providers and other entities involved in the care of its members
  - Relationships with ACOs and MCOs
  - Activities to ensure the CP's or CSA's compliance with contract management, reporting and administrative requirements described in the CP's or CSA's contract with MassHealth and agreements with ACOs and MCOs
  - Workforce development and stability
- A plan to increase the CP's or CSA's capabilities to share information with ACOs and MCOs and among providers involved in care of its members. Such plan will include, at a minimum:
  - The CP's or CSA's current communication practices and capabilities
  - The CP's or CSA's self-assessed gaps in such capabilities and procedures, and how the CP or CSA plans to address such gaps
  - A description of the CP's or CSA's plans, if any, to increase the use of Electronic Health Record and Care Management technology
  - A description of how the CP or CSA plans to ensure the CP or CSA and its partners consistently use the statewide health information exchange to send or receive legally and clinically appropriate patient clinical information and support transitions of care
- Details about how the CP or CSA will not duplicate existing infrastructure with their planned DSRIP investments

## **3.3 Budgets and Budget Narratives**

Each ACO, CP and CSA will submit a Budget and Budget Narrative to MassHealth for approval for each budget period. ACOs will submit a Budget and Budget Narrative to the State prior to each budget period. CPs and CSAs may submit a Budget and Budget Narrative to the State after the start of a budget period. The Budget is an itemized budget for the ACO's, CP's or CSA's proposed DSRIP-funded investments and programs for the Budget Period; the accompanying Budget Narrative explains uses of the funds. The State will provide a budget template for ACOs, CPs and CSAs to utilize. The State will not disburse DSRIP funds for a given budget period to an ACO, CP or CSA that does not have a state-approved Budget and Budget

Narrative for that Budget Period, except that the State may make care coordination supports payments to CPs during the first three months of BP2 before the BP2 budgets have been approved.. The State may withhold DSRIP funds from an ACO, CP or CSA if there are outstanding State requests for amendments to its Budgets or Budget Narratives.

## **3.4 Review and Approval Process and Timelines**

### **3.4.1 Roles and Responsibilities**

#### ***3.4.1.1 State***

The State will review, approve and/or request revisions to ACOs', CPs' and CSAs' Preliminary and Full Participation Plans, Budgets and Budget Narratives. If necessary, the State will work collaboratively with ACOs, CPs and CSAs on revisions to Participation Plans, Budgets and Budget Narratives.

#### ***3.4.1.2 Independent Assessor***

The Independent Assessor will review ACOs', CPs' and CSAs' Full Participation Plans, Budgets (from BP 1 onwards) and Budget Narratives (from BP 1 onwards), as well as any formal requests for modification to these documents submitted by ACOs, CPs and CSAs. The Independent Assessor will make recommendations to the State for each such document or request; these recommendations may be recommendations to approve, deny or propose certain changes to these documents or requests. The State will work closely with the Independent Assessor, and consider its recommendations during the review process. The State retains final decision-making authority regarding approvals, denials or requests for changes to Participation Plans, Budgets and Budget Narratives, as well as to any modification requests. If the Independent Assessor makes a recommendation to the State that differs from the State's final decision, the State will document its decision in the State's quarterly reports to CMS. The Independent Assessor will not determine whether a request to amend a Participation Plan, Budget, Budget Narrative, or Performance Remediation Plan is a material deviation, as this is the responsibility solely of the State.

#### ***3.4.1.3 CMS***

CMS may request to review Participation Plans (Preliminary and Full), Budgets and Budget Narratives. The State will provide requested documents within 45 calendar days of receiving the request. All final approved Participation Plans, Budgets, and Budget Narratives will be sent to CMS. The State will provide the following information to be posted on Medicaid.gov: (1) an executive summary of each ACO's and CP's participation plan; (2) list of each ACO and CP as well as the populations they serve and their website; (3) an executive summary of each ACO's and CP's progress reports; and (4) each ACO's and CP's DSRIP yearly funding amount.

### **3.4.2 Process for State Approval of ACO Participation Plans**

#### ***3.4.2.1 Preliminary Participation Plan Approval for ACOs***

The State's process for submission, review and approval of Preliminary Participation Plans for ACOs will be as follows:

- ACOs submit Preliminary Participation Plans with their procurement response
- The State reviews Preliminary Participation Plans with ACOs' procurement submissions
- At the end of this review process, the State will approve or deny the Preliminary Participation Plans or request additional information and resubmissions of the Preliminary Plans before approval.
- The State anticipates completing approval of ACOs' Preliminary Participation Plans in July/August 2017.



### ***3.4.2.2 Full Participation Plans for ACOs***

The process for submission, review and approval of Full Participation Plans for ACOs will be as follows:

- The State notifies ACOs of anticipated BP1 funding amounts and tentative BP2 through BP5 funding amounts and requests a Full Participation Plan
- ACOs submit Full Participation Plans to the State (the State will provide ACOs up to 30 calendar days from the date of notification). The State intends to work with ACOs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Full Participation Plans in parallel. The State intends to complete its review of the Full Participation Plans, including evaluating the Independent Assessor's recommendations, within 45 calendar days of ACOs' submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the ACOs' Full Participation Plans.
- **The State therefore anticipates completing approvals of Full Participation Plans within 75 calendar days of requesting them from ACOs as follows:**
  - The State anticipates approving Full Participation Plans in April 2018

### **3.4.3 Process for State Approval of CPs and CSAs Participation Plans**

#### ***3.4.3.1 Preliminary Participation Plan approval for CPs and CSAs***

The State's process for submission, review and approval of Preliminary Participation Plans for CPs and CSAs will be as follows:

- CPs submit Preliminary Participation Plans with their request for funding
- CSAs submit Preliminary Participation Plans with their request for funding
- The State reviews CP and CSA Preliminary Participation Plans within 75 calendar days of their submission
- At the end of this review process, the State will approve, deny or request additional information regarding the Preliminary Participation Plan. The State intends to work with CPs and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission.
- **The State therefore anticipates completing reviews and approvals of Preliminary Participation Plans within 75 calendar days of submission as follows:**
  - The State anticipates approval of Preliminary Participation Plans in August 2017

#### ***3.4.3.2 Full Participation Plans for CPs and CSAs***

The process for submission, review and approval of Full Participation Plans will be as follows:

- The State notifies CPs and CSAs of actual BP1 funding and tentative BP2 through BP5 funding amounts and requests a Full Participation Plan
- CPs and CSAs submit Full Participation Plans to the State within 30 calendar days from the date of notification).
  - The State intends to work with CPs and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission

- The State and Independent Assessor review Full Participation Plans in parallel. The State intends to complete its review of the Full Participation Plans, including evaluating the Independent Assessor's recommendations, within 45 calendar days of CPs' and CSAs' submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the Full Participation Plans.
- **The State therefore anticipates completing approvals of Full Participation Plans within 75 calendar days of requesting them from CPs and CSAs as follows:**
  - For CPs and CSAs, the State anticipates approving Full Participation Plans in May 2018

### 3.4.4 Process for State approval of Budgets and Budget Narratives

#### 3.4.4.1 Process for State approval of ACO Budgets and Budget Narratives

The process for submission, review and approval of Budgets and Budget Narratives for Budget Period 1-5 for ACOs will be as follows:

- The State notifies ACOs of the upcoming budget period's anticipated funding amounts, and requests each ACO submit a Budget and a Budget Narrative for the upcoming budget period (See Section 4.4).
- ACOs submit to the State their Budgets and Budget Narratives for the upcoming BP within 30 calendar days of receiving the State's request. The State intends to work with ACOs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Budgets and Budget Narratives in parallel. The State intends to complete its review of the Budgets and Budget Narratives, including evaluating the Independent Assessor's recommendations, within 45 calendar days of their submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the Budgets and Budget Narratives.
  - After approval, the State will disburse the first quarterly DSRIP payment for the new Budget Period.
- If the data required to calculate funding amounts for a given budget period are not available by August of the preceding Budget Period, then the State may provide ACOs with a preliminary funding amount to construct their Budgets and Budget Narratives. The State would disburse the first quarterly payment based on the preliminary funding amount, and then calculate final funding amounts as well as a reconciliation amount to be added to or subtracted from the ACO's subsequent quarterly DSRIP payments in that Budget Period, such that payments for the budget period total the final funding amount for that budget period.
  - If the funding amount for a given ACO changes by more than 20% from the preliminary funding amount on which the ACO based its Budget and Budget Narrative, the State will ask the ACO to revise and resubmit its Budget and Budget Narrative. The State may also request revisions in its discretion.
- **The State therefore anticipates completing approvals of Budgets and Budget Narratives within 75 calendar days of requesting them from ACOs as follows:**
  - For Preparation Budget
    - The State anticipates notifying ACOs of anticipated Preparation Budget funding amounts in June 2017

- The State anticipates ACOs submitting Preparation Budgets and Budget Narratives in July 2017
- The State anticipates approving Budgets and Budget Narratives in August 2017
- For BP 1-5:
  - The State anticipates providing ACOs with anticipated funding amounts in October of the preceding budget period
  - The State anticipates ACOs will submit to the State their Budgets and Budget Narratives and their updated safety net revenue calculation in November of the preceding budget period
  - The State anticipates approving ACOs' Budgets and Budget Narratives in January of the new budget period
  - If the preliminary member count for BP 1 is estimated prior to the Operational Start Date of the program and therefore prior to actual member enrollments being effective, the State may postpone this timeline by several months for BP 1, and delay the first quarterly payment of BP 1 at its discretion. This process may allow the State to adjust for changes in enrollment levels if, for example, member movement exceeds expectations

#### ***3.4.4.2 Process for State Approval of CP and CSA Budget and Budget Narratives***

CPs will receive bi-annual infrastructure development funding as well as be reimbursed monthly for care management and care coordination activities based on the number of members assigned and engaged. CSAs will receive DSRIP funding for Infrastructure development only.

The process for submission, review and approval of CP and CSA Budgets and Budget Narratives for Budget Period 1-5 will be as follows:

- The State notifies CPs and CSAs of preliminary upcoming budget period's funding amounts and requests the Budgets and Budget Narratives for the upcoming budget period
  - Infrastructure development payments will be based on a member snapshot
  - For CPs, the BP1 member snapshot will be an estimate of member engagement
  - For CSAs, the member snapshots will be based on actual caseload
- Within 30 calendar days, CPs and CSAs submit to the State their Budgets and Budget Narratives for the upcoming BP
  - The State intends to work with CPS and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Budgets and Budget Narratives in parallel. The State intends to complete its review of the Budgets and Budget Narratives, including evaluating the Independent Assessor's recommendations, within 45 calendar days of their submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the Budgets and Budget Narratives.
- After approval, the State will disburse funding bi-annually for infrastructure funding and monthly for care coordination funding
- **The State therefore anticipates completing approvals of Budgets and Budget Narratives within 75 calendar days of requesting them from CPs and CSAs as follows:**
  - For Preparation Budget

- The State anticipates notifying CPs and CSAs of Preparation Budget funding in August 2017
- The State anticipates CPs and CSAs submitting Preparation Budgets and Budget Narratives in September 2017
- The State anticipates approving Budgets and Budget Narratives in October 2017
- For BP 1:
  - The State anticipates providing CPs and CSAs with a preliminary version of their anticipated payments in February 2018
  - The State anticipates that CPs and CSAs will submit their BP1 Budgets and Budget Narratives to the State in March 2018
  - The State anticipates approving CP and CSA Budgets and Budget Narratives in May 2018
- For BP 2-5:
  - The State anticipates providing CPs and CSAs with a preliminary version of their anticipated payments in December of the preceding budget period
  - The State anticipates that CPs and CSAs will submit their current year budget period Budgets and Budget Narratives to the State in January of the budget period
  - The State anticipates approving CP and CSA Budgets and Budget Narratives in March of the budget period
  - The State anticipates making bi-annual infrastructure payments in April and October of the budget period and monthly care coordination payments

### **3.4.5 Process for State Approval of Modifications to Participation Plans, Budgets and Budget Narratives**

ACOs, CPs and CSAs may submit ad hoc requests to amend their Participation Plans, Budgets, and Budget Narratives at any time except within 75 days of the end of the Budget Period. ACOs, CPs or CSAs will not be allowed to materially deviate from their approved spending plans without formally requesting such modification and having the modification approved by the State. The State has sole discretion to determine whether an amendment request is a material deviation, and thus a modification. In addition, the State may require ACOs, CPs or CSAs to modify their Full Participation Plans, Budgets or Budget Narratives in certain circumstances (e.g., if a primary care practice where an ACO had previously proposed making investments goes out of business).

The State's process for submission, review and approval of modification requests will be as follows:

- ACOs, CPs or CSAs submit a modification request
- The State and Independent Assessor review the modification request in parallel. The State intends to complete its review of modification requests, including evaluating the Independent Assessor's recommendations, within 45 calendar days of their submission. Further requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information
- The State therefore anticipates completing approvals of modification requests within 45 calendar days of requesting them from ACOs, CPs and CSAs

If the State denies the modification request, the State and Independent Assessor will provide feedback about why the request was denied, and the State may allow the entity to resubmit their modification request after

revisions, as appropriate. The timeline for review would restart upon resubmission, and the same processes would be followed as for an initial submission.

The State may withhold or deduct a portion of ACO, CP, or CSA DSRIP funds for contract management purposes (e.g. in response to significant delays in responding to DSRIP deliverable submission deadlines). If funds are deducted, such funds may be reallocated by the State according to the parameters described in Section 5.1.3 of this Protocol.

## Section 4. DSRIP Payments (ACOs, CPs, CSAs and Statewide Investments)

DSRIP funding will support four streams, as described in Section 1. This Section (Section 4) outlines parameters for DSRIP payments to ACOs, CPs, CSAs and Statewide Investments including sub-streams. A portion of payments from the State to ACOs, CPs and CSAs are at risk based on the ACO, CP and CSA Accountability Framework described in Section 5. Section 5 also describes the linkage between ACO, CP and CSA accountability to the State. Section 4 explores DSRIP payments to ACOs, CPs or CSAs and the sub-streams within them.

Each of ACO and CP payment streams has several “sub-streams,” which differ from each other with respect to three characteristics: (1) purpose/allowable uses; (2) calculation methodology; (3) and accountability. These three characteristics are detailed for each sub-stream in the following three subsections 4.1-4.3, respectively. Section 4.5 provides additional detail on how Accountability Scores are calculated using the accountability framework laid out in Section 4.4.

- Section 4.1: provides an overview of the sub-streams of DSRIP funding for ACOs, CPs and CSAs, as well as their amounts and the process for the State to vary those amounts
- Section 4.2: provides detail on purpose and allowable uses for ACO sub-streams
- Section 4.3: provides detail on purpose and allowable uses for CP and CSA sub-streams
- Section 4.4: provides detail on payment calculation and timing for ACO sub-streams
- Section 4.5: provides detail on payment calculation and timing for CP and CSA sub-streams
- Section 4.6: provides funding information on Statewide Investments
- Section 4.7: provides detail on DSRIP carry forward capacity

### 4.1 Overview and Outline

The State has divided the ACO, CPs and CSA DSRIP funding streams into eleven sub-streams: four for ACOs, three each for BH CPs and LTSS CPs and one for CSAs.

EXHIBIT 4 – ACO, CP and CSA Sub-Streams

ACO Funding Stream 4 sub-streams	CP and CSA Funding Stream 7 sub-streams		
	BH CPs: <i>3 sub-streams</i>	LTSS CPs: <i>3 sub-streams</i>	CSAs: <i>1 sub-stream</i>
<ul style="list-style-type: none"> <li>• Startup/Ongoing: primary care investment</li> <li>• Startup/Ongoing: discretionary</li> <li>• Flexible services</li> <li>• DSTI Glide Path</li> </ul>	<ul style="list-style-type: none"> <li>• Care coordination</li> <li>• Infrastructure and Capacity Building</li> <li>• Outcomes-based</li> </ul>		<ul style="list-style-type: none"> <li>• Infrastructure and Capacity Building</li> </ul>

Per STC 60(e), the State may reallocate funding amounts between the “ACO Funding Stream” and the “CP and CSA Funding Stream” at its discretion. If the actual funding amounts for the ACO Funding Stream or the CP and CSA Funding stream differ from the amounts set forth in Table G of STC 60(e) by more than 15%, the State must notify CMS 60 calendar days prior to the effective reallocation of funds. CMS reserves the right to disapprove any such reallocations prior to the effective date of the reallocation.

Within the “ACO Funding Stream” or “CP Funding Stream”, the State may distribute payments for a given demonstration year among the sub-streams to best meet the State’s programmatic needs, in its discretion without notifying CMS, subject to the parameters described in STC 60(e). Because the mechanisms for holding ACOs and CPs financially accountable differ among these sub-streams, changes in the distribution of funding among the sub-streams may change the amount of funding for an individual ACO or CP that is at risk. For example, if funding is shifted from the “Startup/Ongoing: Discretionary” ACO sub-stream to the “Startup/Ongoing: Primary Care Investment” ACO sub-stream, this would lead to less at-risk funding because funds have shifted from a sub-stream with an at-risk component to a sub-stream without an at-risk component (see Exhibit 19). Exhibit 5 below shows the State’s distribution of DSRIP payments to ACOs, CPs and CSAs by funding stream for each budget period, as well as the State’s anticipated sample distribution of DSRIP payments within the ACO and CP funding streams by sub-stream. The table also shows the percent and total funding for each stream and sub-stream that is at-risk based on the ACOs’, CPs’ and CSAs’ accountability to the State (see Section 5 for more information on accountability). This Exhibit is provided for illustrative purposes only and is an estimate of anticipated funding among funding streams and sub-streams at this point in time.

EXHIBIT 5 – Provider Accountability to State

		Prep BP	BP1	BP2	BP3	BP4	BP5	Total
<b>ACOs (Accountability to State)</b>	<b>Total Funds</b>	\$138.2M	\$284.1M	\$238.0M	\$192.5M	\$132.7M	\$64.0M	\$1,049.5M
	<b>At-Risk %</b>	0%	4%	10%	19%	27%	20%	11%
	<b>At-Risk Funds</b>	\$0.0M	\$10.0M	\$24.1M	\$36.8M	\$36.4M	\$12.9M	\$120.3M
<i>Startup/Ongoing: Primary Care Investment (Not At-Risk)</i>	<b>Total Funds</b>	\$21.8M	\$43.6M	\$29.6M	\$30.5M	\$10.5M	\$10.8M	\$146.7M
<i>Startup/Ongoing: Discretionary</i>	<b>Total Funds</b>	\$94.9M	\$165.1M	\$153.3M	\$117.2M	\$86.5M	\$23.7M	\$640.7M
	<b>At-Risk %</b>	0%	5%	15%	30%	40%	50%	18%
	<b>At-Risk Funds</b>	\$0.0M	\$8.3M	\$23.0M	\$35.2M	\$34.6M	\$11.9M	\$112.9M
<i>Flexible Services (Not At-Risk)</i>	<b>Total Funds</b>	\$0.0M	\$40.8M	\$32.1M	\$27.9M	\$23.6M	\$24.3M	\$148.7M
<i>DSTI Glide Path Funding</i>	<b>Total Funds</b>	\$21.5M	\$34.6M	\$23.0M	\$16.8M	\$12.2M	\$5.2M	\$113.4M
	<b>At-Risk %</b>	0%	5%	5%	10%	15%	20%	7%
	<b>At-Risk Funds</b>	\$0.0M	\$1.7M	\$1.1M	\$1.7M	\$1.8M	\$1.0M	\$7.4M
<b>Community Partners (Accountability to State)</b>	<b>Total Funds</b>	\$15.8M	\$59.0M	\$105.6M	\$125.5M	\$122.0M	\$118.9M	\$546.7M
	<b>At-Risk %</b>	0%	0%	3%	11%	16%	20%	11%
	<b>At-Risk Funds</b>	\$0.0M	\$0.0M	\$3.6M	\$14.3M	\$19.9M	\$23.6M	\$61.4M
<b>Behavioral Health CPs</b>	<b>Total Funds</b>	\$11.7M	\$46.3M	\$80.2M	\$91.1M	\$86.5M	\$83.1M	\$398.9M
	<b>At-Risk %</b>	0%	0%	3%	11%	16%	20%	11%
	<b>At-Risk Funds</b>	\$0.0M	\$0.0M	\$2.5M	\$9.9M	\$13.7M	\$16.2M	\$42.3M
<i>Care Coordination Supports</i>	<b>Total Funds</b>	\$0.0M	\$21.9M	\$60.3M	\$66.4M	\$66.2M	\$65.9M	\$280.6M
<i>Infrastructure and Capacity Building (including CSAs)</i>	<b>Total Funds</b>	\$11.7M	\$24.4M	\$19.9M	\$23.6M	\$19.3M	\$16.2M	\$115.3M
	<b>At-Risk %</b>	0%	0%	13%	42%	71%	100%	37%
	<b>At-Risk Funds</b>	\$0.0M	\$0.0M	\$2.5M	\$9.9M	\$13.7M	\$16.2M	\$42.3M
<i>Outcomes-Based Stream (Incentive Pool, Not At-Risk)</i>	<b>Total Funds</b>	\$0.0M	\$0.0M	\$0.0M	\$1.0M	\$1.0M	\$1.0M	\$3.0M
<b>LTSS CPs</b>	<b>Total Funds</b>	\$4.0M	\$12.7M	\$25.3M	\$34.4M	\$35.5M	\$35.8M	\$147.8M
	<b>At-Risk %</b>	0%	0%	4%	13%	18%	21%	13%
	<b>At-Risk Funds</b>	\$0.0M	\$0.0M	\$1.0M	\$4.5M	\$6.2M	\$7.4M	\$19.1M
<i>Care Coordination Supports</i>	<b>Total Funds</b>	\$0.0M	\$5.7M	\$17.1M	\$23.3M	\$26.3M	\$27.9M	\$100.3M
<i>Infrastructure and Capacity Building</i>	<b>Total Funds</b>	\$4.0M	\$6.9M	\$8.2M	\$10.7M	\$8.8M	\$7.4M	\$46.0M
	<b>At-Risk %</b>	0%	0%	13%	42%	71%	100%	41%
	<b>At-Risk Funds</b>	\$0.0M	\$0.0M	\$1.0M	\$4.5M	\$6.2M	\$7.4M	\$19.1M
<i>Outcomes-Based Stream (Incentive Pool, Not At-Risk)</i>	<b>Total Funds</b>	\$0.0M	\$0.0M	\$0.0M	\$0.5M	\$0.5M	\$0.5M	\$1.5M

## 4.2 Purpose and Allowable Uses for ACO Funding Sub-Streams

### 4.2.1 ACO Sub-Streams 1 & 2: Startup/Ongoing Funding (Primary Care & Discretionary)

ACO sub-streams 1 and 2 are for Startup/Ongoing funds. Startup/Ongoing funds are split into two sub-streams. Sub-stream 1 is explicitly dedicated for primary care investment. ACOs will be required to spend these funds on state-approved investments that support the ACO’s primary care providers such as capital investments in primary care practices (e.g., inter-operable EHR systems), trainings for primary care providers and support staff in population health management protocols, administrative staff to support front-line providers with clinical quality initiatives, etc. Having a dedicated funding stream for primary care investment is an important mechanism for the State to ensure that ACOs and their PCPs are mutually

committed to each other, having mutual discussions about business decisions and working together to meet the State's delivery system reform goals. In order to ensure that primary care investments supported by DSRIP do not duplicate other federal or state investments, ACOs will be required to disclose in their Full Participation Plans what state and federal investments the ACO is using to support primary care investments, and how the ACO is ensuring non-duplication with proposed DSRIP funding uses.

Sub-stream 2 is for discretionary Startup/Ongoing funding and may be used by the ACO for other state-approved investments. Some examples of investment opportunities for ACOs include, but are not limited to: health information technology, contracting/network development, project management, and care coordination/management investment, assessments for members with identified LTSS needs, workforce capacity development and new or expanded telemedicine capability.

The funding amounts for these two sub-streams decrease over the five demonstration years and are intended to support ACO investments as they start their ACO models and provide operating funds to support (during initial years) the ongoing costs of these models. As ACOs progress through the five demonstration years, the State expects ACOs to increasingly self-fund these investments and expenses out of their TCOC-based revenue (e.g., medical gains under capitation rates, or shared savings payments).

#### **4.2.2 ACO Sub-Stream 3: Flexible Services Funding**

A portion of ACO DSRIP funds will be dedicated to spending on flexible services. Flexible services funding will be used to address health-related social needs by providing supports that are not currently reimbursed by MassHealth or other publicly-funded programs. These flexible services must satisfy the criteria described in STC 63(b)(ii), 63(c), and 63(d). ACOs will receive a Flexible Services allocation each Budget Period, as determined by the State. Please see the Flexible Services Protocol for more details on how ACOs will be able to access their Flexible Services funding allocation for BP1 through BP4. During the first half of BP5, the State will pay out the full BP5 flexible services funding amount prospectively, based on the ACO's approved BP5 flexible services budgets. ACOs will still need to submit their flex services documentation and claims during BP5. If the ACOs do not use all of their flexible services allocation in BP5, or if the ACOs make expenditures that are deemed unacceptable by the State, then the ACOs will have to return the appropriate amount of flexible services funding to the State. Additional details about flexible services will be delineated in the Flexible Services Protocol (Attachment R), which is to be reviewed and approved by CMS by July 2017.

If CMS does not approve the Flexible Services Protocol by August 2017, then the State may reallocate the Budget Period 1 flexible services funding allocation detailed in Exhibit 5 to other Budget Period 1 DSRIP funding streams so that the State's expenditure authority is not reduced due to non-approval of the Flexible Services Protocol, or it may carry forward the expenditure authority into subsequent Budget Periods without counting against the 15% benchmark described in STC 60(d)(ii). Similarly, the State may continue to reallocate the flexible services funding allocation for each Budget Period to other DSRIP funding streams for that Budget Period if CMS does not approve the Flexible Services Protocol by the July of the preceding Budget Period. Any such reallocation will be included in an updated funding allocation table in the next quarterly progress report to CMS. CMS will have 90 calendar days to request modifications to the reallocation proposal.

#### **4.2.3 ACO Sub-Stream 4: DSTI Glide Path Funding**

During the five-year demonstration, the State will restructure demonstration funding for safety net hospital systems to be more sustainable and aligned with value-based care delivery and payment incentives. The seven safety net hospitals currently receiving funding through the Delivery System Transformation Initiatives (DSTI) program will instead receive a reduced amount of ongoing operational support through Safety Net Provider payments authorized under the State's restructured Safety Net Care Pool. To create a sustainable transition from current funding levels to these new, reduced levels, the State will provide transitional DSRIP funding to these DSTI safety net hospitals.



Payment of the DSTI Glide Path funding is contingent on a safety net hospital's approved participation with a MassHealth ACO (and therefore on their financial accountability for cost and quality). To receive this funding, a safety net hospital must have a provider arrangement or contract with an ACO that demonstrates its participation in that ACO's efforts, including at a minimum documented participation in the ACO's transitional care management and other contractual responsibilities (e.g., data integration), and financial accountability including the potential for the safety net hospital to share gains from savings and share responsibility for losses.

This DSTI Glide Path funding will be paid directly to any ACO that has a provider arrangement or contract with one of these seven DSTI safety net hospitals. The ACO will be required to give the full amount of this funding to the participating safety net hospitals. The amount of DSTI Glide Path funding will decrease each year, sustainably transitioning safety net hospitals to lower levels of supplemental support.

### **4.3 Purpose and Allowable Uses for CP and CSA Funding Sub-Streams**

MCOs and ACOs will delegate comprehensive care management responsibility to the BH CP for members diagnosed with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD), as well as adult members who exhibit SMI and SUD, but have not been diagnosed, and who are assigned to the BH CPs. BH CPs are required to coordinate care for members enrolled with the BH CP across the full healthcare continuum, including physical and behavioral health, LTSS and social service needs. This section describes the purpose and allowable uses for the three funding sub-streams for each CP (care coordination, infrastructure and capacity building and outcome-based payments) and one sub-stream for CSAs (infrastructure and capacity building):

#### **4.3.1 BH CP Sub-Stream 1: Care Coordination Supports Funding**

BH CPs will receive funds under BH CP sub-stream 1 to perform the following functions for assigned members:

1. Outreaching to and actively engaging members
2. Identifying and facilitating a care team for every engaged member
3. Person-centered treatment planning for every engaged member
4. Coordinating services across the care continuum to ensure that the member is in the right place for the right services at the right time
5. Supporting transitions between care settings
6. Providing health and wellness coaching
7. Facilitating access and referrals to social services and other community services

#### **4.3.2 BH CP Sub-Stream 2: Infrastructure and Capacity Building Funding**

BH CPs will receive funds under BH CP sub-stream 2 to make infrastructure investments to advance their capabilities to support their member populations and to form partnerships with MCOs and ACOs. Infrastructure funding for BH CPs will be disbursed across four categories:

1. Technology – e.g., HIT and care management software, IT project management resources, data analytics capabilities, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring or electronic medication dispensers, and reporting software
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications
3. Business Startup Costs – e.g., staffing and startup costs to develop full caseloads.
4. Operational Infrastructure – e.g., project management, system change resources and performance management capabilities, additional operational support.

#### **4.3.3 BH CP Sub-Stream 3: Outcomes-Based Payments**

BH CPs will have the opportunity to earn additional payments under BH CP sub-stream 3 in Budget Periods 3 through 5 by reaching high levels of achievement on avoidable utilization metrics. The State anticipates submitting performance targets to CMS for approval in Q3 CY2021, in alignment with when it anticipates submitting benchmarks to CMS for the avoidable utilization metrics.

#### **4.3.4 LTSS CP Sub-Stream 1: Care Coordination Supports Funding**

MCOs and ACOs will have responsibility for conducting the comprehensive assessment for enrollees assigned to LTSS CPs and other enrollees identified by EOHHS as having LTSS needs, as specified in their contracts with the State. The LTSS CP will review the results of the comprehensive assessment with a LTSS assigned member as part of the person-centered LTSS care planning process and will inform the member about his or her options for specific LTSS services, programs and providers that may meet the member's identified LTSS needs. LTSS CPs will receive funds under LTSS CP sub-stream 1 to perform the following functions for assigned members:

1. Providing disability expertise consultation as requested by MassHealth, the member's MassHealth managed care entity, or the member on the comprehensive assessment
2. Providing LTSS care planning using a person-centered approach and choice counseling
3. Participating on the member's care team to support LTSS care needs decisions and LTSS integration, as directed by the member
4. Providing LTSS care coordination and support during transitions of care
5. Providing health and wellness coaching
6. Connecting the member to social services and community resources.

The State also intends to allow LTSS CPs to provide optional enhanced functions for members with complex LTSS needs who would benefit from comprehensive care management provided by a LTSS CP. The enhanced supports care model will be similar to that of the BH CP, including the performance of a comprehensive assessment, although adapted to the specific LTSS population to be served, and will include a PMPM rate reflective of the BH CP model. The State will select LTSS CPs to perform enhanced supports via a competitive procurement.

#### **4.3.5 LTSS CP Sub-Stream 2: Infrastructure and Capacity Building Funding**

LTSS CPs will receive funds under LTSS CP sub-stream 2 to make investments to advance the organization's overall capabilities to support its member population and form partnerships with MCOs and ACOs. Infrastructure funding for LTSS CPs will be disbursed across four categories:

1. Technology – e.g., HIT and care management software, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring, electronic medication dispensers and reporting software;
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications;
3. Business Startup Costs – e.g., staffing and startup costs to develop full caseload capacities
4. Operational Infrastructure – e.g., IT project management, system change resources, data analytics capabilities performance management capabilities and additional operational support

#### **4.3.6 LTSS CP Sub-Stream 3: Outcomes-Based Payments**

LTSS CPs will have the opportunity to earn additional payments under LTSS CP sub-stream 3 in Budget Periods 3 through 5 by reaching high levels of achievement on avoidable utilization metrics. The State anticipates submitting performance targets to CMS for approval in Q3 CY2021, in alignment with when it anticipates submitting benchmarks to CMS for the avoidable utilization metrics.

#### 4.3.7 CSA Sub-Stream 1: Infrastructure and Capacity Building Funding

CSAs will receive funds under CSA sub-stream 1 to make investments to advance their overall capabilities to support their member populations and to form partnerships with MCOs and ACOs. Infrastructure funding for CSAs will be disbursed across three categories:

1. Technology – e.g., HIT and care management software, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring, electronic medication dispensers reporting software
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications;
3. Operational Infrastructure – e.g., IT project management, system change resources, data analytics capabilities performance management capabilities and additional operational support

#### 4.4 Payment Calculation and Timing for ACO Sub-Streams

##### 4.4.1 ACO Sub-Streams 1 & 2: Startup/Ongoing Funding (Primary Care & Discretionary)

Each ACO will receive an amount of Startup/Ongoing funds (combined across sub-streams 1 and 2) for each Budget Period that is determined by multiplying the number of members enrolled in or attributed to the ACO by a per member per month (PMPM) amount. The State will determine the number of members.

The State will determine each ACO’s PMPM amount during the Preparation Budget Period and BP 1 – 5 as follows:

- Step 1: The State will set a base rate
- Step 2: The State will increase this rate for each ACO based on the ACO’s safety net category
  - The State will calculate each ACO’s payer revenue mix based on the percentage of its gross patient service revenue that comes from care for MassHealth members or uninsured individuals
  - The State will categorize ACOs into five categories based on their payer revenue mix (each category has a percentage increase associated with it)
  - During the DSRIP program, the State may adjust the safety net PMPM adjustment methodology as described later in this section
- Step 3: The State will further increase this rate for each ACO based on the ACO’s choice of model and risk track (each model/risk track combination has a percentage increase associated with it – (as detailed in Exhibit 8))

Exhibit 6 shows the State’s anticipated average adjusted PMPMs for the ACO Startup/Ongoing sub-streams, after following the steps described above.

EXHIBIT 6 – Average Adjusted PMPMs for ACO Startup/Ongoing Support

Average Adjusted PMPMs for ACO Startup/Ongoing Support					
Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5
\$21.43	\$19.16	\$18.14	\$14.24	\$9.17	\$3.12

Given the potential for variation in anticipated ACO and member participation, these average adjusted PMPMs represent an estimate, and the State may disburse, on average, PMPMs that differ from the PMPMs displayed in Exhibit 6 by up to +/- \$6. Individual ACO PMPMs may vary by greater amounts due to the adjustments described in this section. If a new ACO joins after BP1, e.g. in BP3, it will have the same BP3 base PMPMs as the existing ACOs and will not be assigned PMPMs differently.

ACOs with a higher percentage of revenue generated from Medicaid and uninsured patient services revenue will be placed into a higher safety net category, corresponding to a larger percentage PMPM increase. To determine each ACO's safety net category, ACOs must submit a payer revenue mix attestation form. The form contains detailed instructions on how to calculate revenue as well as the types of revenue that ACOs must provide. For example, the State requires ACOs to include patient health care service revenue from various categories, which include but are not limited to: (1) MassHealth, inclusive of Medicaid and the Children's Health Insurance Plan, (2) Health Safety Net, (3) Medicare, (4) Commercial Health Plans, (5) Other Government Sources, such as Veterans Affairs and Tricare and (6) Other Revenue Sources, such as Self-pay and Workers' Compensation). Using this information, the State will determine the Gross Patient Service Revenue (GPSR) from MassHealth and uninsured patients and place each ACO in the appropriate safety net category. See Exhibit 7 for the PMPM adjustment schedule based on safety net category.

**EXHIBIT 7 – Safety Net PMPM Adjustment**

Safety Net PMPM Adjustment					
Safety Net Category	5	4	3	2	1
% PMPM Increase	40%	30%	20%	10%	0%

As mentioned earlier, the State may also adjust the safety net PMPM adjustment methodology during the DSRIP program, as follows:

- Startup/ongoing PMPMs for members attributed to community health centers may receive a higher safety net PMPM adjustment (e.g., the maximum safety net adjustment of +40%), as described in Exhibit 7, regardless of the ACO's safety net category, reflecting the unique safety net status of these providers
- Under this revised methodology, startup/ongoing PMPMs for members attributed to other PCPs would receive a PMPM adjustment based on the ACO's overall safety net category (i.e., unchanged from current methodology)

The State will also apply a PMPM adjustment each year depending on the ACO's chosen model and risk track. This adjustment will be additive with the safety net PMPM adjustment. If an ACO switches models or risk tracks during the DSRIP period, then its PMPM adjustment will be updated to align with the new ACO model type. See Exhibit 8 for the PMPM adjustment schedule based on ACO Model and Risk Track.

**EXHIBIT 8 – ACO Model and Risk Track PMPM Adjustment**

ACO Model PMPM Adjustment						
ACO Model	Accountable Care Partnership Plan (Model A)	Primary Care ACO (Model B)		MCO-Contracted ACO (Model C)		
		Risk Track 2 (more risk)	Risk Track 1 (less risk)	Risk Track 3 (more risk)	Risk Track 2 (medium risk)	Risk Track 1 (less risk)
% PMPM Increase	40%	40%	30%	30%	10%	0%

For example, using the standard safety net PMPM adjustment methodology, if the base PMPM rate is \$10, and the ACO is a Primary Care ACO (Risk Track 2) and a safety net category 3 provider, then the adjusted startup/ongoing PMPM would be  $\$10 * (100\% + 40\% + 20\%) = \$16$ . If the State modifies its safety net PMPM adjustment methodology, as described above, and this ACO has 60% of members attributed to community health centers, then the ACO would have two different PMPMs for the members attributed to CHCs vs. other PCPs:

- PMPM for members attributed to CHC:  $\$10 * (100\% + 40\% + 40\%) = \$18$
- PMPM for other members:  $\$10 * (100\% + 40\% + 20\%) = \$16$

The PMPMs would be multiplied by their associated member counts, and the sum of these products would be the ACO’s startup/ongoing funding amount.

The amount of funding that ACOs will need to allocate for primary care investment will be based on the following PMPM schedule:

**PMPM Schedule for Startup/Ongoing Funds (Primary Care Investment)**

	Prep Budget Period	BP1	BP2	BP3	BP4	BP5
Startup/Ongoing Funds Designated for Primary Care Investment (\$PMPM)	\$4	\$4	\$3	\$3	\$1	\$1

All remaining startup/ongoing support (i.e. “discretionary” startup/ongoing funds) can be distributed amongst the ACO’s participating providers, as decided by the ACO. This funding could be used to support additional primary care investment or assessments for members with identified LTSS needs, among other things.

Generally speaking, ACO funding sub-streams 1 and 2 will be paid in four quarterly installments for each Budget Period. The State anticipates these installments will be roughly equal; however, the State may alter the payment amounts, frequency, and timing in its discretion. For example, the State may pay a reduced amount for the first quarterly payment, which may be based on preliminary funding amount calculations, to minimize ACO disruption when funding amounts are finalized and the remaining three payments are adjusted accordingly. During BP5, payments will be attributed to the first half of the year; as such, these attributed amounts will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had \$100 total of non-at-risk startup/ongoing funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 (\$50 each), as opposed to \$25 attributed across each of the four quarters of BP5.

If an ACO’s contract with the State is terminated midway through a budget period due to the ACO leaving the ACO program, then the ACO will not receive new startup/ongoing funds for that budget period.

**4.4.2 ACO Sub-Stream 3: Flexible Services Funding**

Each ACO will receive an allotment of flexible services funding for each Budget Period, except for the Preparation Budget Period during which there are no flexible services funds (because ACOs do not yet have enrolled/attributed members). The allotment will be determined on a PMPM basis, as set forth in Exhibit 9. Details for how ACOs will be able to access their Flexible Services funding allotments can be found in the Flexible Services Protocol. The State may redistribute any undisbursed flexible services funding among the other DSRIP funding streams at the State’s discretion, following the same parameters as described in Section 5.1.3 for redistribution of funding not distributed to ACOs, CPs, and CSAs. Any such redistributions would be reported to CMS in the State's quarterly progress reports.

The PMPMs for flexible services allotments are set forth in Exhibit 9. The State may vary these PMPMs in its discretion without obtaining CMS approval. If an ACO’s contract with the State is terminated midway through a budget period due to the ACO leaving the ACO program, then the State at its discretion may provide new flexible services funding to the leaving ACO. If the State decides to provide new flexible services funding to the leaving ACO, then different flexible services base PMPM rates may be used for the leaving ACO and ACOs staying in the program.

EXHIBIT 9 – PMPMs for Flexible Services

PMPMs for Flexible Services					
Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5
\$0.00	\$3.75	\$3.25	\$2.75	\$2.25	\$2.25

**4.4.3 ACO Sub-Stream 4: DSTI Glide Path Funding**

The amount of DSTI glide path funding the State will pay to each safety net hospital is detailed in Exhibit 10 below.

EXHIBIT 10 – DSTI Glide Path Funding by State Fiscal Year (\$ Millions)

DSTI Glide Path Funding (\$M) by State Fiscal Year						
Hospital Provider	SFY 18	SFY 19	SFY 20	SFY 21	SFY 22	Total
Boston Medical Center	\$23.74M	\$13.53M	\$10.10M	\$7.82M	\$6.30M	<b>\$61.49M</b>
Cambridge Health Alliance	\$12.07M	\$8.45M	\$6.36M	\$4.09M	\$3.00M	<b>\$33.99M</b>
Holyoke Medical Center	\$2.67M	\$1.58M	\$1.22M	\$0.99M	\$0.63M	<b>\$7.09M</b>
Lawrence General Hospital	\$0.58M	\$0.34M	\$0.26M	\$0.20M	\$0.43M	<b>\$1.81M</b>
Mercy Medical Center	\$1.18M	\$0.69M	\$0.53M	\$0.13M	\$0.00M	<b>\$2.54M</b>
Signature Healthcare Brockton Hospital	\$1.04M	\$0.61M	\$0.47M	\$0.37M	\$0.08M	<b>\$2.56M</b>
Steward Carney Hospital	\$1.80M	\$1.00M	\$0.81M	\$0.30M	\$0.05M	<b>\$3.96M</b>

These hospitals will only receive DSTI glide path funding through DSRIP if they participate in a MassHealth ACO, where participation means that the DSTI hospital has a provider arrangement or contract with the ACO that involves financial accountability, including the potential for the safety net hospital to share gains from savings and share responsibility for losses. For the purposes of this glide path funding, a DSTI hospital can only have a provider arrangement or contract with one ACO. This funding is not PMPM-based, but was developed to establish a glide path from current safety net care pool (SNCP) supplemental payments to reduced SNCP payments

This glide path funding needs to be converted from the state fiscal year framework to the Budget Period framework in order to align with the at-risk schedule described in Exhibit 20. Funds for the 6 month Preparation Budget Period for each DSTI hospital will be equal to half of the hospital’s glide path payments in SFY18. Budget Period 1 funds for each DSTI hospital will be equal to the sum of half of the hospital’s glide path payments in SFY18 and SFY19. Budget Periods 2 through 4 for each DSTI hospital will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds for each DSTI hospital will be equal to half of the hospital’s glide path payments in SFY22. See Exhibit 11 for a table displaying the DSTI glide path funding by Budget Period.

EXHIBIT 11 – DSTI Glide Path Funding by Budget Period (\$ Millions)

DSTI Glide Path Funding (\$M) by Budget Period							
Hospital Provider	Prep BP	BP 1	BP 2	BP 3	BP4	BP5	Total
Boston Medical Center	\$11.87M	\$18.64M	\$11.81M	\$8.96M	\$7.06M	\$3.15M	<b>\$61.49M</b>
Cambridge Health Alliance	\$6.04M	\$10.27M	\$7.41M	\$5.23M	\$3.55M	\$1.50M	<b>\$33.99M</b>
Holyoke Medical Center	\$1.33M	\$2.12M	\$1.40M	\$1.11M	\$0.81M	\$0.32M	<b>\$7.09M</b>
Lawrence General Hospital	\$0.29M	\$0.46M	\$0.30M	\$0.23M	\$0.32M	\$0.21M	<b>\$1.81M</b>
Mercy Medical Center	\$0.59M	\$0.93M	\$0.61M	\$0.33M	\$0.07M	\$0.00M	<b>\$2.54M</b>
Signature Healthcare Brockton Hospital	\$0.52M	\$0.82M	\$0.54M	\$0.42M	\$0.22M	\$0.04M	<b>\$2.56M</b>
Steward Carney Hospital	\$0.90M	\$1.40M	\$0.91M	\$0.56M	\$0.18M	\$0.03M	<b>\$3.96M</b>

Generally speaking, DSTI glide path funding will be paid in four quarterly installments for each Budget Period. The State anticipates these installments will be roughly equal; however, the State may alter the payment amounts, frequency, and timing in its discretion. During BP5, payments will be attributed to the first half of the year; as such, these attributed amounts will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had \$100 total of non-at-risk DSTI glide path funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 (\$50 each), as opposed to \$25 attributed across each of the four quarters of BP5.

If a DSTI hospital has an affiliated provider arrangement or contract with an ACO whose contract with the State ends midway through a budget period due to the ACO leaving the ACO program, and the DSTI hospital does not enter into a contract or other arrangement with a different ACO and bear risk through ACO participation for the remainder of the budget period, then that DSTI hospital will not receive DSTI Glide Path Funding for the entirety of that budget period. If the DSTI hospital enters into a contract or other arrangement with a different ACO and bears risk through ACO participation, then the leaving ACO will receive half of the non-at-risk DSTI Glide Path funding to pay to the DSTI hospital during the first half of the budget period, as well as the earned at-risk funding that is tied to the first half of the budget period once the ACO DSRIP accountability scores are calculated. Once the DSTI hospital joins a new ACO, it may receive the remainder of its DSTI glide path funding for that budget period. The ACO DSRIP accountability scores (see Section 5.3) used to calculate the amount of at-risk DSTI glide path funding earned for the first and second halves of the year in which the ACO leaves will be the scores earned by the DSTI hospital’s original and new ACOs in that budget period, respectively.

**4.4.4 Detail on calculating member-months**

Each ACO will be accountable for a defined population of members. Because ACOs’ responsibilities scale with their populations, the State will use the size of this population to determine the amount of Startup/Ongoing funding and the Flexible Services allotment for each ACO. For Partnership Plans and Primary Care ACOs, the number of members is simply the number of members enrolled in each ACO. Eligible MassHealth members will either choose to enroll or be assigned to these ACOs. MassHealth records members’ enrollments in the agency’s MMIS system and Data Warehouse. The State will tally a count of members enrolled in each ACO based on this record; this count will be multiplied by the DSRIP PMPM values to calculate the payment amounts per ACO.

For MCO-Administered ACOs, the State will use the number of members attributed to each ACO for the purposes of cost and quality accountability. These attributed members are the subset of MassHealth MCO enrollees who have primary care assignments in their MCOs to PCPs who participate in MCO-Administered ACOs. Massachusetts will know who these Participating PCPs are for each MCO-Administered ACO, and will record this information in its Data Warehouse. Each MCO will report to the State on a regular basis the primary care assignments for the MCO's enrollees. The State will use this information to determine the number of MCO enrollees who have primary care assignments to each MCO-Administered ACO; this number will be multiplied by the DSRIP PMPM values to calculate the payment amounts per MCO-Administered ACO.

The State may use a point-in-time ("snapshot") count of members for each ACO, or may calculate the average members each ACO has over a particular period (e.g., the most recent quarter) in order to ensure DSRIP payment calculations are robust to temporary fluctuations in member enrollments. Once Massachusetts has selected ACOs and is able to perform more analytics on historical ACO-level member enrollment movement, Massachusetts intends to finalize such operational details of this calculation.

## 4.5 Payment Calculation and Timing for CP and CSA Sub-Streams

### 4.5.1 BH CP Sub-Stream 1: Care Coordination Supports Funding

The State will pay each BH CP a PMPM rate for care coordination supports for each member assigned to and engaged with the BH CP during the month. The PMPM rate has been developed to account, in part, based on the staff required to support the BH CP model, including the need for Registered Nurses, licensed clinicians, and access to a medical director for the performance of supports such as comprehensive assessments and medication reconciliation, as well as community health workers, health outreach workers, peer specialists and recovery coaches for the SMI and/or SUD population. Caseloads for each BH CP are expected to be between 35-50 engaged enrollees per FTE. The rate is anticipated to be \$180 PMPM. The State anticipates that the rate will remain constant for the first two years of the program, at which time the State plans to evaluate the program and revisit the PMPM rate. The State may vary the amount of the PMPM in its discretion at any time during the demonstration.

The State will pay the PMPM rate to the BH CP for each month in which the BH CP performs and documents a qualifying activity, beginning in the month when the member is assigned to the BH CP. If the BH CP does not perform any qualifying activities during a month, it will not be paid for that month. A BH CP will be paid for outreach only during the first 90 days of a member's assignment to the BH CP if outreach is attempted and documented during that 90-day period. For members assigned to a BH CP between July 1, 2018 and October 31, 2018, inclusive, the BH CP may be paid for qualifying activities other than outreach during the first 10 months of a member's assignment. After the first 10 months of assignment, the State will not make payments to a BH CP for qualifying activities performed for a member, unless that member is engaged. For members assigned to a BH CP beginning November 1, 2018, the BH CP may be paid for qualifying activities other than outreach during the first 150 days of a member's assignment. After the first 150 days of assignment, the State will not make payments to the BH CP for any qualifying activities performed for a member, unless that member is engaged. A member is considered engaged with the BH CP when a comprehensive assessment is completed and care plan is approved by the member's PCP or PCP designee. The PCP may designate appropriate MCO or ACO clinical staff as the PCP designee. The BH CP must coordinate with the member's PCP or PCP designee, as appropriate, in performing qualifying activities, such as to support or review medication reconciliation for the member, including during the first 10 months of assignment. The State will report to CMS in its quarterly and annual reports the BH CP engagement rates, as data are available.

Example payment calculation with PMPM of \$160:

Example payment amount for one month = (Total number of members assigned but not engaged + total number of members engaged)\*\$160



**4.5.2 BH CP Sub-Stream 2: Infrastructure and Capacity Building Funding**

Each BH CP will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period. BH CPs will propose allocation of funds across the four categories listed in section 4.3.2 in their Preparation Budget Period Budgets and Budget Narratives. The State anticipates disbursing up to \$500,000 to each BH CP for initial infrastructure funding. The State may adjust the amount of the Preparation Budget Period funds disbursed to BH CPs in its discretion.

For Budget Period 1, BH CPs will receive infrastructure funds based on the anticipated number of engaged members, as determined by the State. For Budget Period 2 through 5, BH CPs will receive infrastructure funds based on the number of enrolled members (both assigned and engaged), as determined by the State. Exhibit 12 sets forth the anticipated PMPM schedule for BH CP infrastructure and capacity building funding. The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to BH CPs and CSAs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CP had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5.

**EXHIBIT 12 – Anticipated Schedule for BH CP for Infrastructure and Capacity Building (PMPM)**

BH CP Infrastructure and Capacity Building PMPMs				
BP 1	BP 2	BP 3	BP 4	BP 5
\$35.00 - \$45.00	\$25.00 - \$35.00	\$15.00 - \$25.00	\$10.00 - \$20.00	\$5.00 - \$15.00

The State may vary the amount of the infrastructure PMPMs in its discretion.

As part of the Budget and Budget Narratives, BH CPs will indicate how they intend to use the infrastructure funding for amounts up to a maximum amount of possible funding (i.e., the CP’s PMPM multiplied by the number of members engaged). The State may approve a lower amount based on its review of the Budgets and Budget Narratives.

For example, for a BH CP with 1,000 engaged members with a PMPM of \$40.00:

Maximum amount of Budget Period 1 Infrastructure Funds = \$40.00\*12\*1000 = \$480,000

**4.5.3 BH CP Sub-Stream 3: Outcomes-Based Payments**

Starting in Budget Period 3, the State will designate an annual pool of funding to award to high performing BH CPs based on metrics related to avoidable utilization (see Section 5.4.5). The State anticipates this pool to be approximately \$1M annually, but may vary this amount in its discretion. The State will set the achievement standards following analysis of baseline data from Performance Year 1 and Performance Year 2, subject to CMS approval. The total bonus the State allots yearly will be divided amongst the CPs that meet or exceed the achievement standards based on the number of CPs that meet or exceed the achievement standards. See Section 5.4.5 for more details about how the funding will be distributed to the eligible CPs. The State will not require CPs to submit budgets for Outcomes Based Payments.

**4.5.4 LTSS CP Sub-Stream 1: Care Coordination Supports Funding**

The State will pay each LTSS CP a PMPM rate for care coordination supports for each member assigned to and engaged with the LTSS CP during the month. The PMPM rate has been developed, in part, based on the staff required to support the LTSS CP model, including the need for care coordinators with appropriate supervision at sufficient staffing levels to perform LTSS CP supports. Caseloads for LTSS CPs are expected to be between 70-100 engaged enrollees per FTE. The rate is anticipated to be \$80 PMPM for each member assigned and engaged with the LTSS CPs during the month. The State will set an additional PMPM for enhanced LTSS CP functions and anticipates caseload for enhanced LTSS CP supports to be 35-50 engaged

enrollees. The State may vary the amount of the PMPMs in its discretion at any time during the demonstration.

The State will pay the PMPM rate to the LTSS CP for each month in which the LTSS CP performs and documents a qualifying activity, beginning in the month when the member is assigned to the LTSS CP. If the LTSS CP does not perform any qualifying activities during a month, it will not be paid for that month. An LTSS CP will be paid for outreach only during the first 90 days of a member’s assignment to the LTSS CP if outreach is attempted and documented during that 90-day period. For members assigned to an LTSS CP between July 1, 2018 and October 31, 2018, inclusive, the LTSS CP may be paid for qualifying activities other than outreach during the first 10 months of a member’s assignment. After the first 10 months of assignment, the State will not make payments to an LTSS CP for qualifying activities performed for a member, unless that member is engaged. For members assigned to an LTSS CP beginning November 1, 2018, the LTSS CP may be paid for qualifying activities other than outreach during the first 150 days of a member’s assignment. After the first 150 days of assignment, the State will not make payments to the LTSS CP for any qualifying activities performed for a member, unless that member is engaged. A member is considered engaged with the LTSS CP when the person-centered care plan is approved by the member’s PCP or PCP designee. The PCP may designate appropriate MCO or ACO clinical staff as the PCP designee. The LTSS CP must coordinate with the member’s PCP or PCP designee, as appropriate, in performing qualifying activities, including during the first 10 months of assignment. The State will report to CMS in its quarterly and annual reports the LTSS CP engagement rates, as data are available.

Example payment calculation with PMPM of \$80:

Example payment amount for one month = (Total number of members assigned but not engaged + total number of members engaged)\*\$80

**4.5.5 LTSS CP Sub-Stream 2: Infrastructure and Capacity Building Funding**

Each LTSS CP will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period. LTSS CPs will propose allocation of funds across the four categories listed in section 4.3.2 in their Preparation Budget Period Budgets and Budget Narratives. The State anticipates disbursing up to \$500,000 to each LTSS CP for initial infrastructure funding. The State has the discretion to adjust the amount of the Preparation Budget Period funds disbursed to LTSS CPs without obtaining CMS approval.

For Budget Period 1, LTSS CPs will receive infrastructure funds based on the anticipated number of members engaged, as determined by the State. For Budget Period 2 through 5, LTSS CPs will receive infrastructure funds based on the number of enrolled members (both assigned and engaged), as determined by the State. The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to LTSS CPs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CP had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5.

**EXHIBIT 13 – Anticipated Schedule for LTSS CP for Infrastructure and Capacity Building (PMPM)**

<b>LTSS CP Infrastructure and Capacity Building PMPMs</b>				
<b>BP 1</b>	<b>BP 2</b>	<b>BP 3</b>	<b>BP 4</b>	<b>BP 5</b>
\$30.00 - \$40.00	\$20.00 - \$30.00	\$10.00 - \$20.00	\$8.00 - \$18.00	\$5.00 - \$15.00

The final PMPM will vary based on actual overall enrollment in CPs. The State may vary the amount for the PMPM without CMS approval.

CPs will submit Budgets and Budget Narratives for approval for amounts up to a maximum amount of PMPM \* number of members engaged. The State will review and revise budgets as appropriate.

For example, for a LTSS CP with 1,000 engaged members with a PMPM of \$35.00:

$$\text{The maximum amount of Budget Period 1 Infrastructure Funds} = \$35.00 * 12 * 1000 = \$420,000$$

The State may approve a lower amount based on its review of the Budget and Budget Narrative, without CMS approval.

#### 4.5.6 LTSS CP Sub-Stream 3: Outcomes-Based Payments

Starting in Budget Period 3, the State will designate an annual pool of funding (anticipated to be approximately \$500,000 annually) to award to high performing LTSS CPs based on metrics related to avoidable utilization (see Section 5.4.5). The State will set the achievement standards following analysis of baseline data from Performance Year 1 and Performance Year 2, subject to CMS approval. Total bonus allotted yearly will be divided amongst the CPs that meet or exceed the achievement standards based on the number of CPs that meet or exceed the achievement standards. See Section 5.4.5 for more details about how the funding will be distributed to the eligible CPs. The State will not require CPs to submit budgets for Outcomes Based Payments.

#### 4.5.7 CSA Sub-Stream 1: Infrastructure and Capacity Building Funding

CSAs will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period of between \$75,000 and \$350,000. The State will categorize CSAs based on the number of members they serve and the number of CSA contracts held and will advise CSA of their budget for the Preparation Budget Period. CSAs will propose allocation of funds across the three infrastructure categories listed in section 4.3.7 in their Preparation Budgets and Budget Narratives. The State will then disburse initial infrastructure funding to CSAs based on the approved budget. The State may adjust the amount of the Preparation Budget Period funds disbursed to CSAs in its discretion.

Exhibit 14 sets forth the anticipated PMPM schedule for CSA infrastructure and capacity building funding. The State may vary the infrastructure PMPM amount in its discretion.

EXHIBIT 14 – Anticipated Schedule for CSAs for Infrastructure and Capacity Building (PMPM)

CSA Infrastructure and Capacity Building PMPMs				
BP 1	BP 2	BP 3	BP 4	BP 5
\$35.00 - \$45.00	\$25.00 - \$35.00	\$15.00 - \$25.00	\$10.00 - \$20.00	\$5.00 - \$15.00

The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to CSAs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CSA had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5.

#### 4.6 Statewide Investments Funding Determination Methodology

The DSRIP Statewide Investment funding stream may be utilized by the State to fund the following initiatives: (1) Student Loan Repayment Program, (2) Primary Care Integration Models and Retention, (3) Investments in Primary Care Residency Training, (4) Workforce Development Grant Program, (5) Technical Assistance, (6) Alternative Payment Methods Preparation Fund, (7) Enhanced Diversionary Behavioral Health Activities and (8) Improved Accessibility for People with Disabilities or for Whom English Is Not a Primary Language. Exhibit 15 shows the anticipated funding breakdown for each initiative by demonstration year.

EXHIBIT 15 – Statewide Investments Funding Breakdown

Statewide Investments	Y1	Y2	Y3	Y4	Y5	Total
Student Loan Repayment Program	\$3.9M	\$5.5M	\$3.2M	\$3.5M	\$2.3M	\$18.4M
Primary Care Integration Models and Retention	\$1.7M	\$1.9M	\$1.5M	\$1.2M	\$1.0M	\$7.3M
Investment in Primary Care Residency Training	\$0.2M	\$1.1M	\$2.7M	\$2.1M	\$2.4M	\$8.4M
Workforce Development Grant Program	\$1.7M	\$2.9M	\$ .8M	\$4.1M	\$2.4M	\$11.9M
Technical Assistance for ACOs and CPs	\$10.3M	\$10.6M	\$5.6M	\$11.3M	\$6.2M	\$44.0M
Alternative Payment Methodology Preparation Funds	\$2.2M	\$0.0M	\$0.0M	\$8.5M	\$1.2M	\$11.9M
Enhanced Diversionary Behavioral Health Activities	\$1.3M	\$0.0M	\$0.0M	\$1.9M	\$0.0M	\$3.2M
Improved Accessibility for Members with Disabilities or for Whom English Is Not a Primary Language	\$0.3M	\$2.4M	\$ .5M	\$4.7M	\$2.0M	\$9.9M
<b>Total</b>	\$21.6M	\$24.4M	\$14.2M	\$37.3M	\$17.4M	\$114.8M

\*Displayed numbers are rounded; therefore, totals and updated expenditure authority numbers may not add up exactly

The State may shift funding among and within the eight Statewide Investment initiatives at its discretion, such that the funding totals for each initiative identified in Exhibit 15 and in initiative descriptions in Appendix B may change. The State must obtain CMS approval for any funding shifts within a demonstration year from one investment to another if the shifted amount is (1) greater than 15% of the original funding amount for the investment contributing the shifted amount or (2) if the shifted amount is greater than \$1M, whichever is greater. Otherwise, the State will notify CMS of any funding shifts in its quarterly reports.

Sections 4.6.1 – 4.6.8 discuss the general nature and funding methodology of each Statewide Investment initiative, including which entities or providers will be eligible to apply for DSRIP funds. Appendix B provides additional details on each initiative.

**4.6.1 Student Loan Repayment Program**

The student loan repayment program will repay a portion of awardees’ student loans in exchange for a minimum of an 18 month commitment to work in a community setting. Applicants may either be individual providers working at community mental health centers, or the centers themselves. The program will offer a specified amount of funding in each recipient category per year. Provider applicants may be eligible for different amounts of loan repayment based on their discipline and credentialing level. For providers selected to receive awards, the State will pay their student loan servicer directly. The anticipated provider categories and maximum award amounts are as follows:

- Primary Care Physician – Each awardee is eligible for up to \$50K in total student loan repayments
- Psychiatrists and psychologists – Each awardee is eligible for up to \$50K in total student loan repayments
- Advance Practice Registered Nurses, Physician Assistants and Nurse Practitioners – Each awardee is eligible for up to \$30K in total student loan repayments
- Licensed Social Workers, Licensed Behavioral Health Professionals, and Masters-Prepared Unlicensed Social Workers and Behavioral Health Professionals – Each awardee is eligible for up to \$30K in total student loan repayments
  - Among other eligibility requirements determined by the State, Master-Prepared Unlicensed Social Workers and Behavioral Health Professionals must expect to obtain their license within twelve months from application submission.

- Behavioral Health Professionals (community health workers, peer specialists, recovery support specialists) – Each awardee is eligible for up to \$20K in total student loan repayments

The State may vary the provider categories and award amounts in its discretion. The State may also develop enhancements to the student loan repayment program, such as learning collaboratives that engage distinct cohorts of student loan repayment recipients, which provide additional training and mentorship for providers and deepen their commitment to careers in community settings. The State will define application criteria and eligibility, and then select awardees through a competitive process that will allow the State to evaluate the applicants relative to the criteria established.

#### **4.6.2 Primary Care Integration Models and Retention**

The investment in primary care integration models and retention will support a grant program to community health centers (CHCs), community mental health centers, and entities participating in CPs and CSAs that allows primary care and behavioral health providers to design and carry out one-year projects related to accountable care. The State will define application criteria and eligibility, and will select awardees through a competitive process that will allow the State to evaluate the proposed projects for scope, impact, feasibility, cost and need, among other factors. The State anticipates that awardees will receive up to \$40K per project but the amount of funding may vary by project, as determined by the State. The CHC, CMHC, or entity participating in a CP or CSA will be the primary applicant with a primary care or behavioral health provider as a partner. The State will disburse funds directly to the CHC, CMHC, or entity participating in a CP or CSA.

#### **4.6.3 Investment in Primary Care Residency Training**

The investment in primary care residency training will help offset hospital and community health center costs of filling community health center (CHCs) and community mental health center (CMHC) residency slots. The State will fund hospitals, community health centers, and community mental health centers that are selected for awards. Hospitals and CHCs/CHMCs will apply jointly for the award in the case of PCPs. The State anticipates that funding will vary based on the resident's discipline as follows:

- Primary Care Provider (PCP) – For each PCP residency slot filled, the State will pay the community health center or community mental health center up to \$150K and the hospital up to \$20K for a total of up to \$170K for each year of residency.
- Nurse Practitioner (NP) – For each NP residency slot filled, the State will pay the community health center or community mental health center up to \$85K for each year of residency.

The State will define application criteria and eligibility, and then select awardees through a competitive process that allows the State to evaluate the applications relative to the criteria established.

#### **4.6.4 Workforce Development Grant Program**

The workforce development grant program will support a range of activities to increase and enhance the State's healthcare workforce capacity (e.g., creation or support for workforce training programs, help providers to attend educational events, help ACOs/CPs/CSAs develop programs (one-on-one and group), outreach to potential workforce). The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

#### **4.6.5 Technical Assistance for ACOs, CPs and CSAs**

The technical assistance (TA) program aims to provide ACOs, CPs and CSAs with the training and expertise necessary to implement evidence-based interventions that meet the needs of the new healthcare

landscape. For entities that apply and are awarded funding, the State will pay their TA vendor(s) directly. The State will also use this TA funding to invest in resources to ensure the long-term sustainability of the TA provided to eligible recipients.

Recipients may be required to contribute a certain percentage (e.g., up to 30 percent) of the overall TA costs, which will create an incentive for the recipient to work diligently with the TA vendors and the State to effect change.

TA funding may be allocated to ACOs, CPs and CSAs on a PMPM basis, or based on other factors, such as experience with alternative payment methodologies, or the number of entities receiving TA funding. If the State decides to allocate TA funding based on PMPM amount, the State could set the PMPM amount and may vary the amount in its discretion, for example, based on enrollment or TA applicant volume. The TA funding amount will represent a funding cap; i.e., the State will not award more than this amount to a recipient, but may ultimately pay less than the full TA funding allocation if the recipient's TA costs are lower than anticipated. The State may redistribute or reallocate unused TA funding in its discretion. If the overall cost of TA exceeds the TA funding allocation and recipient contribution combined, the recipient will be responsible for covering the excess cost. For example, if an ACO is required to pay 30% of the overall TA cost and is allocated \$700,000 in TA funding:

- ACO could propose TA plan costing \$1,000,000
  - ACO pays \$300,000 and the State pays \$700,000
- ACO could propose TA plan costing \$1,100,000
  - ACO pays \$400,000 and the State pays \$700,000
- ACO could propose TA plan costing \$900,000
  - ACO pays \$270,000 and the State pays \$630,000
  - State may redistribute or reallocate remaining \$70,000 funding at its discretion

In order to receive TA funds, applicants must submit a detailed TA plan that explains how funding will be used and demonstrates that funding is not duplicative of TA efforts supported by other funding sources (e.g., federal, state, private). The State will evaluate the proposed plans for scope, impact, feasibility, cost and need, among other factors prior to approval.

#### **4.6.6 Alternative Payment Methods (APM) Preparation Fund**

The APM preparation fund will support providers who are not yet ready to participate in an APM but demonstrate interest in and intent to participate in the near future. The State will define application criteria and eligibility, and will select awardees through a competitive process that will allow the State to evaluate the proposed projects for scope, impact, feasibility, cost and need, among other factors. The State will determine the funding amounts based on its evaluation of successful applications. The APM preparation fund may also be used to raise awareness about APM among providers not yet engaged in a MassHealth ACO, CP, or CSA.

#### **4.6.7 Enhanced Diversionary Behavioral Health Activities**

The investment in enhanced diversionary behavioral health activities will support the implementation of strategies to ensure members with behavioral health needs receive care in the most appropriate, least restrictive settings. The State will consider a broad spectrum of strategies for investment (e.g., technological solutions to facilitate providers' access to patients' medical histories upon arrival to the ED, data collection and analysis platforms, etc.).

The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

#### **4.6.8 Improved Accessibility for People with Disabilities or for whom English is not a Primary Language**

This investment will fund programs to support providers in the acquisition of equipment, resources and expertise that meet the needs of people with disabilities or for whom English is not a primary language. The State will consider a broad spectrum of strategies for investments (e.g., funding for purchasing items necessary to increase accessibility for members, accessible communication assistance and development of educational materials for providers and members).

The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

#### **4.7 DSRIP Carry Forward**

Given that a significant portion of DSRIP funds will be disbursed on a PMPM basis, 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 for reasons related to member participation fluctuations. This carry forward authority will extend to the following funding streams; as these areas are directly related to and impacted by member participation fluctuation.

- All ACO funding streams
- All CP funding streams
- Statewide Investments: technical assistance and workforce development grant programs
- State operations/implementation

The State may carry forward the DY2 and DY3 funding for the APM Preparation Fund and the Enhanced Diversionary Behavioral Health Activities Program, and the DY3 funding for the technical assistance program, workforce development grant program, and the Improved Accessibility for Members with Disabilities or for Whom English Is Not a Primary Language statewide investment into DY4 without counting against the carryforward 15% benchmark described in STC 60(d)(ii).

The State does not have carry forward authority for other funding streams within statewide investments.

Per STC 60(d)(ii), if the expenditure authority carried forward from one year to another is more than 15% of the prior year's expenditure authority as set forth in Exhibit 1, then the State will submit a request to carry forward the expenditure authority for review and approval by CMS. Flexible Services funding will not be included in expenditure authority carry forward calculations. CMS will respond to the State's request within 60 business days. If approved, the State will provide an updated funding allocation table to CMS in the next quarterly progress report to CMS. If the carry forward amount is less than or equal to 15% of the prior year's expenditure authority, then the State will provide an updated funding allocation table to CMS in the next quarterly progress report to CMS. The State must ensure that carry over does not result in the amount of DSRIP expenditure authority for DSRIP Year 5 being greater than the amount for DSRIP Year

4. Flexible Services funding will not be counted in either the DSRIP Year 4 or DSRIP Year 5 expenditure authority amounts for the purposes of this comparison.

## **Section 5. DSRIP Accountability Framework (State Accountability to CMS; ACO, CP and CSA Accountability to State)**

### **5.1 Overview**

The State has structured an accountability framework for its DSRIP program, under which the State is accountable to CMS for the State's achievement of delivery system reform goals. The State's failure to achieve the standards set for these goals may result in the loss of DSRIP expenditure authority according to the at-risk schedule set forth in STC 71(b). Any lost expenditure authority will result in parallel reduced DSRIP expenditures by the State. If the State experiences reduced expenditure authority from CMS, the State has discretion to determine whether and to what extent to reduce any of the four funding streams to best meet the State's programmatic needs while adhering to the State's DSRIP expenditure authority.

Separately, to maximize incentives for delivery system reform, ACOs, CPs and CSAs that receive DSRIP funds are each accountable to the State for their individual performance. An ACO's, CP's or CSA's failure to achieve the individual accountability standards set by the State may result in the ACO, CP or CSA receiving less DSRIP funding from the state. Any reduction in DSRIP funding experienced by an individual ACO, CP or CSA will not necessarily impact the State's overall DSRIP expenditure authority under the demonstration.

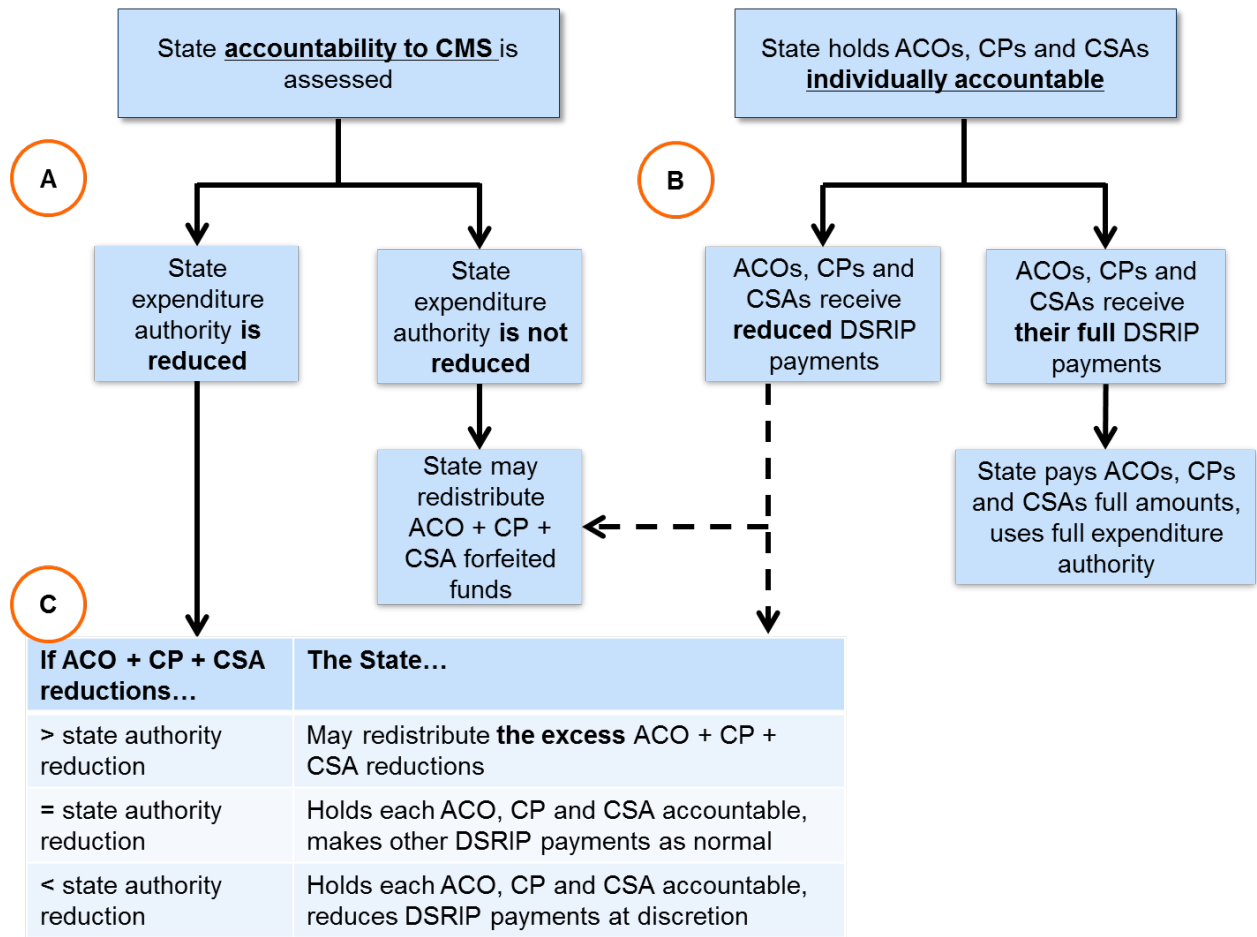
Exhibit 16 below illustrates the State's accountability to CMS, and also illustrates ACOs', CPs' and CSAs' accountability to the State and how these two accountability mechanisms interact.

This section will describe each step of these accountability mechanisms as follows:

- Section 5.1: provides an overview of DSRIP Accountability Framework for the State to CMS and ACOs, CPs and CSAs to the State
- Section 5.2: provides detail on State Accountability to CMS
- Section 5.3: provides detail on accountability framework and performance based payments for ACOs
- Section 5.4: provides detail on accountability framework and performance based payments for CPs and CSAs
- Section 5.5: outlines reporting requirements for ACOs, CPs and CSAs

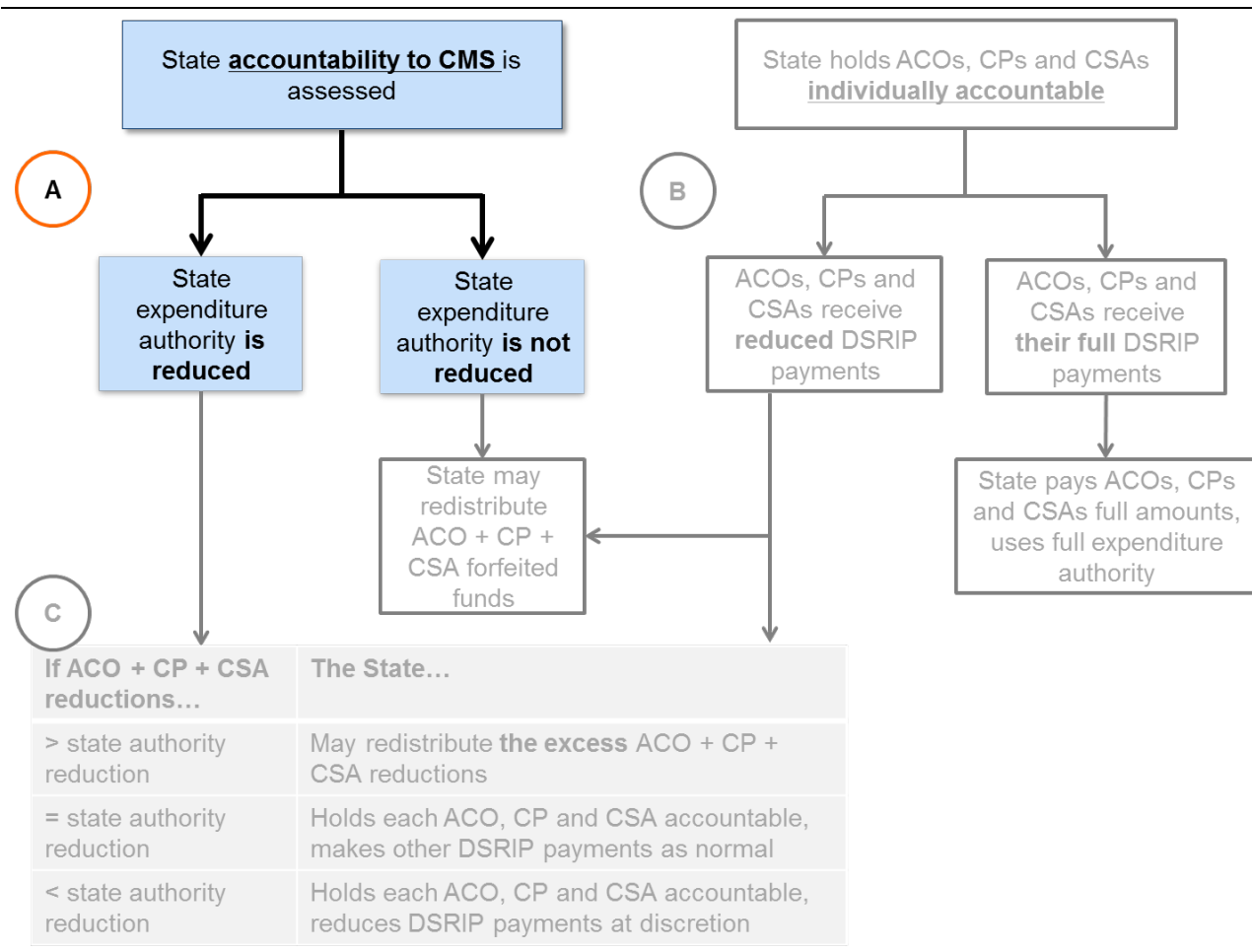


EXHIBIT 16 – Process Flow for State Accountability to CMS and Accountability of ACOs, CPs, and CSAs to the State



### 5.1.1 State Accountability to CMS

EXHIBIT 17 – Process Flow for State Accountability to CMS



A portion of the State’s DSRIP expenditure authority will be at-risk based on the State’s DSRIP Accountability Score according to the schedule set forth in STC 71(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, CPs and CSAs.

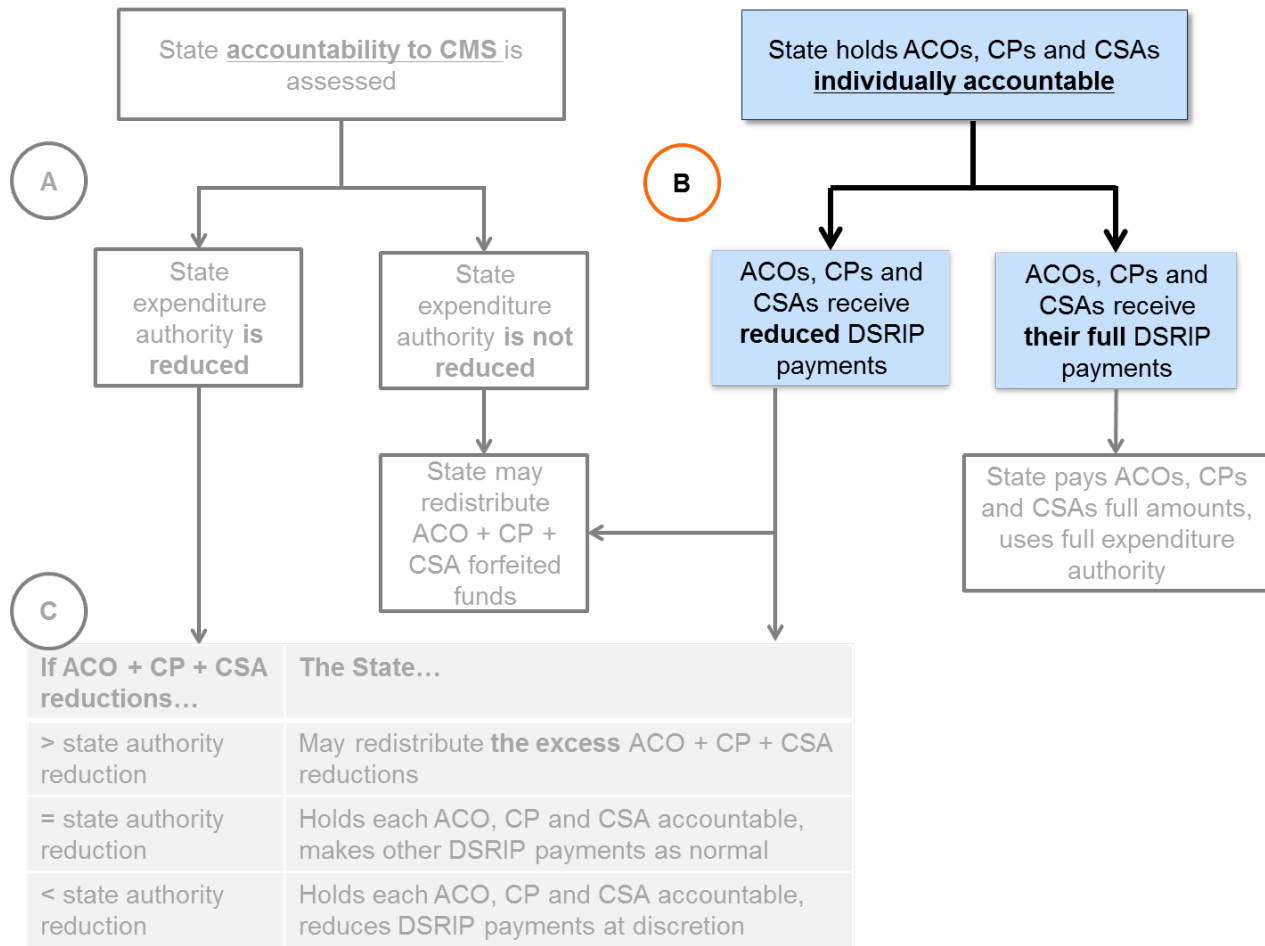
The Preparation Budget Period and BP1 will not have any at-risk expenditure authority. BP 2 has at-risk expenditure authority, and the State anticipates that its Accountability Score will not be determined until the second quarter of BP4 at the earliest. Thus, the State anticipates that any reduced expenditure authority may be reflected in the State’s reduction of DSRIP payments during BP 5. As an example, if the State’s Accountability Score for BP 2 is 70%, then the State will lose the remaining 30% of its \$20.625M of BP 2 at-risk expenditure authority (i.e., \$6.1875M). The State may reflect this by subtracting up to \$6.1875M from its anticipated \$112M BP 5 DSRIP expenditure authority.

The State may also satisfy any reductions in DSRIP expenditure authority through retroactive recoupments from recipients of DSRIP funds, or through the State paying CMS back for any Federal Financial Participation the State retroactively owes for such reductions. For example, for Budget Periods 4 and 5, the State anticipates that there will be no upcoming Budget Periods for which to reduce DSRIP expenditures by the time the Accountability Scores for these Budget Periods are calculated; the State may therefore satisfy any reductions in DSRIP expenditure authority for these Budget Periods through such recoupments, through paying CMS back, or through identifying other cost savings in the DSRIP program, such as in the statewide investments or implementation/oversight funding streams.

If the State decides to recoup funding from ACOs or CPs, then it will first distribute the recoupment amounts among the ACOs and CPs as a class. One potential approach for this initial distribution is to divide the recoupment amount according to the 5-year DSRIP expenditure authority for the ACO and CP funding streams, as detailed in Table G of the STCs (i.e., ACOs: \$1,065.6M, or 66.1%; CPs: \$546.6M, or 33.9%). To determine how much funding is recouped from individual ACOs, the State may take each ACO's DSRIP Accountability Score and calculate the difference from 100%. The State will then calculate a weight for each ACO that is equal to that ACO's "difference from 100%" divided by the summed total of all the ACOs' "difference from 100%". That weight will then be multiplied by the ACO portion of the recoupment amount to determine the amount of funding that the State will recoup from the ACO. As an example, if the State needs to recoup \$100 for BP4, then it will first divide the recoupment between the ACOs and CPs according to Table G of the STCs (i.e., ACOs and CPs will need to pay back \$66.10 and \$33.90, respectively). If there are two ACOs, and ACO 1 scored a 90%, and ACO 2 scored a 60% (corresponding to "differences from 100%" of 10% and 40%, respectively), then ACO 1 would need to pay back  $\$66.10 * (10\% / (10\% + 40\%)) = \$13.22$ , and ACO 2 would need to pay back  $\$66.10 * (40\% / (10\% + 40\%)) = \$52.88$ . The State may implement a different methodology for recouping funds from CPs and CSAs. The State will make a final determination of its recoupment methodology once it decides that it will recoup funds, and once it understands why the State had to recoup funds. For example, the recoupment methodology described above may be appropriate for poor statewide quality performance, but inappropriate for poor statewide APM adoption.

### 5.1.2 ACO, CP and CSA Accountability to the State

EXHIBIT 18 – Process Flow for ACO, CP and CSA Accountability to the State



Regardless of the State’s performance with respect to its accountability to CMS, the State will separately hold each ACO, CP and CSA that receives DSRIP funds individually accountable for its performance on a slate of quality and performance measures. This structure maximizes performance incentives for these recipients.

This individual accountability is applied to each ACO’s, CP’s and CSA’s at-risk DSRIP funding for each budget period. The State intends to withhold the at-risk portion of ACO’s, CP’s and CSA’s funding until the respective Accountability Scores are calculated. The ACOs, CPs and CSAs will then receive a percentage of their withheld funds based on their Accountability Score (e.g., if an entity scores 0.6, it will receive 60% of the at risk funds) and will not receive the remainder. The State will not require ACOs, CPs and CSAs to submit budgets for these earned at risk funds.

As described above, ACOs receive four sub-streams of DSRIP payment. The mechanism for accountability differs slightly by stream, as explained in the table below.

EXHIBIT 19 – ACO ACCOUNTABILITY MECHANISM BY FUNDING SUB-STREAM

ACO Accountability Mechanism by Funding Sub-Stream		
Provider Type	Funding Sub-Stream	Mechanism for Individual Accountability
ACOs	<b>Startup/Ongoing:</b> <i>Primary Care Investment</i>	Fixed amount, not withheld or at-risk
	<b>Startup/Ongoing:</b> <i>Discretionary</i>	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	<b>DSTI Glide Path</b>	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	<b>Flexible Services</b>	Not at performance risk. ACOs fully at risk for any expenses not approved by the State.

The portion of Startup/Ongoing funding that is provided for each ACO to support primary care investments are not at performance risk in order to provide some measure of predictability and stability in this funding stream, to encourage innovative investments in primary care infrastructure, and to mitigate the risk of costly delays or changes in funding that might make front-line primary care providers more hesitant to invest in practice-level change.

The at-risk withheld amount differs between the discretionary Startup/Ongoing stream, and the DSTI Glide Path. In general, a smaller percentage of the DSTI Glide Path funding is at risk. This difference reflects the safety net status of these hospitals.

EXHIBIT 20 – Percent of ACO Funding At Risk by Budget Period

Percent of ACO Funding At Risk by Budget Period						
DSRIP Budget Period	Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5
Startup/Ongoing (Discretionary) At-Risk	0%	5%	15%	30%	40%	50%
Glide Path Funding At-Risk	0%	5%	5%	10%	15%	20%

For ACOs that join after BP1, their at-risk schedule will start at the BP1 percent (i.e. 5%), and then follow the schedule above with appropriate lag. For example, if an ACO joins in BP3, their at-risk schedule for the discretionary startup/ongoing funds would be: BP3 – 5%, BP4 – 15%, BP5 – 30%

CPs and CSAs also receive several funding streams, as described below. Funds for Infrastructure and Capacity Building are at risk for BH and LTSS CPs, and for CSAs. The amount of CP and CSA funds that are at-risk increases over the course of the program.

The accountability mechanisms for CPs and CSAs also vary by funding sub-streams, as described below. Funds for Infrastructure and Capacity Building are at risk for BH and LTSS CPs, and for CSAs.

EXHIBIT 21 – CP and CSA Accountability Mechanism by Funding Sub-Stream

CP and CSA Accountability Mechanism by Funding Sub-Stream		
Provider Type	Funding Sub-Stream	Mechanism for Individual Accountability
BH CPs	Care Coordination Supports	Funds are not at-risk
	Infrastructure & Capacity Building	Withheld portion is fully at-risk each BP based on CP's Accountability Score
	Outcome-Based Payments	Incentive pool based on performance on avoidable utilization measures
CSAs	Infrastructure & Capacity Building	At-risk portion of each BP based on CSA's Accountability Score
LTSS CPs	Care Coordination Supports	Funds are not at-risk
	Infrastructure & Capacity Building	Withheld portion is fully at-risk each BP based on CP's Accountability Score
	Outcome-Based Payments	Incentive pool based on performance on avoidable utilization measures

Exhibit 22 sets forth the anticipated amount of CP and CSA funding that is at risk by budget period.

EXHIBIT 22 – Amount of At-Risk CP and CSA Infrastructure and Capacity Building Funding by Budget Period

Percent of CP and CSA Infrastructure and Capacity Building Funding At-Risk by Budget Period						
DSRIP Budget Period	Prep BP	BP1	BP2	BP3	BP4	BP5
% of CP Infrastructure and Capacity Building Funding At-Risk	0%	0%	13%	42%	71%	100%
% of CSA Funding At-Risk	0%	0%	5%	10%	15%	20%

The State may update the at-risk percentages for CP infrastructure funding such that the total amount of at-risk CP funding is comparable to the original \$58.2M of at-risk CP funding, to the greatest extent possible based on the State's understanding of CP enrollment trends and other assumptions at the time of the update.

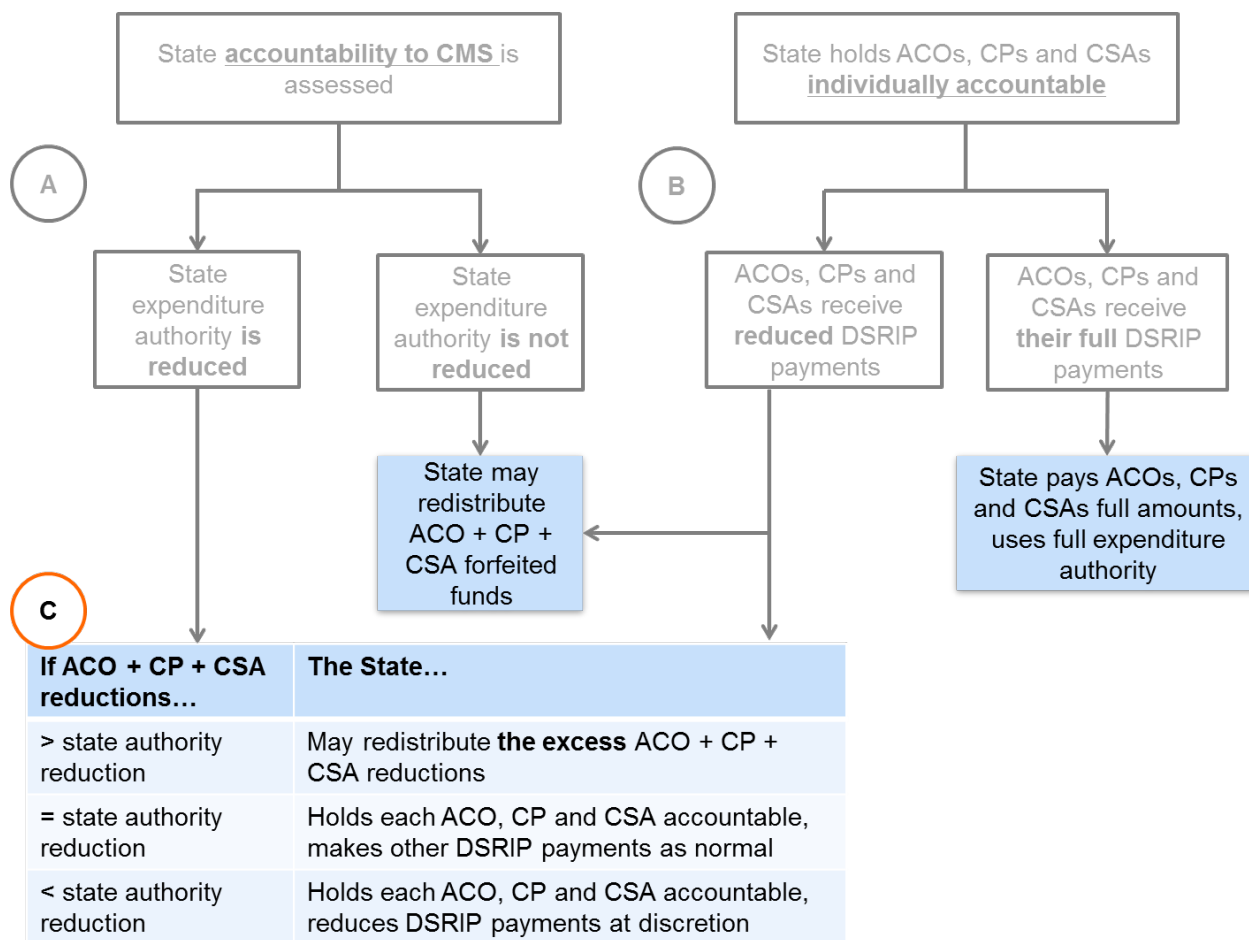
For CPs or CSAs that join after BP1, their at-risk schedule will start at the BP1 percent (i.e. 0%), and then follow the schedule above with appropriate lag. For example, if a CP joins in BP3, their at-risk schedule for the DSRIP funds would be: BP3 – 0%, BP4 – 71%, BP5 – 100%.

In addition to holding ACOs, CPs, and CSAs accountable by designating a portion of their DSRIP funding as at-risk, the State will manage its contracts with these entities to ensure compliance with and satisfactory

performance of contractual requirements related to the DSRIP program. In the event of noncompliance or unsatisfactory performance, the State will determine the appropriate recourse, which may include contract management activities such as, but not limited to: working collaboratively with the ACOs, CPs, or CSAs to identify and implement new strategies to meet their contractual requirements, requiring the ACOs, CPs, or CSAs to implement corrective action plans, or reducing DSRIP payments to the ACOs, CPs, or CSAs. If the State reduces DSRIP payments to ACOs, CPs, or CSAs as part of its contract management efforts, the undisbursed funds may be redistributed among the other DSRIP funding streams at the State's discretion, following the parameters described in Section 5.1.3.

### 5.1.3 Distribution of Funds Based on Accountability

EXHIBIT 23 – Process Flow for Distribution of Funds Based on Accountability



Based on the State's assessments of individual accountability for each ACO, CP and CSA, individual ACOs, CPs and CSAs may not receive a certain amount of DSRIP funds each Budget Period, relative to the maximum each could potentially receive.

If the State's expenditure authority is not reduced based on its accountability to CMS, the State has discretion to redistribute the DSRIP funds not distributed to ACOs, CPs, and CSAs (e.g., to determine how much each of the funding streams and sub-streams is increased) to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. For example, the State will identify the amount of forfeited DSRIP funds it has available to redistribute, and then determine how it might reallocate

the funds to other DSRIP funding streams. Any such redistributions would be reported with CMS in the State's quarterly progress reports.

For example, as early as the end of Q2 of BP4, the State anticipates that the BP2 Accountability Scores for the State, ACOs, CPs and CSAs will become available. If ACOs lost \$1M of at-risk BP2 funds and the State earned a 100% DSRIP Accountability Score, then the State could reallocate that \$1M to a different funding stream or sub-stream, at the State's discretion, based on the State's assessment of program needs, in the remaining time left in BP4 (e.g., increase flexible services allocation for ACOs, increase care coordination funding amounts or the outcomes-based incentive pool for CPs, increase statewide investments funding or implementation/oversight funding), or may be used for future BP4 or BP5 payments. The allowable categories that the redistributed funds could be reallocated to are:

- ACO funding stream
  - Startup/ongoing
  - Flexible services
- Community Partners funding stream
  - Infrastructure and capacity building
  - Care coordination
  - Outcomes-based payments
- Statewide Investments funding stream
  - All statewide investments

If the State's expenditure authority has been reduced based on its accountability to CMS, the State will base its actions on the relative sizes of these reductions, as follows:

- If the amount of funds not distributed to ACOs, CPs and CSAs pursuant to their accountability scores is equal to the State's expenditure authority reduction based on the State's accountability to CMS, the State will satisfy its obligation to reduce DSRIP spending by reducing payments to these ACOs, CPs and CSAs based on their individual accountability arrangements with the State, and will make other DSRIP payments pursuant to this Protocol
- If the amount of funds not distributed to ACOs, CPs and CSAs pursuant to their accountability scores exceeds the State's expenditure authority reduction based on the State's accountability to CMS, the State will satisfy its obligation to reduce DSRIP spending by reducing payments to these ACOs, CPs and CSAs based on their individual accountability arrangements with the State, but the State may have left over expenditure authority after doing so. The State has discretion to redistribute these excess DSRIP funds not distributed to ACOs, CPs, and CSAs pursuant to their accountability scores (e.g., to determine how much each of the funding streams and sub-streams is increased) to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. Such redistribution of funds would follow the same processes described above for when the State's expenditure authority has not been reduced.
- If the amount of funds not distributed to ACOs, CPs and CSAs is less than the State's expenditure authority reduction based on the State's accountability to CMS (including if ACOs, CPs and CSAs receive all DSRIP funds under their accountability arrangements with the State), the State has discretion to determine whether and to what extent each of the four funding streams and sub-streams is reduced for an upcoming Budget Period to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. The State also has discretion to determine whether and to what extent to satisfy the reduced expenditure authority through retroactive recoupments from recipients of DSRIP payments or through separately paying CMS back for the Federal Financial Participation for any such reduced expenditure authority.
  - State DSRIP expenditures can be categorized as (1) non-at-risk payments and (2) at-risk payments which are dependent on the calculation of Accountability Scores. The State will



make non-at-risk payments and then retroactively claim FFP for those payments. Given that the FFP claiming for the non-at-risk payments for a particular Budget Period may occur before the State's Accountability Score is calculated for that Budget Period, it is possible for the State to claim more FFP than its reduced expenditure authority would allow. In this scenario, the State would reconcile its claimed FFP amount with CMS. If the State retroactively recoups funds from ACOs, CPs, or CSAs, it will follow the process laid out in Section 5.1.1.

## 5.2 State Accountability to CMS

As set forth in STC 71, a portion of the State's DSRIP expenditure authority will be at-risk. In accordance with STC 71, if the State's DSRIP expenditure authority is reduced based on an Accountability Score that is less than 100%, then the State will reduce future DSRIP payments in proportion to the reduced expenditure authority to ensure sufficient state funding to support the program. The portion of at-risk DSRIP expenditure authority is set forth in Exhibit 24. The amount of DSRIP Expenditure Authority expressed in row 1 of Exhibit 24 (and the corresponding table in STC 71(b)) is divided into Budget Periods solely for the purpose of calculating the amount of Actual Expenditure Authority At-Risk as indicated in row 3 of Exhibit 24.

EXHIBIT 24 – Percent of DSRIP Expenditure Authority At-Risk

DSRIP Budget Period	Prep BP and BP1	BP 2	BP 3	BP 4	BP 5
DSRIP Expenditure Authority	\$637.5M	\$412.5M	\$362.5M	\$275M	\$112.5M
% of Expenditure Authority At-Risk	0%	5%	0%	15%	20%
Actual Expenditure Authority At-Risk	\$0M	\$20.625M	\$0M	\$41.25M	\$22.5M

The amount of at-risk DSRIP expenditure authority lost will be determined by multiplying the State's DSRIP Accountability Score for a given BP by the amount of Actual Expenditure Authority At-Risk as indicated in row 3 of Exhibit 24. The Actual Expenditure Authority At-Risk as indicated in row 3 of Exhibit 24 will not vary based on carry forward or forfeited funds. The methodology for calculating the State's DSRIP Accountability Score is discussed in Section 5.2.1.

### 5.2.1 Calculating the State DSRIP Accountability Score

The State DSRIP Accountability Score will be based on three domains: (1) MassHealth ACO/APM Adoption Rate; (2) Reduction in State Spending Growth; and (3) ACO Quality and Utilization Performance.

Each domain will be assigned a weight that varies by Budget Period. The weights for the State DSRIP Accountability domains are detailed in Exhibit 25:

EXHIBIT 25 – State DSRIP Accountability Domains

State DSRIP Accountability Domain	Prep Budget	% Contribution to State DSRIP Accountability Score			
		BP 1	BP 2	BP 3	BP 4-5
MassHealth ACO/APM Adoption Rate	NA	NA	30%	NA	20%
Reduction in State Spending Growth	NA	NA	NA	NA	25%
ACO Quality Performance	NA	NA	70%	NA	55%

The State will calculate the State DSRIP Accountability Score by multiplying the Score for each State DSRIP Accountability domain by the associated weight and then summing the totals together.

For example, the BP 5 State DSRIP Accountability Score is calculated using the following equation:

State DSRIP Accountability Score = (MassHealth ACO/APM Adoption Rate Score) \* 20% + (Reduction in State Spending Growth Score) \* 25% + (ACO Quality Performance Score) \* 55%

If the State is able to earn 100% for the MassHealth/APM Adoption Rate Score, 30% for the Reduction in State Spending Growth Score, and 70% for the ACO Quality Performance Score, then the State's DSRIP Accountability Score would be:

State DSRIP Accountability Score = (100%) \* 20% + (30%) \* 25% + (70%) \* 55% = 66%

The State estimates that it will take approximately 18 months after the close of a Budget Period to calculate the State DSRIP Accountability Score, due to claims rollout and other administrative considerations. Thus, the State anticipates that it will provide its DSRIP Accountability Score and supporting documentation for a given Budget Period 7-8 quarters after the Budget Period ends. If the State DSRIP Accountability Score is not 100%, pursuant to STC 71(d), the State may submit to CMS a proposed Corrective Action Plan at the same time as it submits its State DSRIP Accountability Score and supporting documentation.

#### Corrective Action Plan

The Corrective Action Plan will include steps the State may 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. CMS will render a decision on approval or disapproval of requested Corrective Action Plan within 60 business days of receipt of Plan and prior to determining the amount of reduction to the State's DSRIP expenditure authority. If CMS does not approve the Corrective Action Plan, then the State's DSRIP expenditure authority will be reduced in accordance with the State DSRIP Accountability Score. If CMS approves the Corrective Action Plan, the State's DSRIP expenditure authority for the relevant Budget Period will be held intact and not reduced, contingent on the State successfully implementing the approved Corrective Action Plan. If the State fails to implement the Corrective Action Plan, then CMS will retrospectively reduce the State's DSRIP expenditure authority in accordance with the State's DSRIP Accountability Score. If the State partially implements the Corrective Action Plan, then CMS has the discretion to require a smaller retrospective reduction in the State's DSRIP expenditure authority. If the State chooses not to submit a Corrective Action Plan for a certain Budget Period, then the State's DSRIP expenditure authority for that Budget Period will be reduced in accordance with the State DSRIP Accountability Score.

#### *5.2.1.1 State Accountability Domain 1: Calculating the MassHealth ACO/APM Adoption Rate*

Under the MassHealth ACO/APM Adoption Rate accountability domain, the State will have target percentages for the number of MassHealth ACO-eligible members who are enrolled in or attributed to ACOs or who receive service from providers paid under APMs. The State will calculate the percentage of ACO-eligible members enrolled in or attributed to ACOs or who receive services from providers paid under APMs, as follows:

- ACO-eligible members shall be all members who are eligible to enroll in or be attributed to MassHealth ACOs
- The State shall count towards the State's achievement of ACO/APM adoption, all members who:
  - Are enrolled in or attributed to an ACO during the Budget Period

- Are enrolled with a MassHealth MCO and receive primary care from a PCP that is paid by that MCO under a shared savings and/or shared risk arrangement, or is similarly held financially accountable by that MCO for the cost and quality of care under a State-approved APM contract
- Receive more than 20% of their non-primary care services (either gross patient service revenue or net patient service revenue) from providers who are paid under episode-based payments, shared savings and/or shared risk arrangements, or who are similarly held financially accountable for the cost and quality of care under a State-approved APM contract

The target adoption percentages will follow the schedule detailed in Exhibit 26.

EXHIBIT 26 – Target ACO/APM Adoption Rates

DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
ACO/APM adoption (as defined above)	NA	25%	30%	35%	40%	45%

If the State meets or surpasses the target for a given Budget Period, the State will earn a 100% score on this domain for that Budget Period. If the State does not meet the target, then it will earn a 0% score for that Budget Period.

**5.2.1.2 State Accountability Domain 2: Reduction in State Spending Growth**

In accordance with STC 71(f), the State will calculate its performance on reduction in state spending growth compared to the trended PMPM, as detailed in Exhibit 27 and the domain score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed in STC 71(g). The PMPM used will be as follows:

4.4% - 2017 President’s Budget Medicaid Baseline smoothed per capita cost trend, all populations combined, 2017-2022

The State will be accountable to a 2.1% reduction in PMPMs for the ACO-enrolled population, off of “trended PMPMs” (described below) by BP 5. In Budget Periods 3 and 4, the State will have target reductions smaller than 2.1% off of the trended PMPM, as preliminarily detailed in Exhibit 27.

EXHIBIT 27 – Proposed Reduction Targets for ACO-Enrolled PMPMs

DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
% Reduction Target in ACO-enrolled PMPM vs. trended PMPM	NA	NA	NA	0.25% off of trended PMPM	1.1% off of trended PMPM	2.1% off of trended PMPM

The State and CMS will revisit the reduction targets for BP4 and BP5 by July 2021 in order to fully account for the impact of the state of emergency declared by the federal or state government.

*Gap to Goal Methodology*

In accordance with STC 71(f), the State will calculate its performance on reduction in State spending growth 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 in STC 71(g).

The State anticipates measuring spending performance against the PMPM spending reduction target up to 22 months after the close of each Calendar Year (CY) as follows. Baseline spending trends will be determined as early as Q4 of CY2020, according to the following methodology:

- Baseline PMPM spending in CY2017 will be calculated by dividing actual expenditures for dates of service in CY2017 in Included Spending Categories (as defined below), by the number of member months for all MCO and PCC -enrolled members (i.e., ACO-eligible population) for each Rating Category (RC).
  - RC 1 – Child: Enrollees who are non-disabled, under the age of 21, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505
  - RC 1 – Adult: Enrollees who are non-disabled, age 21 to 64, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505
  - RC 2 – Child: Enrollees who are disabled, under the age of 21, and in MassHealth Standard or CommonHealth as described in 130 CMR 505
  - RC 2 – Adult: Enrollees who are disabled, age 21 to 64, and in MassHealth Standard or CommonHealth as described in 130 CMR 505
  - RC 9: Individuals ages 21 through 64 with incomes up to 133% of the federal poverty level (FPL), who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage
  - RC 10: Individuals ages 21 through 64 with incomes up to 133% of the FPL, who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage, who are receiving Emergency Aid to the Elderly, Disabled, and Children (EAEDC) through the Massachusetts Department of Transitional Assistance
  - Note: The medically frail population will be in RC 9 for the purposes of this Baseline PMPM calculation.
- A weighted-average Baseline PMPM will then be calculated by multiplying the PMPM rate for each RC by the proportion of ACO-eligible population member months represented within each RC to derive the Baseline PMPM.

$$Baseline\ PMPM^{CY2017} = \sum_n Actual\ PMPM_{RC\ n}^{CY2017} \times ACO\ elig\ pop\ RC\ proportion_{RC\ n}^{CY2017}$$

- Trended PMPMs for each RC will be calculated by applying a 4.4% annual growth rate to the CY2017 Actual Baseline PMPMs for each RC and year from CY2018 through CY2022, summarized as follows:

$$Trended\ PMPM_{RC\ n}^{YEAR\ t} = 1.044^t \times Actual\ Baseline\ PMPM_{RC\ n}$$

- For each measurement period, a weighted average Trended PMPM (the “Avg Trended PMPM”) will then be calculated by multiplying the Trended PMPM for each RC by the proportion of total CY2017 ACO-eligible member months represented within each RC, summarized as follows:

$$Avg\ Trended\ PMPM^{YEAR\ t} = \sum_n Trended\ PMPM_{RC\ n}^{YEAR\ t} \times ACO\ Elig\ RC\ proportion_{RC\ n}^{CY2017}$$

- If during the measurement period there are changes to Included Spending Categories or other material program changes not captured in the annual growth rate, the CY2017 Baseline and Trended PMPMs may be recalculated to reflect these changes, subject to CMS approval.
  - In particular, if the State identifies a material difference between the CY2017 ACO eligible population and the population of members and provider networks that participate in the ACO program during the performance years (e.g., if ACOs that have historically high costs for their member populations join the program), the State may request that CMS adjust the CY2017 baseline to account for such difference; the State shall provide supporting analysis in the event of such a request, and CMS will have 90 calendar days to review and approve the request.

For each Calendar Year, performance of the ACO population will be measured as follows:

- The medically frail population will be in RC 9 for all calendar years for the purposes of the following calculations.
- The State will divide actual expenditures in Included Spending Categories by eligible member months during the CY to generate raw PMPM spending for the ACO population within each RC. Actual expenditures will be based on date of service, and will be derived from Medicaid claims data, MCO encounter data, and/or accounting reports, summarized as follows:

$$ACO\ Pop\ Raw\ PMPM_{RC\ n}^{YEAR\ t} = ACO\ Pop\ Actual\ Expenditures_{RC\ n}^{YEAR\ t} \div ACO\ pop\ MM_{RC\ n}^{YEAR\ t}$$

- To adjust for differences in acuity, an average risk score for the ACO enrolled population in each measurement period as well as an average risk score for the CY17 ACO eligible population will be calculated using the DxCG risk model employed for ACO pricing.
- Raw PMPMs for the ACO population will be divided by risk scores to calculate risk-adjusted PMPMs, summarized as follows:

$$Adj\ PMPM_{RC\ n}^{YEAR\ t} = \frac{Raw\ PMPM_{RC\ n}^{YEAR\ t}}{ACO\ Pop\ Risk\ Score_{RC\ n}^{YEAR\ t} / ACO\ Elig\ Risk\ Score_{RC\ n}^{CY2017}}$$

- A weighted average risk-adjusted PMPM for the ACO population will be calculated by aggregating the products of the risk-adjusted PMPMs for each RC multiplied by the proportion of total CY2017 ACO-eligible population member months represented within each RC, summarized as follows:

$$Avg\ Adj\ PMPM^{Year\ t} = \sum_n Adj\ PMPM_{RC\ n}^{YEAR\ t} \times ACO\ Elig\ pop\ RC\ proportion_{RC\ n}^{CY2017}$$

- Savings attributed to the “DSTI Glide Path” sub-stream payments will be subtracted from the weighted average risk-adjusted PMPM on an aggregate basis each CY.
  - DSTI Glide Path payments made during the CY will be subtracted from the DSTI payments made during CY2017 and divided by the total member months included in measurement year’s weighted average risk-adjusted PMPM. The resulting savings PMPM will be subtracted from the weighted average risk-adjusted PMPM to derive total PMPM spending for the ACO population (“Actual PMPM”), summarized as follows:

$$\begin{aligned}
 \text{Actual PMPM}^{\text{YEAR } t} & \\
 &= \frac{\text{Avg Adj PMPM}^{\text{YEAR } t} \times (\text{DSTI payments}^{\text{CY2017}} - \text{DSTI Glide Path payments}^{\text{YEAR } t})}{\text{ACO pop member months}}
 \end{aligned}$$

- The percent reduction in Actual PMPM will be determined according to the following calculation: percent reduction = (Avg Trended PMPM minus Actual PMPM) / (Avg Trended PMPM), summarized as follows:

$$\text{Percent reduction}^{\text{YEAR } t} = \frac{\text{Avg Trended PMPM}^{\text{YEAR } t} - \text{Actual PMPM}^{\text{YEAR } t}}{\text{Avg Trended PMPM}^{\text{YEAR } t}}$$

### *Included Spending Categories*

Determination of spending baseline and actual performance of the ACO population will take into consideration all expenses included in ACOs' capitation rates and TCOC Benchmark calculations for year 1 of the ACO program. For the population of members attributed to MCO-Administered ACOs, the determination of spending will be based on actual MCO expenditures for services to the population attributed to the ACO, and not on the State's capitated payments to the MCO. These costs include costs for covered services such as physical health, behavioral health, most pharmacy, and supplemental maternity payments, but do not include costs for Long Term Services and Supports (LTSS) and certain other costs that are similarly excluded from ACO capitation rates and TCOC Benchmarks. In addition, the following expenditure categories shall be excluded from both baseline and actual performance measurement for the purposes of the state's TCOC accountability to CMS, regardless of their inclusion in or exclusion from ACO TCOC:

- Hepatitis C drugs
- Other high-cost emerging drug therapies (e.g., treatment for cystic fibrosis) that result in a significant increase in spending that is not reasonably in the control of an ACO to manage
- Children's Behavioral Health Initiative
- Applied Behavioral Analysis
- Substance Use Disorder Services listed in STC 41, Table D
- Non-covered services
- All DSRIP expenditures except those for the DSTI Glide Path sub-stream as described above
- Payments made in accordance with Attachment Q of the 1115 Waiver Demonstration and other quality incentive payments
- All administrative payments made to ACOs, or to MCOs for MCO-Administered ACO members

The State may submit requests for additional exclusions or Baseline PMPM adjustments for CMS approval by submitting an amendment to the Protocol. CMS will have 60 business days to review and respond to these methodology modification requests.

### *PMPM Spending Reporting Tool*

The State and CMS will jointly develop a reporting tool (using a mutually agreeable spreadsheet program) for the State to use for annual PMPM spending demonstration and in other situations when an analysis of ACO-enrolled population PMPM spending is required. A working version of the reporting tool will be available for the State’s report for the fourth quarter of the third Budget Period.

### 5.2.1.3 State Accountability Domain 3: Overall Statewide Quality Performance

In accordance with STC 71, the State will annually calculate the State performance score for each quality domain by aggregating the performance scores across all ACOs in an unweighted fashion. The anticipated weighting of each domain to the Overall Statewide Quality Performance is detailed in Exhibit 28. The overall DSRIP quality domain score will be determined by calculating a weighted sum of the DSRIP domain scores, according to the domain weights detailed in Exhibit 28. Please see Appendix D for example calculations.

EXHIBIT 28 – Anticipated Weighting of State Quality Domains

Domain	BP1	BP2	BP3	BP4-5
<i>Clinical Quality Measures</i>				
Prevention & Wellness	N/A	85%	N/A	45%
Care Integration		N/A	N/A	40%
<i>Patient Experience Surveys</i>				
Overall Rating and Care Delivery	N/A	15%	N/A	7.5%
Person-centered Integrated Care	N/A	N/A	N/A	7.5%

*N/A – indicates no quality measures are in Pay-for-Performance (P4P) and do not factor into the State Accountability scoring.*

The measures within the domains are the same measures for the State as for the ACOs (i.e., Appendix D). For an ACO, measures within a given domain all contribute to that ACO's domain score equally (unless otherwise indicated in Appendix D). For the State Accountability Domain Scores, ACO domain scores are aggregated across all ACOs, where each ACO domain score contributes to its associated State Accountability Domain Score equally.

#### Scoring for All Domains

The State will calculate two scores:

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

For the purposes of calculating the aggregate domain scores for State Accountability, the State will include only Achievement points from the ACOs (as outlined in Section 5.3.1). Pay-for-Reporting (P4R) points obtained in BP1 or Improvement Points obtained in BP 2-5 (as outlined in Section 5.3.1) are not included in the State Accountability calculations.

The aggregate domain score is determined by calculating the median value across all ACOs for the particular domain in question. To allow for consistent comparisons, only ACO achievement points are used in the calculation. For example, if the State has three ACOs (ACO<sub>1</sub>, ACO<sub>2</sub>, ACO<sub>3</sub>), and those ACOs achieve domain scores of 30%, 50% and 70% for the Prevention & Wellness (P&W) domain, respectively, then the

aggregate domain score for the P&W domain would be 50%, as this value is the median (i.e., middle) value from this distribution.

After calculating the aggregate domain scores for the current BP and a particular domain, the State will calculate the DSRIP domain score for that particular domain. The State will use a two-tailed, un-matched, Wilcoxon rank-sum test (hereinafter “Wilcoxon test”) to calculate whether the aggregate domain score in the current BP is statistically better, not statistically different, or statistically worse, as compared to the pooled aggregate domain score from previous BPs. The State will use a p-value of 0.05 to establish statistical significance.

- If the aggregate domain score in the current BP is better and statistically significant ( $p < 0.05$  using a Wilcoxon test) or not statistically different ( $p \geq 0.05$  using a Wilcoxon test) than the pooled aggregate domain score from prior BPs; the State receives a 100% DSRIP domain score for the domain.
- If the aggregate domain score in the current Budget Period is worse, and statistically significant ( $p < 0.05$ , using a Wilcoxon test) than the pooled aggregate domain score from prior BPs; the State receives a 0% DSRIP domain score for the domain.

Using the Prevention & Wellness (P&W) domain in BP2 as an example:

- The P&W pooled aggregate domain score from BP1 is calculated using only the Achievement Points (as outlined in Section 5.3.1.2). Pay-for-Reporting (P4R) Points earned by ACOs in BP1 for the purposes of calculating ACO Accountability are not included.
- If the P&W aggregate domain score in BP2 is not statistically worse (i.e., comparable or statistically better) than the P&W aggregate domain score in BP1, then the BP2 P&W DSRIP domain score is 100%.
- If the P&W aggregate domain score in BP2 is statistically worse than the P&W aggregate domain score in BP1, then the BP2 P&W DSRIP domain score is 0%

Using the Prevention & Wellness (P&W) domain in BP4 as an example:

- The P&W aggregate domain score for BP1 is calculated using only the Achievement Points (as outlined in Section 5.3.1.2). Pay-for-Reporting (P4R) Points earned by ACOs in BP1 for the purposes of calculating ACO Accountability are not included. The P&W aggregate domain score for BP2 is calculated using the Achievement Points (as outlined in Section 5.3.1.2). Improvement points potentially earned by ACOs in BP2 for the purposes of calculating ACO Accountability are not included. Therefore, the pooled aggregate domain score from BP1 through BP2 is based only on the Achievement Points earned during those BPs.
- If the P&W aggregate domain score in BP3 is not statistically worse (i.e., comparable or statistically better) than the pooled P&W aggregate domain scores from BP1 through BP2, then the BP3 P&W DSRIP domain score is 100%
- If the P&W aggregate domain score in BP3 is statistically worse than the pooled P&W aggregate domain scores from BP1 through BP2, then the BP3 P&W DSRIP domain score is 0%

See Appendix C for a more detailed example of how to calculate the State’s Quality Domain score.



### **5.2.2 DSRIP Expenditure Authority and Claiming FFP**

The State must use a permissible source of non-federal share to support the DSRIP program. The non-federal share of DSRIP payments consists of revenues deposited in the State's MassHealth Delivery System Reform Trust Fund administered by the Executive Office of Health and Human Services. Sources of funds in the Delivery System Reform Trust Fund are deposited at the direction of the Legislature and include hospital assessments transferred from the Health Safety Net Trust Fund, General Fund dollars, and interest earned. The non-federal share will be used to support claiming of Federal Financial Participation (FFP), up to the State's DSRIP expenditure authority. The amount of DSRIP expenditure authority is dependent on the State DSRIP Accountability Score, which is described above in Section 5.2.1, which describes:

- How the State DSRIP Accountability Score is calculated
- The review and approval process for the State DSRIP Accountability Score, including how the State may submit a Corrective Action Plan to CMS if the State's DSRIP Accountability Score is not 100% for a given Budget Period
- If the State chooses not to submit a Corrective Action Plan for a certain Budget Period, then the State's DSRIP expenditure authority for that Budget Period will be reduced in accordance with the State DSRIP Accountability Score.

Federal Financial Participation is only available for DSRIP payments to ACOs and CPs in accordance 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 State may claim FFP for up to two years after the calendar quarter in which the State made DSRIP payments to eligible entities.

The State may claim FFP for up to \$1.8 billion in DSRIP expenditures, subject to all requirements set forth in the demonstration Expenditure Authority, Special Terms and Conditions, and this DSRIP protocol. A portion of DSRIP payments to ACOs, CPs and CSAs are at-risk (Exhibits 16 and 17), and the State will withhold these at-risk payments from the entities until their DSRIP Accountability Scores or elements of the DSRIP Accountability Scores are calculated by the State. If only some of the elements comprising the DSRIP Accountability Scores have been calculated, the State will pay out only the withheld earned at-risk funds tied to those elements. The draw of the FFP match for all at-risk funds, or reporting of payments on the CMS-64 form, will not occur until DSRIP Accountability Scores (see Sections 5.3 and 5.4.1), elements comprising DSRIP Accountability Scores, or DSRIP Performance Remediation Plan Scores (see Sections 5.3.4.2 and 5.4.6.1) have been calculated by the State. As described in Sections 5.3.4.2 and 5.4.6.1, the State will calculate each element of the DSRIP Accountability Scores and disburse the portion of the earned at-risk funds tied to each element, as appropriate. The State will report such expenditures on the CMS 64 form and draw down FFP accordingly.

### **5.2.3 Modification to State Accountability Targets**

The State may modify State Accountability Targets during the demonstration period (e.g., in situations where an expensive, but highly needed prescription drug enters the market). The State will submit modification requests to CMS for review and approval. CMS will review and approve the proposed modifications within 90 calendar days of submission.

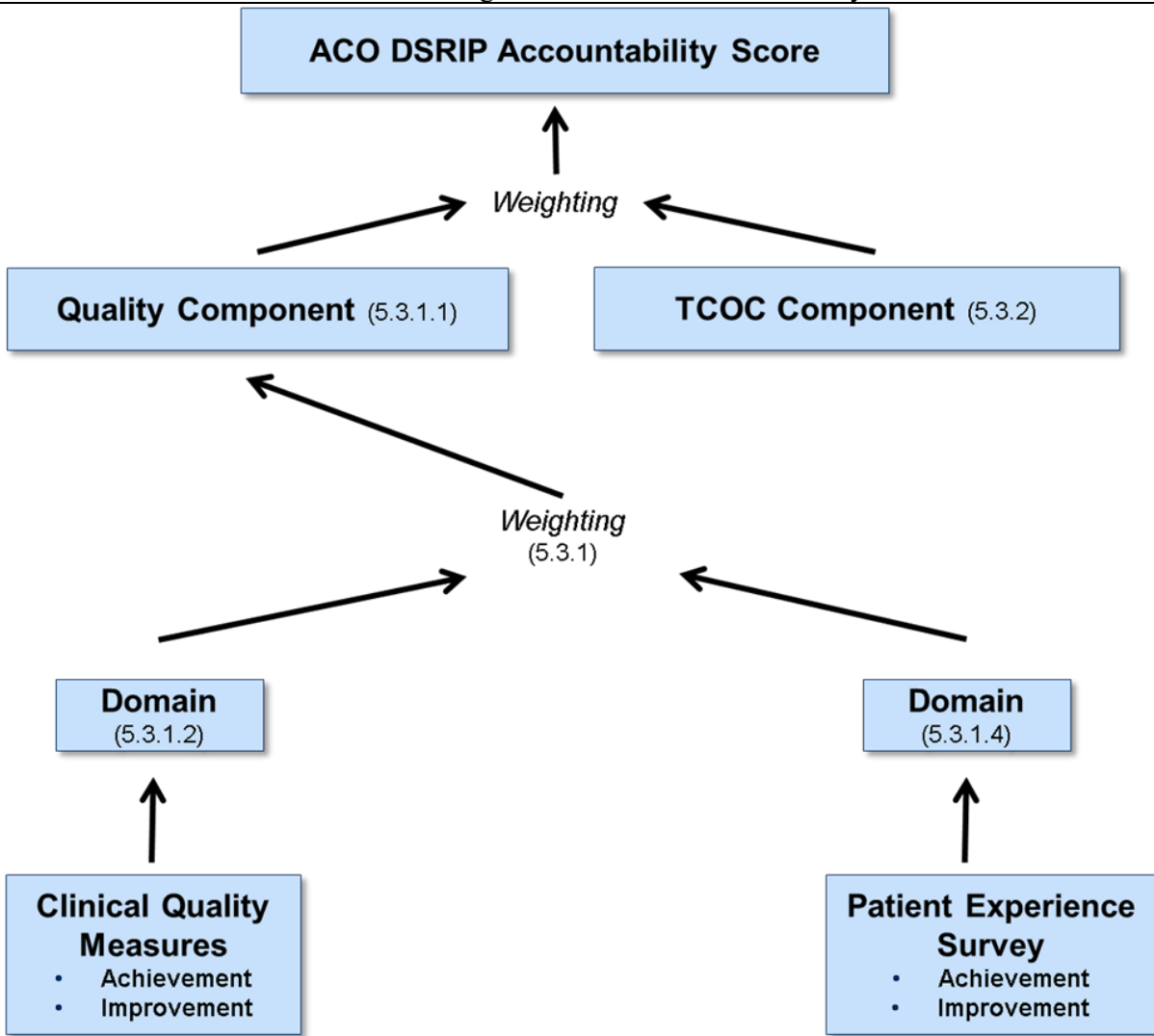
## **5.3 Accountability Framework & Performance Based Payments for ACOs**

As described in Section 4.4 above, each of the four sub-streams of DSRIP funding that the State will pay to ACOs is subject to an accountability framework that aligns ACO incentives with the State's delivery system reform goals. For two of these sub-streams (Startup/Ongoing: discretionary; and DSTI Glide Path), the State will hold each ACO accountable for the ACO's individual performance by withholding a

percentage of the funds each Budget Period, and retrospectively paying out a portion of the withheld amounts to the ACO based on the ACO's performance on clinical quality and member experience measures as well as on Total Cost of Care.

The State will measure ACO performance using a state-calculated score called the "ACO DSRIP Accountability Score." The ACO DSRIP Accountability Score is a value between zero (0) and one (1), expressed as a percentage (i.e., between 0% and 100%). The State will multiply each ACO's withheld funds for a given Budget Period by the ACO's ACO DSRIP Accountability Score for that Budget Period, and will retrospectively pay the ACO the resulting amount. Sections 4.4.1-4.4.3 focus on the technical methodology for calculating these scores. Section 4.4 describes process, timelines, key players and roles and responsibilities for calculating the scores.

- **Section 5.3.1: Quality and TCOC Components of the ACO DSRIP Accountability Score**
- **Section 5.3.2: TCOC Component of the ACO DSRIP Accountability Score**
- **Section 5.3.3: Impact of DSRIP Accountability Scores on Payments to ACOs**
- **Section 5.3.4: Process, Roles, and Responsibilities for calculating the ACO DSRIP Accountability Score**
- **Section 5.3.5: Timeline of ACO DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments**



### 5.3.1 Quality and TCOC Components of the ACO DSRIP Accountability Score

Each ACO’s ACO DSRIP Accountability Score is produced by blending two separate measures of the ACO’s performance during the Budget Period: (1) the Quality component of the ACO DSRIP Accountability Score; and (2) TCOC component of the ACO DSRIP Accountability Score. The Quality component of the ACO DSRIP Accountability Score is a score that the State will calculate that represents the ACO’s performance on quality measures during the Budget Period. The TCOC component of the ACO DSRIP Accountability Score is a score that the State will calculate that represents the ACO’s performance on TCOC management during the Budget Period. Each of these two scores is a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%).

For each ACO, the State will blend these two scores each Budget Period using a weighted average (i.e., the Quality component of the ACO DSRIP Accountability Score will be multiplied by a weight; the TCOC component of the ACO DSRIP Accountability Score will be multiplied by a weight; and the two resulting products will be summed to produce the ACO’s ACO DSRIP Accountability Score). Exhibit 30 below shows the anticipated weights for each Budget Period.

### EXHIBIT 30 – ACO DSRIP Accountability Domains

ACO DSRIP Accountability Domain Weights			
	Prep BP	BP 1-2	BP 3-5
Quality component of the ACO DSRIP Accountability Score	N/A	100%	75%
TCOC component of the ACO DSRIP Accountability Score	N/A	N/A	25%

ACOs do not have ACO DSRIP Accountability Scores during the Preparation Budget Period because no funds are withheld. ACOs will not have enrolled or attributed members during this period, and the State will therefore not be able to calculate performance on quality measures and TCOC metrics. During Budget Periods 1 and 2, the State will not hold ACOs accountable for TCOC performance in the ACO DSRIP Accountability Score, to allow ACOs time to analyze baseline TCOC performance, which will not be finalized for Budget Period 1 until close to the end of Budget Period 2.

#### *5.3.1.1 Calculating the Quality Component of the ACO DSRIP Accountability Score by Combining Domain Scores*

The State will calculate each ACO's Quality Component of the ACO DSRIP Accountability Score based on the ACO's performance on a range of State-defined quality measures. The quality measure slate was chosen to support the goals of the DSRIP program including promoting member-driven, integrated, coordinated care and improving integration among physical health, behavioral health, long-term services and supports, and health-related social services. In addition, the ACO measure slate has significant overlap with the CP measure slate, helping to align ACO quality evaluation with CPs and furthering integration.

These measures are organized across four (4) Quality Domains. The State will calculate a Domain Score for each of these four (4) Quality Domains; each Domain Score will be a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). The State will combine these four (4) Domain Scores using a weighted average (i.e., the State will multiply each Domain Score by a Domain Weight and will sum the weighted products to produce the ACO's Quality Score for the Budget Period). The four (4) Quality Domains and their anticipated weights are listed below in Exhibit 31.

If an ACO does not meet eligibility requirements for a specific measure, then the weight assigned to the measure within the measure's domain will be redistributed equally among all other measures within that domain. Thus, the overall domain weights will not increase or decrease as a result of measure ineligibility. If an ACO is ineligible to provide data on all measures within a given domain, the redistribution of that domain weight to other eligible domains will be reviewed by the DSRIP Quality Committee and the State, and will be submitted to CMS for review and approval within 90 calendar days prior to final DSRIP Accountability scoring.

If an ACO receives approval from the State to down-weight one or more measures in a domain, then the excess weight assigned to the measure or those measures within the measure's domain will be redistributed equally among all other measures within that domain. Such a redistribution of measure weights will not impact the overall domain weights. For example, if a domain has 10 measures, each measure begins as being weighted at 10% of the domain score. If four of the measures are down-weighted such that they only contribute 2.5% each to the domain score, then the excess 30% is redistributed to the other six measures, such that they would be weighted at 15% of the domain score.

### EXHIBIT 31 – ACO Quality Domains and Domain Weights

ACO Quality Domain Weights					
Quality Domain		Domain Weight: BP 1	Domain Weight: BP 2	Domain Weight: BP3	Domain Weight: BP 4-5
<i>Clinical Quality Measures</i>					
1	Prevention & Wellness	100% (P4R only)	85%	65%	45%
2	Care Integration		--	20%	40%
<i>Patient Experience Surveys</i>					
3	Overall Rating and Care Delivery	--	15%	15%	7.5%
4	Person-centered Integrated Care	--	--	--	7.5%

Appendix D displays the Clinical Quality Measures, including an indication as to whether the measure data will be collected via claims and encounter data only (“Admin”) or whether chart or record review data (“Hybrid”) will be utilized. Additionally, there is an indication of the expected “Pay-for-Reporting (P4R)”, “Reporting” and/or “Pay-for-Performance (P4P)” role in the program by Budget Period. Appendix D includes further details regarding the measures including measure descriptions. The State will send the initial measure specifications to CMS for review and approval by July 2017.

For Quality Measures that are primarily based on national measure specifications (e.g., NCQA HEDIS), where minimal changes have been made to the specification (e.g., a change from health plan population to ACO population), the State will use nationally available Medicaid benchmarks to establish its Attainment Thresholds and Goal Benchmarks where feasible (see Section 5.3.1.2). The State will propose these Attainment Thresholds and Goal Benchmarks to CMS by August 2017.

For Quality Measures for which there are related (i.e., same measure description) national measure specifications (e.g., ADA, AMA, CMS) but where changes may be significant (e.g., a change in risk adjustment methodology or a change from all-payer population to Medicaid-only population), the State will research existing data to determine if the related national and/or state/local data is applicable. If the existing data are relevant, the State will propose Attainment Thresholds and Goal Benchmarks for these measures to CMS by August 2017. If the existing data are not relevant, the State will propose Attainment Thresholds and Goal Benchmarks for these measures to CMS by November 2018 using CY2017 data (for claims-based measures) or November 2019 using CY2018 (for measures requiring chart review).

For novel measures, including member experience, the State will attempt to identify similar measures with similar specifications from other data sources (e.g., other DSRIP programs, statewide data, etc.) as a source for Attainment Thresholds and Goal Benchmarks. Should other sources not be available, the State will use state-specific data reported from its ACOs. In particular, the State anticipates using CY2017 historical MassHealth benchmarks for claims-based measures without appropriate national measure specifications, with the benchmark dataset potentially based on performance of MassHealth ACO-eligible members. For these measures, the State will propose Attainment Thresholds and Goal Benchmarks to CMS by November 2018.

The State anticipates using CY2018 MassHealth ACO-attributed benchmarks for patient experience measures, most measures that require chart review, or for most claims-based measures that were not previously collected prior to DSRIP (e.g. the measures in the Care Integration Domain). For these measures, the State will propose Attainment Thresholds and Goal Benchmarks to CMS by November 2019.

For claims-based measures that require more time to develop risk adjustment methodologies the State anticipates using CY2018 and/or CY2019 MassHealth ACO data for the purposes of benchmarking and will propose Attainment Thresholds and Goal Benchmarks to CMS in Q1 CY2022.

For ACO measures which require processing of CP qualifying activities, the State will propose Attainment Thresholds and Goal Benchmarks to CMS in Q4 CY2021.

All proposed benchmarks that the State submits to CMS will have been reviewed by the DSRIP Advisory Committee on Quality, and will be accompanied by individual rationales for each benchmark. CMS will provide written feedback on the proposed benchmarks and rationale within 90 calendar days. If CMS has not provided written feedback within 90 calendar days, then the benchmarks will be deemed approved, given the necessity of providing these benchmarks to ACOs prior to the start of their next Budget Period.

The State will annually evaluate the impact(s) of any measure specification changes on the measure benchmarks, and will review the changes and any need for adjusting established benchmarks with the DSRIP Advisory Committee on Quality. The State will submit to CMS a list of proposed changes to measure benchmarks each November prior to the start of the measurement year. The State will also share a rationale for such changes to CMS, and any changes will be subject to CMS approval.

In response to the public health emergency declared by the state or federal government, the State will utilize CY2020 data to assess the appropriateness of ACO benchmarks (informed by data prior to the start of the public health emergency) on measures in "Pay-for-Performance" status after the start of the public health emergency. Data obtained from CY2020 may be utilized to adjust benchmarks for measures deemed impacted by the public health emergency (i.e., any measure demonstrating a statewide median decrease in performance from CY2019 to CY2020). Updated benchmarks will be proposed to CMS by Q2 CY2022 for approval and will be applied to impacted measures for CY2021.

#### ***5.3.1.2 Calculating ACO Quality Score in Budget Period 1 (BP1)***

Clinical Quality measures in BP1 will be categorized as either "Reporting" or "Pay-for-Reporting" (P4R). Member Experience measures do not factor into the ACO Quality Score in BP1.

"Pay-for-Reporting" (P4R) applies to Hybrid measures which require ACOs to collect and report chart-review data (designated as "Hybrid" in Appendix D). P4R measures factor into the ACO Quality Score for BP1.

"Reporting" applies to administrative or claims-based measures (designated as "Admin" in Appendix D) which do not require ACOs to collect and report chart or record-review data. Reporting measures do not factor into the Total ACO Quality Score for BP1.

#### **Domain-based scoring will not be used in Budget Period (BP) 1**

The score for each Quality Measure in BP1 is calculated using a common methodology, described in this section. Each ACO may receive either zero (0) or one (1) Pay-for-Reporting (P4R) point for each Quality Measure.

- ACOs will earn one (1) Pay-for-Reporting (P4R) point if they provide timely and complete data for each Hybrid measure.
- ACOs will earn zero (0) Pay-for-Reporting (P4R) points if they do not provide timely and complete data for each Hybrid measure. There is no partial credit.

The Total ACO Quality Score in BP1 will be calculated by counting the number of Pay-for-Reporting (P4R) points earned in BP1 (as outlined above) and dividing this number by the number of assigned P4R measures (designated as "Hybrid" in Appendix D).

For example, if an ACO submits timely and complete hybrid or clinical data on four (4) out of the five (5) P4R measures in BP1, the ACO will receive a Total ACO Quality Score in BP1 of **80%**.

### 5.3.1.3 Calculating the Domain Score for Clinical Quality Measures (BP2, BP4, and BP5)

Clinical Quality Measures in BP2 through BP5 will be categorized as either “Reporting” or “Pay-for-Performance” (P4P). “Pay-for-Performance” (P4P) applies to the quality measures for which actual performance (measure score) will be used to calculate the Total ACO Quality Score for BP2 through BP5. Measures enter P4P status in BP2, BP3, or BP4 (as outlined in Appendix D). “Reporting” applies to administrative or claims-based measures which do not require ACOs to collect and report chart-review data. Reporting measures do not factor into the Total ACO Quality Score for BP2 through BP5. There are no Pay-For-Reporting (P4R) points included in BP2 through BP5.

ACOs are eligible to receive two (2) types of points for each Quality Measure: *achievement points* and *improvement points*. The achievement and improvement points are calculated using the methodology described in this section.

#### Achievement Points

Each ACO may receive up to a maximum of ten (10) achievement points for each Quality Measure, as follows:

1. The State will establish an “Attainment Threshold” and a “Goal Benchmark” for each Quality Measure as follows:
  - a. “Attainment Threshold” sets the minimum level of performance at which the ACO can earn achievement points
  - b. “Goal Benchmark” is a high performance standard above which the ACO earns the maximum number of achievement points (i.e., 10 points)
2. The State will calculate each ACO’s performance score on each Quality Measure based on the measure specifications which will be reviewed and approved by CMS (see Section 5.3.4.2). Each Quality Measure’s specifications will describe the detailed methodology by which this performance score is calculated.
3. The State will award each ACO between zero (0) and ten (10) achievement points for each Quality Measure as follows:
  - a. If the ACO’s performance score is less than the Attainment Threshold: 0 achievement points
  - b. If the ACO’s performance score is greater than or equal to the Goal Benchmark: 10 achievement points
  - c. If the performance score is between the Attainment Threshold and Goal Benchmark: the ACO receives a portion of the maximum 10 achievement points in proportion to the ACO’s performance. The State will calculate the number of achievement points using the following formula:
    - i.  $10 * ((\text{Performance Score} - \text{Attainment Threshold}) / (\text{Goal Benchmark} - \text{Attainment Threshold}))$
4. If the State finds that 75% of ACOs have not met the Attainment Thresholds for a particular measure, then the State may reset this benchmark to a lower standard for future Budget Periods with input from the DSRIP Advisory Committee for Quality, and CMS approval. If the State finds

that 75% or more of ACOs have met the Goal Benchmarks for a particular measure, then the State may reset this benchmark to a higher standard for future Budget Periods with input from the DSRIP Advisory Committee for Quality, and CMS approval. If 75% of ACOs meet the adjusted Goal Benchmark, then the State may retire the measure and replace it with a new measure from the same domain. The new measure will enter into the slate as reporting only (if claims measure) or pay for reporting (if hybrid measure) for its first reporting year, switching over to pay for performance in the second or third year, depending on benchmark availability. Benchmarking for the new measure will follow the same methodology as outlined in Section 5.3.1.1

5. The State will calculate Achievement Point totals for every measure, for every BP, for the purposes of the baseline period of the State Accountability Score Calculation (as outlined in Section 5.2.1.3).

Exhibit 32 below shows an example calculation of an ACO’s achievement points for a Quality Measure.

**EXHIBIT 32 – Example Calculation of Achievement Points for Measure A**

**Measure A Attainment Threshold** = 45% (e.g., corresponding to 25<sup>th</sup> percentile of HEDIS benchmarks)  
**Measure A Goal Benchmark** = 80% (e.g., corresponding to 90<sup>th</sup> percentile of HEDIS benchmarks)

Example Calculation of Achievement Points for Measure A		
	Measure A Performance Score	Achievement Points Earned
Scenario 1	25%	0
Scenario 2	90%	10
Scenario 3	60%	4.29 *

*\*Achievement points earned = 10\*((60% - 45%) / (80% - 45%)) = 4.29 points*

**Improvement Points (BP2, BP4, and BP5)**

In addition to receiving achievement points based on performance (on a 0 to 10 scale), ACOs may earn improvement points for reaching established improvement targets for each Quality Measure. Improvement points will be calculated as follows:

1. The State will calculate each ACO’s performance score on each Quality Measure based on the measure specifications. Each Quality Measure’s specifications will describe the detailed methodology by which this performance score is calculated.
2. The State will compare each ACO’s performance score on each Quality Measure to the ACO’s performance score on that same Quality Measure from a previous Performance Year (excluding BP3 due to a state of emergency declared by the federal or state government)
3. The State will calculate an Improvement Target for each Quality Measure using the following formula. The Improvement Target is based on at least a 20% improvement each year in the gap between Goal Benchmark and the Attainment Level of each ACO measure.

a. Improvement Target formula = [(Goal Benchmark – Attainment Level) /5]

*For example, for Measure A, if the Attainment Level is 50% and the Goal Benchmark is 60%, the Improvement Target is 2% [(60 – 50)/5]*



- b. For the purposes of calculating the Improvement Target, the result is rounded to the nearest tenth (i.e., one decimal point).

*For example, for Measure B, if the Attainment Level is 80% and the Goal Benchmark is 90.2%, the Improvement Target is calculated to 2.04%  $[(90.2 - 80)/5]$  which rounds to 2.0%.*

- c. Starting in BP2, the ACO may earn up to five (5) improvement points per measure per year for increases in measure score which meet or exceed the improvement target. The same improvement target is used for every ACO for each measure.

*For example, for Measure B, the Improvement Target is 2.0%. If ACO performance in BP4 is 54.0% and if ACO performance in BP5 is 60.0%, the ACO improvement from BP4 to BP5 is 6.0%  $[(60.0-54.0)]$  and the ACO is awarded 5 improvement points. No points above 5 are awarded for increases in excess of the improvement target.*

- d. For the purposes of calculating the difference in ACO quality performance over a previous year, the results are rounded to the nearest tenth (i.e., one decimal point). Rounding takes place after the calculation.

*For example, for Measure B, if ACO performance in BP4 is 54.54% and if ACO performance in BP5 is 60.17%, the ACO improvement from BP4 to BP5 is 5.63%  $[(60.17-54.54)]$ , and the ACO improvement will be rounded to the nearest tenth (i.e., one decimal point) to 5.6%.*

- e. The Improvement Target is based on the higher of the original baseline (BP1) or any year's performance prior to the current BP. This is intended to avoid rewarding regression in performance.

*For example, for Measure B, assume ACO A performance in BP1 is 90.0% and the Improvement Target is 2.0%. If in BP4 the performance for ACO A decreases to 89.0%, in BP5 the ACO would need to reach 92.0% to reach the Improvement Target.*

- f. ACOs will not earn improvement points if performance is lower in the current BP as compared to the prior BP (excluding BP3 due to a state of emergency declared by the federal or state government)

*For example, for Measure B, the Improvement Target is 2.0%. If ACO performance in BP4 is 54.0% and if ACO performance in BP5 is 53.0%, the ACO improvement from BP4 to BP5 is -1.0% and the ACO is not eligible to receive any improvement points.*

- g. There are several special circumstances:
- i. *At or Above Goal:* ACOs with prior BP performance scores equal to or greater than the Goal Benchmark may still earn up to five (5) improvement points in each BP if improvement from the prior BP (excluding BP3 due to a state of emergency declared by the federal or state government) is greater than or equal to the Improvement Target.
  - ii. *At or Below Attainment:* ACOs with prior BP performance scores less than the Attainment Threshold may still earn up to five (5) improvement points each BP if

improvement from the prior BP (excluding BP3 due to a state of emergency declared by the federal or state government) is greater than or equal to the Improvement Target, and performance in the current BP does not equal or exceed the Attainment Threshold. Additionally, ACOs with prior BP performance scores less than the Attainment Threshold and current BP performance scores equal to or above the Attainment Threshold may still earn up to five (5) improvement points if the improvement is greater than or equal to the Improvement Target.

**EXHIBIT 33 – Example Calculation of Improvement Points for Measure B**

Measure B Attainment = 48.9% | Goal = 59.4% | Improvement Target = 2.1%

	BP4 Score	BP5 Score	Improvement	Improvement Target Met	Improvement Points Earned
Scenario 1:	50.0%	52.1%	2.1%	Yes	5
Scenario 2:	50.0%	56.7%	6.7%	Yes	5
Scenario 3:	59.5%	63.0%	3.5%	Yes; above Goal Benchmark	5
Scenario 4	45.0%	48.0%	3.0%	Yes; below Attainment Threshold	5
Scenario 5:	46.0%	49.0%	3.0 %	Yes; crossing Attainment	5
Scenario 6:	45.0%	46.0%	1.0%	No	0

**Domain Score**

Domain-based scoring will not be used in Budget Period (BP) 1, as described in Section 5.3.1.2. In BP2, BP4, and BP5, for each ACO, the State will sum the ACO’s achievement and improvement points for all Quality Measures within each Quality Domain. Improvement points earned in one Quality Domain may only be summed with achievement points from the same Quality Domain. The total number of points earned by the ACO in each domain cannot exceed the maximum number of achievement points available in the domain. The maximum number of achievement points in the domain is calculated by multiplying the number of Pay-for-Performance (P4P) measures in the domain, in the given BP, by the number of available achievement points per measure.

*For example, if in BP4, there are ten (10) clinical quality measures in Domain X in Pay-for-Performance, and each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 100. Assume that in BP5 there are now twelve (12) clinical quality measures in Domain X in Pay-for-Performance, and that each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 120.*

*Cumulative Example:*

*Total number of measures in domain: 2*

*Maximum number of achievement points in the domain = 20*

*Measure Attainment = 48.9% | Goal = 59.4%*

*Improvement Target = [(Goal Benchmark – Attainment Level) /5] = [59.4-48.9]/5 = 2.1*

For example, for Measure A, if ACO performance in BP4 is 54.54% and if ACO performance in BP5 is 58.17% the ACO will earn 8.8 Achievement Points  $[10 * (58.17 - 48.9)/(59.4 - 48.9)]$ . The ACO has

improved from BP4 to BP5 by 3.63% [(58.17 - 54.54)] which will be rounded to the nearest tenth (e.g., one decimal point) to 3.6% which exceeds the Improvement Target of 2.1%. Thus the ACO will earn five (5) improvement points. No points above 5 are awarded for increases in excess of the improvement target.

*In this scenario the ACO would earn 13.8 points.*

If there is only one (1) additional measure in the Domain and the ACO earned 9 total points for this measure; the total score for the ACO would be 20.0 (out of 20) given that domain scores are capped at the maximum number of achievement points (20) in the domain.

Once the total number of points has been calculated, the State will divide the resulting sum by the maximum number of achievement points that the ACO is eligible for in the domain to produce the ACO’s Domain Score. Domain Scores are a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). In BP2, BP4, and BP5, the State will score each ACO on each P4P Quality Measure unless the ACO does not meet eligibility requirements for a specific measure based on the measure specifications (e.g., it does not meet the minimum denominator requirement) or as otherwise specified in Appendix D. In cases like this, the measure is not factored into the denominator. Reporting measures do not factor into the Domain Score. Additionally, improvement points do not count towards the denominator; they are therefore “bonus” points. Domain Scores are each capped at a maximum value of 100%.

Exhibit 34 below shows an example calculation of an ACO’s unweighted Domain Score for a Quality Domain.

**EXHIBIT 34 – Example Calculations of Unweighted Domain Score**

Example Calculations of Unweighted Domain Score	
Example 1	Domain only has two Quality Measures (Measure A and Measure B)
	Therefore, maximum number of achievement points is 2x10 = 20 points
	Measure A: Achievement points: 1.5
	Improvement Points: 0
	Measure B: Achievement points: 0
	Improvement Points: 5
	Total achievement points: 1.5 + 0 = 1.5 points
	Total improvement points: 0 + 5 = 5 points
	Sum of achievement and improvement points: 1.5 + 5 = 6.5 points
Unweighted domain score = 6.5/20 * 100 = 32.5%	
Example 2	Domain only has two Quality Measures (Measure A and Measure B)
	Therefore, maximum number of achievement points is 2x10 = 20 points
	Measure A: Achievement points: 8
	Improvement Points: 5

	Measure B:	Achievement points: 9.3
		Improvement Points: 0
	Total achievement points: $8 + 9.3 = 17.3$	
	Total improvement points: 5 points	
	Sum of achievement and improvement points: $17.3 + 5 = 22.3$ points	
	However, total number of points cannot exceed maximum number of achievement points (20)	
	Therefore, total domain points = 20	
	Unweighted domain score = $20/20 * 100 = 100\%$	

#### 5.3.1.4 Calculating the Domain Score for Clinical Quality Measures in BP3

In order to address the impact of the state of emergency declared by the federal or state government on ACO quality performance, domain scores for BP3 are calculated using the following methodology.

##### Achievement Points

For each measure in pay-for-performance status in BP3 (as set forth in Appendix D), the State will decide whether to set the individual ACOs' BP3 measure performance rates to 1) the higher of the ACOs' BP3 or BP2 actual measure rates, or 2) the higher of the ACO's BP2 actual rates or the statewide median rates (i.e., measure level median performance among all ACOs) in BP2.

If the State determines BP3 measure performance rates by comparing the individual ACOs' BP2 actual rates to BP3 actual rates, then ACOs earn achievement points following the scoring approach set forth in Section 5.3.1.3. If the State determines BP3 measure performance rates by comparing individual ACOs' BP2 actual rates to the BP2 statewide median rates, then:

- For measures where an ACO demonstrates a higher BP2 rate than the BP2 statewide median, the ACO earns achievement points based on its own rate, following the scoring approach set forth in Section 5.3.1.3
- For measures where the statewide median demonstrates a higher rate than the ACO's own rate, the ACO earns achievement points based on the statewide median, following the scoring approach set forth in Section 5.3.1.3
- In order to prevent such cases where an ACO's measure performance rate would improve excessively through the use of the statewide median, the number of raw (i.e., percentage) points an ACO may earn when replacing an ACO actual measure rate with that of the statewide median rate is capped at 10 raw points

EXHIBIT 35 - BP3 Measure Rate Calculation with Raw Point Cap = 10.0

	Measure	ACO BP2 Rate	BP2 Statewide Median	Performance Rate Used For BP3	Raw Point Cap
	A	73.0%	74.0%	74.0%	No

B	73.0%	70.0%	73.0%	No
C	73.0%	80.0%	80.0%	No
D	73.0%	84.0%	83.0%*	Yes

\*BP3 Performance Rate ‘capped’ at 83.0% (i.e., 73.0% + maximum allowance of 10.0 raw points, using BP2 state median)

Results from the ‘Performance Rate Used for BP3’ column are then compared to measure benchmarks for the calculation of Achievements Points, following the scoring approach described in Section 5.3.1.3

### Improvement Points

If the State sets individual ACOs’ BP3 measure performance rates to be the ACOs’ actual BP3 measure rates, then the improvement point calculation process will follow the process used for BP2, BP4, and BP5, as described above in Section 5.3.1.2. If the State sets individual ACOs’ BP3 measure performance rates as either individual ACOs’ BP2 rates or the BP2 statewide median rates (capped or uncapped), then improvement point calculation for BP3 is determined by the following methodology:

#### *Step 1: ACO Improvement*

- a. For each applicable measure, ACO BP2 actual rates are compared to ACO BP1 actual rates
  - i. For measures where an ACO demonstrates improvement (i.e., reaches the predetermined improvement targets), the ACO earns improvement points
  - ii. For measures where an ACO fails to demonstrate improvement, then Step 2 is implemented

#### *Step 2: Statewide Median Improvement*

- a. For each applicable measure (i.e., from Step 1.a.ii), the statewide median for BP1 is compared to the statewide median for BP2
  - i. For measures where the State demonstrates improvement (i.e., reaches the predetermined improvement targets), the ACO earns improvement points  
*Note:* The number of measures by which an ACO may use Step 2.a.i to earn improvement points is capped at a number to be determined by the State, thereby preventing an unintended inflation of ACO scores (see example in Exhibit 36)
  - ii. For measures where the State fails to demonstrate improvement, the ACO does not earn improvement points

EXHIBIT 36 - Example of Improvement Point Calculation with Cap = 3 Measures

Note: For purposes of simplicity, this example assumes each measure has the same Improvement Target across measures A-G

Measure Improvement Target = 2.1

State Improvement Median = 2.1

Measure	ACO BP1 Actual Rate	ACO BP2 Actual Rate	ACO Improvement	Improvement Used	Improvement Points Received (Source)
A	50.0%	53.1%	3.1	ACO = 3.1	YES (Step 1)
B	40.0%	49.1%%	9.1	ACO = 9.1	YES (Step 1)
C	59.0%	58.0%	-1.0	State Med = 2.1	YES (Step 2) cap count 1/3
D	65.0%	65.0%	0.0	State Med = 2.1	YES (Step 2) cap count 2/3
E	20.0%	22.0%	2.0	State Med = 2.1	YES (Step 2) cap count 3/3
F	25.0%	26.0%	1.0	State Med = 2.1	NO cap reached*
G	20.0%	30.0%	10.0	ACO = 10.0	YES (Step 1)

\*In this example, this ACO used the state median improvement (2.1) for measures C, D, E, thereby reaching the cap of using the state median 3 times. As such, this ACO may not utilize the state median for measure F.

Note: Use of the state median only ‘counts’ toward the cap in such measures where its usage results in the allocation of improvement points. In other words, in such cases where the state median is higher than ACO improvement, but does not reach the Improvement Target, then use of the state median does not count toward the cap.

**5.3.1.5 Calculating the Domain Score for Member Experience Quality Domains for BP 4-5**

The Member Experience Quality Domains will be calculated based on surveying a representative sample of an ACO’s attributed members to assess their experience of care. The State anticipates assessing member experience for (1) primary care (commencing in CY2018), (2) BH (commencing in CY2019), and (3) LTSS (commencing in CY2020) services.

The State plans to procure a vendor to administer these member experience surveys for ACOs. The State will work in collaboration with its procured vendor to finalize the survey instruments, and identify questions and methodology for calculating survey results. The State is planning to use or adapt (as appropriate) validated instruments wherever possible to capture member experience for each population. For example, the State may use:

- For the population receiving primary care services:

- CAHPS Clinician and Group Survey + CAHPS PCMH supplemental questions
- For the population receiving behavioral health services:
  - Massachusetts Department of Mental Health, Massachusetts Consumer Surveys (MCS): Based off of the Substance Abuse and Mental Health Services Administrations (SAMHSA’s) Mental Health Statistics Improvement Program (MHSIP) survey
- For the population receiving LTSS Services:
  - HCBS CAHPS Survey: recently released by CMS, is the first cross-disability survey of home and community-based service (HCBS) beneficiary’s experience receiving long-term services and supports

ACOs will be evaluated based on surveys of a representative sample of their attributed members. Scores will be based on performance on a combination of composite and specific questions contained in each survey. Examples of question categories include but are not limited to:

EXHIBIT 37 – Examples of Survey Question Categories

Primary Care	Behavioral Health	LTSS
<ul style="list-style-type: none"> <li>● Access to care</li> <li>● Communications</li> <li>● Comprehensiveness</li> <li>● Self-management support</li> <li>● Coordination of care</li> <li>● Helpful, Courteous, and Respectful Office Staff</li> <li>● Patient Ratings of the Provider</li> <li>● Self-management support (composite measure)</li> <li>● Comprehensiveness</li> <li>● Integration or coordination of physical health, BH, LTSS, and health-related social services</li> </ul>	<ul style="list-style-type: none"> <li>● Access to services</li> <li>● Quality and appropriateness</li> <li>● Treatment outcomes</li> <li>● Person-centered planning</li> <li>● Social connectedness</li> <li>● Functioning</li> <li>● Self-determination</li> <li>● Integration or coordination of BH services by Community Partners</li> </ul>	<ul style="list-style-type: none"> <li>● Getting needed services</li> <li>● HCBS staff reliability</li> <li>● Communication with HCBS staff</li> <li>● Getting help from case managers</li> <li>● Choice of services</li> <li>● Personal safety</li> <li>● Adequacy of medical transportation</li> <li>● Community inclusion and empowerment</li> <li>● Employment (supplement)</li> <li>● Integration or coordination of LTSS services by Community Partners</li> </ul>

The scoring approach will be similar to the approach used for clinical quality measures where scoring is based on attainment of benchmarks for excellent performance and/or improved performance relative to previous performance (as described in Section 5.3.1.3).

#### Calculating the Domain Score for Member Experience Quality Domains for BP2 and BP3

In order to address the impact of the state of emergency declared by the federal or state government on ACO quality performance, member experience domain scores for BP2 and BP3 are calculated using the following methodology:

#### Achievement Points

For each composite in the Overall Care Delivery domain, the State will decide whether to set the individual ACOs’ BP3 performance rates to 1) the higher of their BP1 or BP2 actual rates, or 2) the higher of their BP2 or BP3 actual rates. Regardless of which comparison the State decides to use, the rate selected will be

used not just for the BP3 performance rates, but also the BP2 performance rates, given that the timing of BP2 data collection (i.e., January through May of 2020) could lead to BP2 actual rates being variably impacted across ACOs as a result of the state of emergency declared by the federal or state government. Upon determination of the ACOs' BP2 and BP3 performance rates, achievements points will be determined following the process set forth in Section 5.3.1.3.

**EXHIBIT 38 Example of Member Experience Calculation When Deciding Between BP1 and BP2 Actual Rates**

	<b>Composite (Willingness to recommend - Adult)</b>	<b>ACO BP1 Actual Rate</b>	<b>ACO BP2 Actual Rate</b>	<b>Performance Rate Used for Scoring BP 2 and BP3</b>
	<b>ACO A</b>	85%	87.0 %	87.0%
	<b>ACO B</b>	89%	87.0%	89.0%

**Improvement Points**

Improvement point calculation for BP2 and BP3 is determined by the following methodology:

*Step 1: ACO Improvement*

- a. For each composite within a domain, compare ACO BP1 actual rates to BP2 performance rates
  - i. For composites where an ACO demonstrates improvement (i.e., reaches the improvement target), the ACO earns improvement points
  - ii. For composites where an ACO fails to demonstrate improvement, then Step 2 is implemented

*Step 2: Statewide Improvement*

- a. If the State sets individual ACOs' BP2 and BP3 performance rates to be the higher of their actual BP1 or BP2 rates, then for each composite within a domain, compare BP1 statewide median rates to BP2 statewide median rates. If the State sets ACOs' BP2 and BP3 performance rates to be the higher of their BP2 or BP3 actual rates, then for each composite within a domain, compare BP1 statewide median rates to the higher of BP2 statewide median rates or BP3 statewide median rates.
  - i. For composites where the State demonstrates improvement (i.e., reaches the improvement target), the ACO earns improvement points
  - ii. For composites where the State fails to demonstrate targeted improvement, the ACO does not earn improvement points

Note: In order to prevent such cases where an ACO's performance would improve excessively through the use of the statewide median, the number of composites by which an ACO may use Step 2.a.i to earn improvement points is capped at one



**EXHIBIT 39 - Example of Improvement Point Calculation with Cap = 1 Composite**

Note: This example assumes each composite has the same Improvement Target across composites A-D, and that the State is comparing BP1 rates to BP2 rates.

Measure Improvement Target = 1.0

State Improvement Median = 1.0

Composite - Example	ACO BP1 Actual Rate	ACO BP2 Performance Rate	ACO Improvement	Improvement Used	Improvement Points Received (Source)
<b>A – Willingness to Recommend (Adult Survey)</b>	75.1%	75.9%	0.8 (target not met by ACO)	State Med = 1.0	YES (Step 2 applied)
<b>B - Willingness to Recommend (Child Survey)</b>	85.1%	87.0%	1.9 (target met by ACO)	ACO = 1.9	YES (Step 2 not needed)
<b>C - Communications (Adult Survey)</b>	89.5	88.7%	-0.8 (target not met by ACO)	State Med = 1.0	NO (Capped at 1: Composite A already received points)
<b>D - Communications (Child Survey)</b>	78.1%	78.5%	0.4 (target not met by ACO)	State Med = 0.8 (target not met by State)	NO

**Calculation of Composite Scores**

This section clarifies calculation of measures consisting of composite scores, applicable to a specific subset of ACO and CP measures. Two distinct calculations are applicable to composite scores with (1) equally weighted component measures, or (2) unequally weighted component measures. Composite scores with equally weighted component measures consist of ACO and CP member experience measures, ACO *Engagement* measures, ACO *Community Tenure* measure, as well as the ACO and BH CP versions of *Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (IET)* measure.

Calculation of these composite scores consists of the following methodology:

- Achievement points are averaged across component measures within the composite (rounded to nearest tenth)
- Improvement points (applicable to ACO measures only) are averaged across component measures within a composite (rounded to nearest tenth)
- The average composite achievement points value is applied to the sum of total achievement points in the domain
- The average composite improvement points value is applied to the sum of total improvement points in the domain

Composite scores with unequally weighted component measures consist of the BH CP Treatment Plan based composite (i.e., *Engagement* and *Annual Treatment Plan Completion* measures) and the LTSS CP

Care Plan based composite (i.e., *Engagement* and *Annual Care Plan Completion* measures). Calculation of these composite scores consists of the following methodology:

- Achievement points are weighted across component measures within a composite score. The Annual Treatment/Care Plan Completion measure is 80% of the composite score and Engagement is 20% of the composite (rounded to the nearest tenth)
- The weighted composite achievement points value is applied to the sum of total achievement points in the domain

**EXHIBIT 40: Example of Composite Scoring (Equally and Unequally Weighted Component Measures)**

<b>Composite Scores: Equally Weighted Components</b>	
<b>Domain: Overall Rating and Care Delivery (consisting of 4 composite scores)</b>	Point Calculation
<b>Composite 1: Willingness to Recommend-Adult Survey</b>	Achievement points: 5.6 Improvement points: 5
<b>Composite 2: Willingness to Recommend-Child Survey</b>	Achievement points: 7.5 Improvement points: 0
<b>Composite 3: Communications-Adult Survey</b>	Achievement points: 8.0 Improvement points: 0
<b>Composite 4: Communications-Child Survey</b>	Achievement points: 9.1 Improvement points: 5
<b>Average Achievement points: <math>(5.6 + 7.5 + 8.0 + 9.1)/4 = 7.6</math></b>	
<b>Average Improvement points: <math>(5 + 0 + 0 + 5)/4 = 2.5</math></b>	
<b>Average Achievement points (7.6) and Average Improvement points (2.5) are summed (10.1) as total points. Total number of points cannot exceed the maximum available achievement points within a given domain (in this case 10); therefore, total domain points for the Overall Rating and Care Delivery domain = 10.0</b>	
<b>Composite Scores: Unequally Weighted Components</b>	
<b>Domain: Care Integration (consisting of 2 composite scores)</b>	Point Calculation
<b>Component 1: BH CP Engagement</b>	Achievement points: 5.6 Weighted (20%): $5.6 * (0.2) = 1.1$
<b>Component 2: Annual Treatment Plan</b>	Achievement points: 7.5 Weighted (80%): $7.5 * (0.8) = 6.0$
<b>Sum of weighted components: <math>(1.1 + 6.0) = 7.10</math></b>	

### **5.3.1.6 Quality Data Collection Approach**

Quality measure data will be collected in one of three ways. Claims and encounter data will flow through the normal channels currently used to process and pay claims. Clinical data (i.e., data that will be extracted from EHRs) will initially be submitted to the State by ACOs, using spreadsheets and secure transmission methods (e.g., Secure File Transfer Protocol). The ultimate goal will be to have secure two-way data exchange between the State and ACOs to support continuous sharing of clinical quality data. Member experience will be measured via a patient experience survey performed by a vendor. The State anticipates that the survey will be conducted by typical methodologies such as by mail and/or phone.

### **5.3.2 TCOC component of the ACO DSRIP Accountability Score**

Each ACO's TCOC component of the ACO DSRIP Accountability Score will be a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%) that reflects an ACO's performance at managing TCOC for its enrolled or attributed members. Each ACO's TCOC component of the ACO DSRIP Accountability Score will be calculated in the following manner:

If the ACO is a Primary Care ACO or MCO-Administered ACO, the State will perform the following comparison:

1. In advance of each Budget Period, the State will establish a Preliminary TCOC Benchmark for each ACO, working with the State's actuaries and following the detailed methodology for setting TCOC Benchmarks outlined in the State's ACO contracts
2. Approximately 7-8 quarters after the Budget Period has ended, the State will retrospectively calculate each ACO's TCOC Performance for the Budget Period
3. The State will retrospectively compare each ACO's TCOC Performance to its Final TCOC Benchmark, as set forth in the Primary Care ACO or MCO-Administered ACO contract. TCOC Performance, which will include only the Included Spending Category services set forth in Section 5.2.1.2, will reflect savings or losses after taking into account risk sharing arrangements with the State for the Budget Period. In the process, the State will make several updates to each ACO's Preliminary TCOC Benchmark to produce the ACO's Final TCOC Benchmark for the Included Spending Category services, including, for example, actuarial adjustments to account for the ACO's risk profile and population mix during the Budget Period

If the ACO is an Accountable Care Partnership Plan, the State will perform the following comparison:

4. Approximately 7-8 quarters after the Budget Period has ended, the State will retrospectively calculate each ACO's TCOC Performance for the Budget Period
5. The State will retrospectively compare capitation payments to the Partnership Plan's Non-High Cost Drug/Non-HCV actual medical expenditures (hereinafter "Total Medical Expense (TME)") as set forth in the Accountable Care Partnership Plan contract. TME performance, which will include only the Included Spending Category Services set forth in Section 5.2.1.2, will reflect gains or losses after taking into account risk sharing arrangements with EOHHS for the Budget Period, such as market level risk corridors. Administrative or underwriting gains or losses will not count towards gains or losses used to calculate the TCOC component of the ACO DSRIP Accountability Score

For all ACOs, after performing the above comparisons, the State will calculate the ACO's TCOC component as follows:

6. Based on the comparison, the State will calculate each ACO's TCOC component of the ACO DSRIP Accountability Score as follows:

- If the ACO has savings or medical gains after risk sharing, then the ACO's TCOC component of the ACO DSRIP Accountability Score equals 100%
- If the ACO has losses after risk sharing that exceed 5% of the Final TCOC Benchmark or exceed 5% of the ACO's risk adjusted medical capitation payments, then the ACO's TCOC component of the ACO DSRIP Accountability Score equals 0%
- If the ACO has losses after risk sharing but they do not exceed 5% of the Final TCOC Benchmark or 5% of the ACO's risk adjusted medical capitation payments, then the ACO's TCOC component of the ACO DSRIP Accountability Score is proportionate to the magnitude of the ACO's losses, and is equal to:
  - For Primary Care ACOs and MCO-Administered ACOs:  $(105\% * \text{Final TCOC Benchmark} - \text{TCOC Performance after risk sharing}) / (5\% * \text{Final TCOC Benchmark})$
  - For Partnership Plans:  $(105\% * \text{risk-adjusted medical capitation payments} - \text{TME Performance after risk sharing}) / (5\% * \text{risk adjusted medical capitation payments})$
- If the ACO has neither savings or medical gains nor losses after risk sharing, then the ACO's TCOC component of the ACO DSRIP Accountability score equals 100%.

EXHIBIT 41 – Example Calculations of TCOC component of the ACO DSRIP Accountability Score

Example Calculations of TCOC Component of the ACO DSRIP Accountability Score	
Final TCOC Benchmark = \$500 PMPM	
Scenario 1	ACO's TCOC Plan Share Performance is \$490 PMPM
	ACO has savings after risk sharing of \$10 PMPM, or 2%
	ACO has achieved savings, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score is 100%
Scenario 2	ACO's TCOC Performance is \$550 PMPM
	ACO has losses after risk sharing of \$50, or 10%
	ACO has losses that exceed 5% of the TCOC Benchmark, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score is 0%
Scenario 3	ACO's TCOC Performance is \$520 PMPM
	ACO has losses after risk sharing of \$20, or 4%
	ACO has losses that are less than 5% of the TCOC Benchmark, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score = $((5\% \text{ of the TCOC Benchmark} - \$20) / 5\% \text{ of the TCOC Benchmark}) = ((\$25 - \$20) / \$25) = (\$5/\$25) = 20\%$

### 5.3.3 Impact of DSRIP Accountability Scores on Payments to ACOs

Once the State has determined the ACO's Quality and TCOC components of the ACO's DSRIP Accountability Score, it will calculate the DSRIP Accountability Score using the methodology described in Section 5.3.1. As an example:

#### Example Calculation of ACO DSRIP Accountability Score in BP4

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- Quality Component of DSRIP Accountability Score in BP4: 75% (calculated as described in Section 5.3.1)
- TCOC Component of DSRIP Accountability Score in BP4: 80% (calculated as described in Section 5.3.2)
- Weight for Quality Component of DSRIP Accountability Score in BP4: 75% (as described in Exhibit 30)
- Weight for TCOC Component of DSRIP Accountability Score in BP4: 25% (as described in Exhibit 30)

$$\text{ACO DSRIP Accountability Score} = (\text{Quality Component} * \text{Weight of Quality Component}) + (\text{TCOC Component} * \text{Weight of TCOC Component}) = (75\% * 75\%) + (80\% * 25\%) * 100\% = 76.2\%$$

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The DSRIP Accountability Score will then be applied to the ACO funding sub-streams that have a portion of funds at-risk. Specifically:

- ACO Sub-Stream #1 - Startup/Ongoing Funding (Primary Care): No at-risk funds
- ACO Sub-Stream #2 - Startup/Ongoing Funding (Discretionary): Portion of funds are at-risk, according to schedule detailed in Exhibit 20; DSRIP Accountability Score is multiplied by the at-risk funding amount to determine how much is earned
- ACO Sub-Stream #3 - Flexible Services Funding: No at-risk funds
- ACO Sub-Stream #4 - DSTI Glide Path Funding: Portion of funds are at-risk, according to schedule detailed in Exhibit 20; DSRIP Accountability Score is multiplied by the at-risk funding amount to determine how much is earned

### 5.3.4 Process, Roles, and Responsibilities for calculating the ACO DSRIP Accountability Score

#### 5.3.4.1 Roles and responsibilities

The State will be responsible for establishing the elements that comprise the ACO DSRIP Accountability Score, including its Quality Measures, the specifications for each Quality Measure, the data sources for calculating the Quality Measures, the methodology for setting the Attainment Threshold and Goal Benchmark for each Quality Measure (where applicable) and the values of the thresholds and benchmarks themselves. This sub-section 5.3.4.1 details the roles and responsibilities of the State, the State's DSRIP Quality Advisory Committee, and CMS with respect to these elements.

#### 5.3.4.2 The State

The State will establish the elements that comprise the ACO DSRIP Accountability Score, based on the advice of the DSRIP Advisory Committee on Quality as described in this Protocol (see Section 6.2.1). By August 2017, the State will submit the Quality Measure slate and specifications, the benchmark sources, and performance thresholds (i.e., Attainment Thresholds and Goal Benchmarks) to CMS for review and approval.

The State may request modification to any element that comprises the ACO DSRIP Accountability Score, based on its own assessment or on the recommendation of the State's DSRIP Advisory Committee on Quality. In the event that the State wishes to change a previously approved element that is a component of

the ACO DSRIP Accountability Score, the State will submit a formal, written modification request to CMS for review and approval. CMS will have 90 calendar days to review and approve.

As part of its program management and contract oversight processes, the State will establish a structured process for ACOs to seek clarification on or request revisions to certain aspects of their ACO DSRIP Accountability Scores (e.g., if an ACO seeks clarification on the inclusion of certain members in the denominator for a Quality Measure's performance score). Each ACO will identify a key contact, responsible for raising such issues to the State and working with the appropriate State personnel to discuss and resolve issues as appropriate. The State will also identify a reciprocal contact to liaise with each ACO and support these types of requests.

The State may provide an opportunity for ACOs to submit DSRIP Performance Remediation Plans to earn back a portion of the unearned, withheld funds, at the State's discretion. The State may combine remediation opportunities for multiple years to streamline processes (e.g., combining BP2 and BP3 remediation processes into a single remediation process). If the State allows this opportunity, then an ACO may choose to provide the State a DSRIP Performance Remediation Plan within 30 calendar days of receipt of the State's notification of the opportunity to submit a Performance Remediation Plan, in which case the ACO may have the opportunity to earn back up to 60% of the unearned, withheld funds, as further described below.

The DSRIP Performance Remediation Plan will include:

- As specified by the State, a detailed assessment of the reason(s) why:
  - The ACO did not or is not anticipated to achieve a 100% Quality Score, separately addressing State-specified measures on which the ACO scored less than full points; or
  - The ACO did not or is not anticipated to achieve a 100% TCOC Score; or
  - The ACO did not or is not anticipated to perform well on other quality, utilization, cost, or member experience metrics or analyses
- As specified by the State, discrete project(s) the ACO will undertake to address some or all of the reasons identified in the detailed assessment described above, along with rationale for why these activities are appropriate; or other discrete projects that align with the goals of the ACO's DSRIP Participation Plan
- A workplan, which includes a timeline for the implementation of these activities during a time period determined by the State, as well as identification of the resources that will be responsible for their completion
- An accountability plan for these activities, including any milestones or metrics the ACO anticipates and when the ACO anticipates realizing them, and also including a proposed model for the State to monitor the ACO's implementation of the proposed activities and their success or failure throughout the implementation time period (e.g., a schedule of site visits, staff interviews, desk reviews, etc.)

Within 45 calendar days of receiving the Performance Remediation Plan, the State and the Independent Assessor will review the Plan in parallel, and the State, considering the Independent Assessor's recommendation, will either request additional information regarding the Performance Remediation Plan, or approve it. During the State's review process, it will determine how much of the 60% of unearned, withheld funds the ACO will be able to earn back, based on the caliber and relevance of the Performance Remediation Plan to the goals of the ACO's DSRIP Participation Plan. The State will monitor the Plan during the implementation period on an ongoing basis. Additionally, the State will assign a Performance Remediation Plan Score to the ACO, based on the State's ongoing monitoring of the Plan, and supporting documentation submitted by the ACO in its semiannual progress report for the first half of the Budget

Period in question. The Performance Remediation Plan Score will be a single point value between 0 and 10 inclusive, and will determine how much of the ACO's unearned, withheld funds can be earned back.

For example, if (1) an ACO has \$100,000 of unearned, withheld funds; (2) the State determines that an ACO will be able to earn back 50% of the ACO's unearned, withheld funds (out of a 60% maximum percentage); and (3) the ACO achieves a Performance Remediation Plan Score of 7 out of 10, then the ACO's final earned funds will be equal to  $\$100,000 * 50% * (7 / 10) = \$35,000$ .

#### **5.3.4.3 The DSRIP Advisory Committee on Quality**

See Section 6.2.1 for discussion of the Advisory Committee on Quality's role.

### **5.3.5 Timeline of ACO DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments**

The timeline for ACO DSRIP Accountability Score calculation and disbursement of DSRIP payments to ACOs is anticipated to be as follows:

- ACO Budget Period Closes
- Member experience survey results 270 calendar days of BP closing
- State determines denominators and sample populations (i.e., the specific members whose data each ACO must submit) for the clinical quality measures within 210 calendar days of BP closing
- ACOs submit clinical quality data within 90 calendar days of receiving the denominators and sample populations for the clinical quality measures
- State calculates ACO DSRIP Accountability Score within 90 calendar days of receiving all underlying required data
- Once ACO DSRIP Accountability Scores have been calculated by the State, the State notifies ACOs of ACO DSRIP Accountability Score within 30 calendar days of determining Score
- State disburses DSRIP at-risk payments to ACOs within 30 calendar days of notification of their ACO DSRIP Accountability Scores

### **5.3.6 ACO Exit from the DSRIP Program**

Per STC 69(b)(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.

ACO exit from the DSRIP program is defined as termination of the contract between an ACO and MassHealth for reasons other than the following reasons:

- Material financial losses resulting from poor total cost of care performance, as determined by the State
- Reasons outside of the ACO's control, including but not limited to material changes to the Medicaid program, or material changes to the nature of the ACO's participation in MassHealth resulting from legislation or other developments, as determined by the State
- Transition to a different ACO model (e.g., the ACO Partner in an Accountable Care Partnership Plan is approved to become a Primary Care ACO)

#### **5.3.6.1 Other ACO Contract Terminations**

Under its MassHealth contract, an ACO may experience material financial loss, defined as a loss greater than 3% medical losses relative to risk-adjusted medical capitation for Partnership Plans, or relative to the

TCOC benchmark for Primary Care ACOs and MCO-Administered ACOs. If an ACO experiences material financial loss in one or more preceding Budget Periods and has a projected material financial loss in the current Budget Period, the contract between the ACO and MassHealth may be terminated and the ACO will be required to return DSRIP startup/ongoing and DSTI Glide Path funding in accordance with percentages established by the State.

If the ACO’s contract is terminated because the ACO, or in the case of an ACPP, the ACO Partner, is transitioning to a different ACO model, the State may waive the requirement that the ACO return DSRIP startup/ongoing and DSTI Glide Path funding to the State.

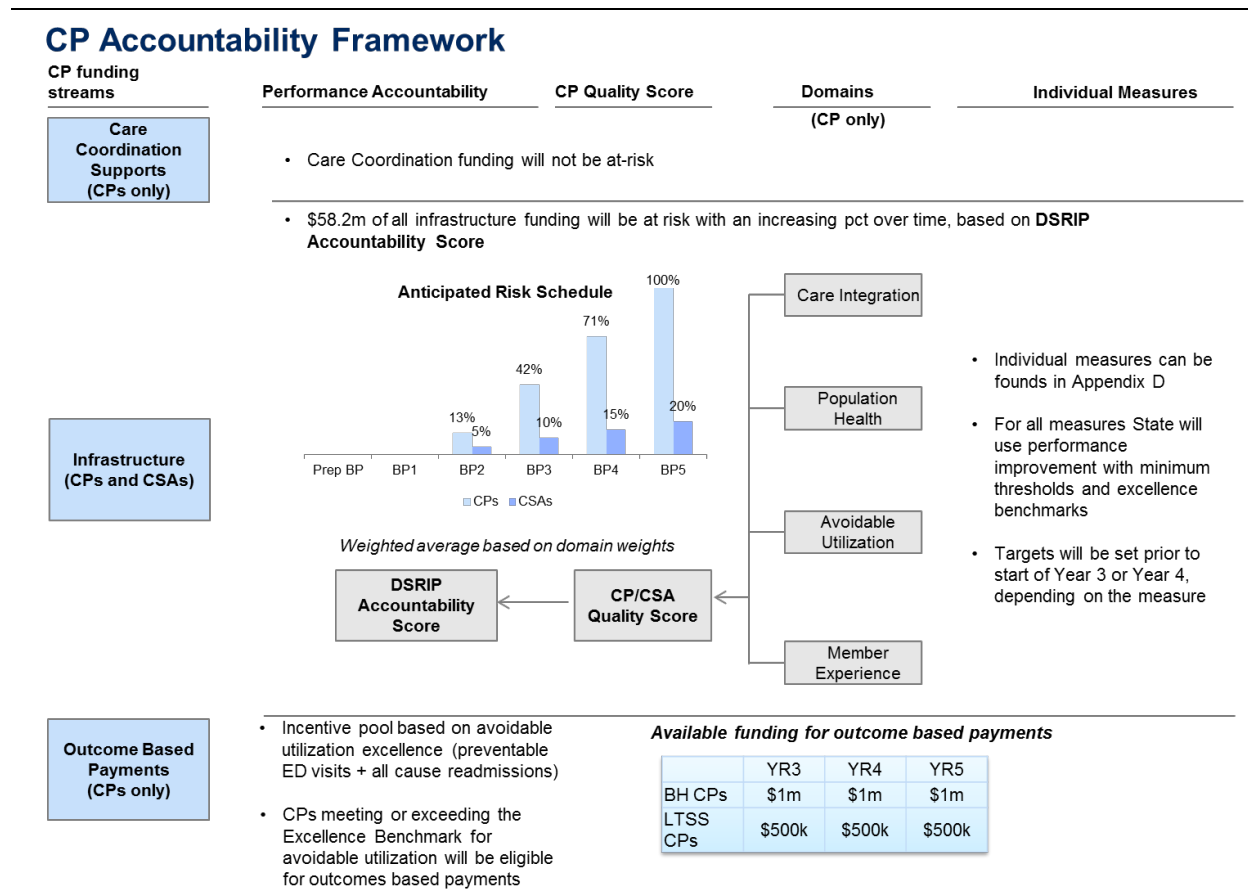
If the ACO’s contract is terminated and a portion of its practice sites join another ACO, then the State may reduce the amount of DSRIP startup/ongoing and DSTI Glide Path funding that the ACO is required to return to the State. In such cases, the State may reduce the required amount to be returned by the percentage of the ACO’s enrolled members attributed to the primary care practice sites joining another ACO.

## 5.4 Accountability Framework & Performance Based Payments for CPs and CSAs

### 5.4.1 Overview

As described in Section 4.5 above, payment streams for CPs and CSAs are subject to an accountability framework that aligns the CPs’ and CSAs’ incentives with the State’s delivery system reform goals. For CPs and CSAs, a portion of the Infrastructure funds will be at-risk based on performance.

EXHIBIT 42 – CP and CSA Accountability Framework





#### **5.4.2 Alignment of Quality Measure Slate with Overall Goals of the DSRIP program**

The quality measure slate was chosen to support the goals of the DSRIP program including promoting member-driven, integrated, coordinated care and improving integration among physical health, behavioral health, long-term services and supports, and health-related social services. In addition, the CP and CSA measure slate has many cross-cutting measures with the ACO measure slate thus aligning the ACOs with their CPs and with CSAs.

Appendix D contains the measures for the LTSS and BH CPs and CSAs, along with an indication as to whether the measure data will be collected via claims and encounters only or whether chart review will be utilized. Additionally, there is an indication of the expected “reporting” and/or “performance” role in the program by program year. Appendix D includes further details regarding the measures including measure descriptions, measure stewards, benchmark sources and reporting frequency.

In the event of a state of emergency declared by the federal or state government, due dates for quality-related benchmarks and rates that the State must submit to CMS shall be extended by at least two months, as determined by the State and CMS.

#### **5.4.3 Pay for Reporting vs. Pay for Performance**

As demonstrated in Appendix D, the State anticipates that most Quality Measures will transition from Pay for Reporting (P4R) to Pay for Performance (P4P) over the duration of the program. All CP measures in the first two performance years are Reporting or Pay for Reporting (P4R), with a subset transitioning to Pay for Performance (P4P) starting in Performance Year 3. All measures will transition to P4P by Performance Year 4. Given the unique needs and demographics of the member populations supported by the CPs and CSAs, there are challenges to utilizing nationally established benchmarks for performance that reflect the overall population. Therefore, the State will utilize the first two Performance Years of the demonstration to establish an appropriate baseline and achievement targets as described below for the quality measures. This will allow time for familiarization with the measures, data collection, reporting, as well as to provide baseline performance. This will also allow for two years of data to confirm, as needed:

- Numerator details
- Denominator details and exclusions
- Sampling methodology
- Sample size
- Data sources
- Measure reliability from year-to-year

#### **5.4.4 Calculating the CP/CSA DSRIP Accountability Score**

The State will measure performance using a state-calculated score called the CP/CSA DSRIP Accountability Score. The CP/CSA DSRIP Accountability Score is a value between zero (0) and one hundred (100), expressed as a percentage (i.e. between 0%-100%). This section details the State’s calculation of each CP’s and CSA’s CP/CSA DSRIP Accountability Score as follows:

- 5.4.4.1 Measure Scoring Methodology for All Measures
- 5.4.4.2 Calculating the Domain Score
- 5.4.4.3 Combining Domain Scores to Produce Quality Score
- 5.4.4.4 Comparing Quality Scores to Calculate the CP/CSA DSRIP Accountability Score

#### *5.4.4.1 Measure Scoring Methodology for All Measures*

CPs and CSAs will be accountable for all measures as indicated in Appendix D unless the CP or CSA does not meet eligibility requirements for a specific measure based on the measure's specifications (e.g., a minimum denominator required).

#### **Benchmark Determination**

Given that the CP population is defined by utilization criteria and therefore does not have national benchmarks, the State anticipates using historical CY2018 and/or CY2019 data to inform benchmarking determinations for all claims-based measures, and CY2018 through CY2020 data to inform benchmarking determinations for all member experience measures. For example, the BH CP population by definition will include high-risk members with significant behavioral health diagnoses in addition to high utilization. National benchmarks for a general Medicaid population will be difficult to use for this selected high risk population; accordingly, the State will need to develop state-specific benchmarks.

In addition to requiring standard MassHealth administrative data for calculation, many CP and CSA measures also require additional data types or inputs including Medicare administrative data, data from the submission of Qualifying Activities, hybrid data, and risk-adjusted data. Given the limitations associated with availability of those data and in recognition of time needed for processing and analysis, the State will propose Attainment Thresholds and Goal Benchmarks to CMS as follows (see Appendix D for reference):

- For all LTSS CP and BH CP measures that can be calculated from MassHealth administrative data alone, inclusive of measures requiring Qualifying Activities, thresholds and benchmarks will be submitted in Q4 CY2021.
- For BH CP claims-based measures that require Medicare data in addition to Medicaid data, thresholds and benchmarks will be submitted in Q4 CY2021.
- For the CSA hybrid measure, thresholds and benchmarks will be submitted by September 2020 based on data sampled from CY2019 performance.
- For the CSA member experience measures, thresholds and benchmarks will be submitted by September 2020.
- For the BH CP and LTSS CP member experience measures (member engagement and care planning submeasures), thresholds and benchmarks will be submitted by Q4 2021.
- For the BH CP and LTSS CP member experience measures (community tenure submeasure), thresholds and benchmarks will be submitted in Q4 CY2021.

All proposed benchmarks that the State submits will have been reviewed by the DSRIP Advisory Committee on Quality, and will be accompanied by individual rationales for each benchmark. CMS will provide written feedback on the proposed benchmarks and rationale within 90 calendar days. If CMS has not provided written feedback within 90 calendar days, then the benchmarks will be deemed approved, given the necessity of providing these benchmarks to CPs so that they have sufficient time to plan accordingly.

Benchmarks will be adjusted based on expert clinical judgment from the DSRIP Advisory Committee on Quality and the State, with approval by CMS. Attainment Thresholds will be reviewed yearly and may be adjusted by the State based on prior CP or CSA performance, in consultation with the DSRIP Advisory Committee for Quality, and CMS approval. If all CPs have high levels of achievement on a particular measure, that measure will be retired and a new one may be added. Goal Benchmarks will be reviewed yearly and set with respect to the CP performance from the prior year. This will properly reward maintenance of quality, while not overly penalizing CPs.

In response to the public health emergency declared by the state or federal government, the State will utilize CY2020 data to assess the appropriateness of CP benchmarks (informed by data prior to the start of the public health emergency) on measures in "Pay-for-Performance" status after the start of the public health

emergency. Data obtained from CY2020 may be utilized to adjust benchmarks for measures deemed impacted by the public health emergency (i.e., any measure demonstrating a statewide median decrease in performance from CY2019 to CY2020). Updated benchmarks will be proposed to CMS by Q2 CY2022 for approval and will be applied to impacted measures for CY2021.

CPs and CSAs will be assigned achievement points based on their performance on each Quality Measure. The Domain Score will be calculated as the average of the achievement points for all the Quality measures in a given Domain.

Each CP or CSA may receive up to a maximum of one (1) achievement point for each Quality Measure in a given Domain, as follows:

1. The State will establish an “Attainment Threshold” and an “Goal Benchmark” for each Quality Measure
  - a. “Attainment Threshold” sets the minimum level of performance at which the CP or CSA can earn achievement points
  - b. “Goal Benchmark” is a high performance standard above which the CP or CSA earns the maximum number of achievement points (i.e., 1 point)
2. The State will calculate each CP’s and CSA’s performance score on each Quality Measure based on the measure specifications which will be reviewed and approved by CMS (see Section 5.4.6.1). Each Quality Measure’s specifications will describe the detailed methodology by which this performance score is calculated
3. The State will award each CP or CSA between zero (0) and one (1) achievement point for each Quality Measure as follows:
  - a. If the CP’s or CSA’s performance score is less than the Attainment Threshold: 0 achievement points
  - b. If the CP’s or CSA’s performance score is greater than or equal to the Goal Benchmark: 1 achievement point
  - c. If the CP’s or CSA’s performance score is between the Attainment Threshold and Goal Benchmark: the CP or CSA receives a portion of the maximum 1 achievement point; this portion is proportional to the CP’s or CSA’s performance. The State will calculate the achievement point using the following formula:
    - i.  $1 * ((\text{Performance Score} - \text{Attainment Threshold}) / (\text{Goal Benchmark} - \text{Attainment Threshold}))$

Exhibit 43 below shows an example calculation of a CP’s achievement points for a Quality Measure.

**EXHIBIT 43 – Example Calculation of Achievement Points for Measure A**

**Measure A Attainment Threshold = 45%**

**Measure A Goal Benchmark = 80%**

Example Calculation of Achievement Points for Measure A	
Measure A Performance Score	Achievement Points Earned

Scenario 1	25%	0
Scenario 2	90%	1
Scenario 3	58%	0.37 *

\*Achievement points earned =  $1 * ((58\% - 45\%) / (80\% - 45\%)) = 0.37$  points

#### 5.4.4.2 Calculating the Domain Score

Each Quality Domain comprises several Quality Measures. For each CP or CSA, the State will calculate the average achievement points for all Quality Measures in each Quality Domain.

Exhibit 44 below shows an example calculation of a CP's or CSA's Domain Score for a Quality Domain.

EXHIBIT 44 – Example Calculation of CP or CSA Quality Domain Score

Example Calculation of a CP's or CSA's Domain Score for a Quality Domain				
Measures in Quality Domain	Attainment Threshold	Goal Benchmark	Performance Score	Achievement Points Earned
Measure A	45%	80%	58%	0.37
Measure B	40%	75%	60%	0.57
Measure C	41%	85%	79%	0.86
<b>Average Achievement Points Earned</b>				<b>0.60</b>

#### 5.4.4.3 Combining Domain Scores to Produce the Quality Score

A CP's or CSA's Quality Score will be a weighted average of scores the CP or CSA achieves on the different Domains for which it is accountable. The anticipated Domains and Domain weighting is different across BH CPs, LTSS CPs and CSAs, as set forth in the following Exhibits.

EXHIBIT 45 – Domain Weighting for BH CPs

BH CP Quality Domain Weights			
Quality Domain		Domain Weight BP 3	Domain Weight BP 4 - 5
1	Care Integration	45%	40%
2	Population Health	40%	35%
3	Avoidable Utilization	15%	10%
4	Member Experience	--	15%
<b>TOTAL</b>		<b>100%</b>	<b>100%</b>

See Appendix D for the full list of BH CP Quality Measures

EXHIBIT 46 – Domain Weighting for CSAs

CSA Quality Domain Weights		
Quality Domain	Domain Weight BP 3	Domain Weight BP 4 - 5

1	Care Integration	100%	50%
2	Member Experience	0%	50%
TOTAL		100%	100%

See Appendix D for the full list of CSA Quality Measures.

EXHIBIT 47 – Domain Weighting for LTSS CPs

LTSS CP Quality Domain Weights			
Quality Domain		Domain Weight BP 3	Domain Weight BP 4 - 5
1	Care Integration	52%	40%
2	Population Health	32%	25%
3	Avoidable Utilization	16%	15%
4	Member Experience	0%	20%
TOTAL		100%	100%

See Appendix D for the full list of LTSS CP Quality Measures

EXHIBIT 48 – Example Calculation of the Quality Score for a BH CP

Example Calculation of Total Quality Score			
Domain	Weighting	Average Attainment Score	Weighted Attainment Score
Care Integration	40%	0.51	40%*0.51= 20.4%
Population Health	35%	0.60	35%*0.60= 21.0%
Avoidable Utilization	10%	0.73	10%*.73= 7.3%
Member Experience	15%	0.88	15%*0.88= 13.2%
Total Quality Score			61.90%

*5.4.4.4 Comparing Quality Scores to Calculate the CP/CSA DSRIP Accountability Score in BP3*

This section clarifies the application of sections 5.4.4.2 and 5.4.4.3 to BP3 to address the impact of the state of emergency declared by the federal or state government.

**Achievement Points**

For each measure in pay-for-performance status in BP3 (as set forth in Appendix D), the State will decide whether to set the individual CPs/CSAs' BP3 measure performance rates to 1) the higher of the CPs/CSAs' BP3 or BP2 actual measure rates, or 2) the higher of the CPs/CSAs' BP2 actual rates or the statewide median rates (i.e., measure level median performance among all CPs/CSAs) in BP2.

If the State determines BP3 measure performance rates by comparing the individual CPs/CSAs' BP2 actual rates to BP3 actual rates, then CPs/CSAs earn achievement points following the scoring approach

set forth in Section 5.3.1.3. If the State determines BP3 measure performance rates by comparing individual CPs/CSAs' BP2 actual rates to the BP2 statewide median rates, then:

- For measures where a CP/CSA demonstrates a higher BP2 rate than the BP2 statewide median, the CP/CSA earns achievement points based on its own rate, following the scoring approach described in Section 5.4.4.1
- For measures where the statewide median demonstrates a higher rate than the CP/CSA's own rate, the CP/CSA earns achievement points based on the statewide median, following the scoring approach described in Section 5.4.4.1
- In order to prevent such cases where a CP/CSA's performance measure rate would improve excessively through the use of the statewide median, the number of raw (i.e., percentage) points a CP/CSA may earn when replacing a measure rate with that of the Statewide Median rate is capped at 15 raw points

EXHIBIT 49 - BP3 Measure Rate Calculation with Raw Point Cap = 15.0

Measure	BP2 CP/CSA Actual Rate	BP2 Statewide Median	Performance Rate Used For BP3	Raw Point Cap
A	73.0%	74.0%	74.0%	No
B	73.0%	70.0%	73.0%	No
C	73.0%	80.0%	80.0%	No
D	73.0%	89.0%	88.0%*	Yes

\*BP3 Rate 'capped' at 88.0% (i.e., 73.0% + maximum allowance of 15.0 raw points, using BP2 State Median)

Results from the 'Performance Rate Used For BP3' column are then compared to measure benchmarks for the calculation of Achievements Points (as outlined in Section 5.4.4.1)

**5.4.4.5 Comparing Quality Scores to Calculate the CP/CSA DSRIP Accountability Score**

For each Performance Period CPs and CSAs will be measured on their (1) Total Quality Score and on (2) Improvement Over Self from the previous Performance Period. For each Performance Period, the State will set a Minimum Quality Score Threshold and a Goal Quality Score Benchmark for LTSS CPs, for BH CPs and for CSAs. Improvement Over Self will be calculated as 50% of the CP's or CSA's improvement year over year in percentage points.

The CP/CSA DSRIP Accountability Score, therefore, will be the sum of the (1) Total Quality Score and the (2) Improvement Over Self contribution. CP/CSA DSRIP Accountability Scores will be calculated as follows:

- An entity with a Total Quality Score at or above the Goal Quality Score Benchmark will receive a DSRIP Accountability Score of 100% and be eligible for 100% of at-risk funds.
- An entity with a Total Quality Score below the Minimum Quality Score Threshold will receive a DSRIP Accountability Score for Total Quality of Zero and will be eligible for only that portion of at-risk funds equal to the Improvement Over Self contribution. The entity would receive a Quality Score equal to 50% of the Improvement Over Self percentage points.
- An entity with a Total Quality Score between the Minimum Quality Score Threshold and the Goal Quality Score Benchmark will receive a DSRIP Accountability Score = (Total Quality Score) +

(50% of the Improvement Over Self percentage points) and will be eligible for that proportion of the at-risk funds.

For example:

In a Performance Period in which, for BH CPs, the Minimum Quality Score Threshold is set at 45% and the Goal Quality Score Benchmark is set at 85%

- A BH CP with a Total Quality Score  $\geq 85\%$  has a DSRIP Accountability Score of 100% and is eligible for 100% of the at-risk funds
- A BH CP with a Total Quality Score  $< 45\%$  and with no improvement from the previous period has a DSRIP Accountability Score of 0% and is eligible only for improvement points. If a CP's Total Quality Score = 40% and a previous period Total Quality Score of 30%, then they would receive half of their Improvement Over Self percentage points, or  $50\% * 10\% = 5\%$  of at-risk DSRIP funds.
- A BH CP with a Quality Score of 75% and a previous period Quality Score of 65% has a DSRIP Accountability Score of 80% ( $75\% + 50\%$  of  $(75\% - 65\%)$ )

Budget Period 1 is reporting only and Budget Period 2 is reporting or pay-for-reporting as outlined in Appendix D. CPs and CSAs will be eligible for funds at risk in Budget Period 2 provided they comply with pay-for-reporting requirements. For example, if all required reporting elements are met (i.e., within minimum reporting standards set by the State), the entity will be eligible for 100% of the at-risk funds.

Should a new CP or CSA join the program, the new CP's or CSA's first Budget Period will be used to establish baseline data for relevant Quality Measures. Should significant numbers (e.g., 10% increase in members) of new CPs or CSAs join the program, achievement targets may need to be re-calculated. The State will submit any such modification requests as described below in Section 5.4.6.1.

#### **5.4.5 Outcomes Based Payments**

Beginning in Performance Year 3, the State will establish an annual outcomes-based payment pool for both the BH and LTSS CPs. Any CP equaling or exceeding the Goal Benchmark for either of the two measures in the Avoidable Utilization domain in a given Budget Period will be eligible for outcomes-based payments for that Budget Period. Further, each of the two measures within the Avoidable Utilization domain will correspond to 50% of available funds within the outcomes-based payment pools for the BH CP and LTSS CP programs. For example, a BH CP that equals or exceeds the Goal Benchmark for an Avoidable Utilization measure will be eligible to share in the 50% of available funds within the BH CP outcomes-based payment pool for a specific Budget Period.

Each eligible CP will receive a portion of the outcomes-based payment pool based on the total number of eligible CPs. For example, if the total number of CPs that equal or exceed the Goal Benchmark for a measure within the Avoidable Utilization domain is 3, then each CP would receive 33.3% of the 50% of available funds within the outcomes-based payment pool corresponding to that measure.

#### **5.4.6 Process for calculating CP/CSA DSRIP Accountability Scores**

##### **5.4.6.1 Roles and responsibilities**

The State will be responsible for establishing the elements that comprise the calculating CP/CSA DSRIP Accountability Scores, including its Quality Measures, the specifications for each Quality Measure, the data sources for calculating the Quality Measures, the methodology for setting the Attainment Threshold and Goal Benchmark for each Quality Measure (where applicable), and the values of the thresholds and benchmarks themselves. The State will also establish the Minimum Quality Score Threshold and the Goal Quality Score Benchmark used to calculate the CP/CSA DSRIP Accountability Score. This sub-section

5.4.6.1 details the roles and responsibilities of the State, the State’s DSRIP Advisory Committee, and CMS with respect to establishing these elements.

#### The State

The State will establish the elements that comprise the CP and CSA DSRIP Accountability Score, based on the advice of the DSRIP Advisory Committee on Quality (see Section 6.2.1). The State will submit the Quality Measure slate and specifications to CMS for review and approval by November 2017.

Given that the State will be using the first two Budget Periods to gather baseline data to inform performance target setting beginning in BP3 (i.e. CY 2020), it will not have finalized data to calculate the BP3-BP5 targets until after the start of BP3. As such, the State will submit benchmark sources and preliminary performance thresholds (i.e., Attainment Thresholds and Goal Benchmarks) to CMS for review and approval in Q4 CY2021 (see Appendix D for reference). CMS will have 90 calendar days to review and approve. Once the State has processed the BP2 data, in November 2020, it will submit finalized performance targets based on both BP1 and BP2 data to CMS for review and approval. CMS will have 90 calendar days to review and approve.

The State may request modification to any element that comprises the CP/CSA DSRIP Accountability Score, based on its own assessment or on the recommendation of the State’s DSRIP Advisory Committee on Quality. In the event that the State wishes to change a previously approved element that is a component of the CP/CSA DSRIP Accountability Score, the State will submit a formal, written modification request to CMS for review and approval. CMS will have 90 calendar days to review and approve.

As part of its program management and contract oversight processes, the State will establish a structured process for CPs and CSAs to seek clarification on or request revisions to certain aspects of their CP/CSA DSRIP Accountability Scores (e.g., if a CP seeks clarification on the inclusion of certain members in the denominator for a Quality Measure’s performance score). Each CP and CSA will identify a key contact, responsible for raising such issues to the State and working with the appropriate State personnel to discuss and resolve issues as appropriate. The State will also identify a reciprocal contact to liaise with each CP and CSA and support these types of requests.

The State may provide an opportunity for CPs or CSAs to submit DSRIP Performance Remediation Plans to earn back a portion of the unearned, withheld funds, at the State’s discretion. The State may combine remediation opportunities for multiple years to streamline processes (e.g., combining BP2 and BP3 remediation processes into a single remediation process). If the State allows this opportunity, then a CP or CSA may choose to provide the State a DSRIP Performance Remediation Plan within 30 calendar days of receipt of the State’s notification of the opportunity to submit a Performance Remediation Plan, in which case the CP or CSA may have the opportunity to earn back up to 60% of the unearned, withheld funds, as further described below.

The DSRIP Performance Remediation Plan will include:

- As specified by the State, a detailed assessment of the reason(s) why:
  - The CP or CSA did not or is not anticipated to achieve a 100% Accountability Score, separately addressing State-specified measures on which the CP or CSA scored less than full points; or
  - The CP or CSA did not or is not anticipated to perform well on other quality, utilization, cost, or member experience metrics or analyses
- As specified by the State, discrete project(s) the CP or CSA will undertake to address some or all of the reasons identified in the detailed assessment described above, along with rationale for why these activities are appropriate; or other discrete projects that align with the goals of the CP or CSA’s DSRIP Participation Plan



- A workplan, which includes a timeline for the implementation of these activities during a time period determined by the State, as well as identification of the resources that will be responsible for their completion
- An accountability plan for these activities, including any milestones or metrics the CP or CSA anticipates and when the CP or CSA anticipates realizing them, and also including a proposed model for the State to monitor the CP or CSA implementation of the proposed activities and their success or failure throughout implementation time period (e.g., a schedule of site visits, staff interviews, desk reviews, etc.)

Within 45 calendar days of receiving the Performance Remediation Plan, the State and the Independent Assessor will review the Plan in parallel, and the State, considering the Independent Assessor recommendation, will either request additional information regarding the Performance Remediation Plan, or approve it. During the State's review process, it will determine how much of the 60% of unearned, withheld funds the CP or CSA will be able to earn back, based on the caliber and relevance of the Performance Remediation Plan to the goals of the CP or CSA's DSRIP Participation Plan. The State will monitor the Plan during the implementation period on an ongoing basis. Additionally, the State will assign a Performance Remediation Plan Score to the CP or CSA, based on the State's ongoing monitoring of the Plan, and supporting documentation submitted by the CP or CSA in its semiannual progress report for the first half of the Budget Period in question. The Performance Remediation Plan Score will be a single point value between 0 and 10 inclusive, and will determine how much of the CP or CSA's unearned, withheld funds can be earned back.

For example, if (1) a CP or CSA has \$100,000 of unearned, withheld funds; (2) the State determines that a CP or CSA will be able to earn back 50% of the CP or CSA's unearned, withheld funds (out of a 60% maximum percentage); and (3) the CP or CSA achieves a Performance Remediation Plan Score of 7 out of 10, then the CP or CSA's final earned funds will be equal to  $\$100,000 * 50% * (7 / 10) = \$35,000$ .

#### The DSRIP Advisory Committee on Quality

See Section 6.2.1 for discussion of the Advisory Committee on Quality's role.

#### **5.4.7 Timeline of CP DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments**

The timeline for CP DSRIP Accountability Score calculation and disbursement of DSRIP payments to CPs is anticipated to be as follows:

- CP and CSA Budget Period Closes
- Member experience survey results within 270 calendar days of BP closing
- State determines denominators and sample populations (i.e., the specific members whose data each CP must submit) for the clinical quality measures within 210 calendar days of BP closing
- CPs and CSAs submit clinical quality data within 30 calendar days of receiving the denominators and sample populations for the clinical quality measures
- State calculates CP and CSA DSRIP Accountability Score within 120 calendar days of receiving all underlying required data
- Once CP and CSA DSRIP Accountability Scores have been calculated by the State, the State notifies CPs and CSAs of CP and CSA DSRIP Accountability Score within 30 calendar days of determining Score
- State disburses DSRIP at-risk payments to CPs and CSAs within 30 calendar days of notification of their CP and CSA DSRIP Accountability Scores

## 5.5 Reporting Requirements for ACOs, CPs and CSAs

### 5.5.1 Semiannual Participation Plan Progress Reports

ACOs, CPs, and CSAs participating in the DSRIP program will submit semiannual reports to the State demonstrating progress with their Participation Plans, plans for continued implementation of the approved Participation Plan, areas for improvement and an account of budget expenditures. The State will provide templates for the semiannual progress report which will specify the data that ACOs, CPs and CSAs will need to submit. ACOs, CPs and CSAs must submit their semiannual progress reports in order to receive further DSRIP funding. For example, if an ACO, CP or CSA submits a semiannual progress report three months after the end of BP2, then it will be able to receive DSRIP payments from three months after the end of BP2 until the next required semiannual progress report submission date (i.e. two months after the midway point of BP3).

ACO semiannual progress reports will be submitted in a form and format prescribed by the State, and may include information such as:

- The ACO's progress toward implementation of the Participation Plan
- The progress and status of specific investments and programs supported by DSRIP funds, including any findings from or modifications to these investments and programs
- Descriptions of recent activities and accomplishments
- Descriptions of upcoming activities and challenges
- Budget expenditures for all DSRIP funding
- If relevant, supporting documentation for a DSRIP Performance Remediation Plan
- Additional information as requested by EOHHS.

As noted above, ACOs will submit progress reports twice annually. The Progress Report 1 will be due two months after the midway point of a given BP and Progress Report 2 will be due three months following the close of the Budget Period. The below provides the timeline for submission of such reports for the Preparation Budget Period as well as Budget Period 1. Budget Periods 2-5 will follow the same pattern as Budget Period 1, adjusted for the respective years.

- **Preparation Budget Period Progress Report:** This report is due no later than **March 31, 2018** and shall include the information detailed above for the **Preparation Budget Period (July 1 – December 31, 2017)**
- **BP1 Progress Report 1:** This report is due no later than **August 31, 2018** and shall include the information detailed above for the period of **January 1 - June 30, 2018**
- **BP1 Progress Report 2:** This report is due no later than **March 31, 2019** and shall include the information detailed above for the period of **January 1 - December 31, 2018**

The content for ACO Progress Reports 1 and 2 for a given Budget Period may differ, as Progress Report 2 provides detailed information about the entire Budget Period, whereas Progress Report 1 only covers the first half of the Budget Period. In the event of a state of emergency declared by the federal or state government, due dates for reports shall be extended by at least a month, as determined by the State.

For CPs and CSAs, semiannual progress reports will be submitted in a form and format prescribed by the State, and may include:

- Descriptions of successes, barriers, challenges, and lessons learned regarding, at a minimum, outreach, care coordination, and integration of care
- Summary of CP care coordination supports activities
- Budget expenditures for all DSRIP funding
- Supporting documentation for DSRIP Performance Enhancement Plans (if relevant)
- Additional information as requested by EOHHS

The below provides the timelines for submission of such reports for the CPs/CSAs Preparation Budget Period as well as Budget Periods 1 and 2. Budget periods 3-5 will follow the same pattern as Budget Period 2 adjusted for the respective year

- **Preparation Budget Period Progress Report:** This report is due no later than **August 31, 2018** and shall include the information detailed above for the **Preparation Budget Period (October November 2017 – May 31, 2018)**
- **BP1 Progress Report 2:** This report is due no later than **March 31, 2019** and shall include the information detailed above for the period of **June 1, 2018 – December 31, 2018**
- **BP2 Progress Report 1:** This report is due no later than **August 31, 2019** and shall include the information detailed above for the period of **January 1 - June 30, 2019**
- **BP2 Progress Report 2:** This report is due no later than **March 31, 2020** and shall include the information detailed above for the period of **January 1 - December 31, 2019**

The content for CP or CSA Progress Reports 1 and 2 for a given Budget Period may differ, as Progress Report 2 provides detailed information about the entire Budget Period, whereas Progress Report 1 only covers the first half of the Budget Period. In the event of a state of emergency declared by the federal or state government, due dates for reports shall be extended by at least a month, as determined by the State.

### 5.5.2 Review and Approval of Semiannual Progress Reports

The State and the Independent Assessor will review the semiannual progress reports (see Section 6.2.2 for details). The State and the Independent Assessor will have a total of 45 calendar days to review and approve the report, or request additional information regarding the information reported. All approved semiannual progress reports will be sent to CMS.

### 5.5.3 Additional Reporting Requirements

ACOs, CPs, and CSAs must annually submit clinical quality data to the State for quality evaluation purposes. For example, as noted in Appendix D, the State has proposed three types of quality measures. The first type is solely based on claims or administrative data and will be calculated by the State with no further input (other than claims previously submitted) from the ACO/CP/CSA. The second type of quality measure is based on patient experience survey data, and will be collected by a state-procured survey vendor. The third type of quality measure will require both claims information and clinical (e.g. blood pressure) or administrative (e.g. completion of an assessment) information not available through claims. The State will produce the denominators for quality measures based on claims or other information and then submit the denominator to the ACO, CP, or CSA for completion of the numerator information. The State will then receive the numerator information from the ACOs, CPs, or CSAs and calculate performance. The State will conduct audits of the clinical quality data submitted by ACOs, CPs, and CSAs to ensure that the data are accurate.

Additionally, ACOs will need to submit their ACO revenue payer mix for safety net categorization purposes. CPs will need to submit to the State their roster of engaged members. All entities will also be responsible for ad hoc reporting as requested by the State.

## **Section 6. State Operations, Implementation, Governance, Oversight and Reporting**

The State will utilize the small portion of DSRIP funding allocated to the State Operations and Implementation to support robust operations, implementation, governance and oversight of the DSRIP program. These state expenditures associated with implementation of the DSRIP program will be claimed as administrative costs on the CMS 64. Appendix C provides additional detail on anticipated personnel, fringe and contractual costs.

### **6.1 Internal Operations and Implementation**

The State will use a robust internal implementation team to ensure the DSRIP program towards its goals as outlined in STC 60. The team will include, but not be limited to:

- ACO program and contract management team
- CP program and contract management team
- Statewide Investments program and contract management team
- MassHealth operations team

The State will develop an internal steering committee that will make recommendations to the Assistant Secretary for MassHealth on policy and programmatic decisions related to the DSRIP program. This steering committee will include representation from several MassHealth teams involved in the design and implementation of the DSRIP program.

Committee members will meet regularly and will solicit feedback from the DSRIP Advisory Committee on Quality and other stakeholders as needed. While the steering committee will provide timely information and consultation, ultimate decision-making power rests with the Assistant Secretary for MassHealth.

### **6.2 Advisory Functions**

#### **6.2.1 DSRIP Advisory Committee on Quality**

The State will establish a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities as set forth in STC 75.<sup>2</sup> 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. The Committee will be made up of:

- Representatives from community health centers serving the Medicaid population
- Clinical experts in behavioral health, substance use disorder and long term services and supports. Clinical experts are physicians, physician assistants, nurse practitioners, licensed clinical social workers, licensed mental health counselors, psychologists, or registered nurses who satisfy two or more of the following criteria:

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<sup>2</sup> Note STC 75 called the Committee the “DSRIP Advisory Committee.” State has decided to re-name it as the “DSRIP Advisory Committee on Quality” for clarification purposes.

- Five years of patient care in the relevant area of expertise
- Experience managing clinical programs focused on the relevant patient populations
- Service on national or statewide advisory committees or panels for relevant topic areas
- 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

At least 30% of 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, at managed care plans, at health systems, or from companies providing quality measurement services to above listed provider types and managed care plans.

To minimize risk of conflicts of interest, no more than three members may be directly employed by Massachusetts hospitals, MassHealth ACOs, or Community Partners. To further minimize conflicts of interest, no CEO, CFO, COO, or CMO of a Massachusetts hospital, MassHealth ACO, or Community Partners will be appointed to the Committee. Additionally, any members whose affiliated organizations have financial interests in performance target setting for quality measures must recuse themselves when the Committee is discussing performance target setting. Finally, potential conflicts of interest will be considered when selecting Committee members to try to minimize such conflicts.

### **6.2.2 Independent Assessor**

The State will identify an Independent Assessor with expertise in delivery system improvement to assist with DSRIP administration, oversight, and monitoring as set forth in STC 74. The Independent Assessor will provide an added, ongoing layer of review and monitoring. The State and the Independent Assessor will concurrently review ACOs', CPs', and CSAs' Full Participation Plans, Budgets, Budget Narratives, and Semi-Annual Progress Reports to ensure compliance with the STCs and DSRIP Protocol. Preliminary ACO and CP Participation Plans and the Budgets and Budget Narratives for the Preparation Budget Period will not be subject to review by the Independent Assessor. The Independent Assessor shall make recommendations to the State regarding approvals, denials or recommended changes to Participation Plans, Budgets, Budget Narratives, and Semi-Annual Progress Reports, but final decision-making authority regarding all approvals, denials or requests for modifications rests with the State. However, the State will carefully consider the Independent Assessor's recommendations. The State has the authority to change Independent Assessors at the State's discretion.

Additionally, the Independent Assessor shall perform a midpoint assessment, which will systematically assess the performance of key demonstration entities, including identification of specific challenges and actionable mitigation strategies for mid-course correction for the State's consideration. Specifically, the midpoint assessment will focus on ACO and CP implementation of their DSRIP Participation Plans, Budgets, and Budget Narratives, as well as key vendors procured by the State for the purposes of developing and implementing the Statewide Investments. The midpoint assessment report shall cover implementation activities from July 1, 2017 through December 31, 2019, and the midpoint assessment report will be submitted to CMS by the end of September 2020. Notwithstanding STC 74, in the event of a state of emergency declared by the federal or state government, the midpoint assessment due date shall be extended by at least two months, as mutually agreed upon by CMS and the State. The State may focus on issues identified in the midpoint assessment and may implement changes where necessary.

In contrast, the Independent Evaluator is charged with reviewing the DSRIP program as a whole (see Section 6.4). At the midpoint and conclusion of DSRIP, the Evaluator will undertake an interim and summative evaluation, respectively, which will seek to determine the effectiveness of the DSRIP program in relationship to its goals. To accomplish such reviews, the Evaluator will use a quantitative and qualitative approach. These reviews may include evaluating the work of the Independent Assessor.

## **6.3 Stakeholder Engagement**

### **6.3.1 Independent Consumer Support Program**

The State will create Independent Consumer Support Program to assist beneficiaries in understanding their coverage models and in the resolution of problems regarding services, coverage, access, and rights. The Independent Consumer Support Program will assist beneficiaries to navigate and access covered services in accordance with STC 65.

### **6.3.2 State Public Outreach for ACO Program**

The State aims to facilitate a seamless transition to the new care model for MCO and ACO enrollees and will do so through the State Public Outreach for ACO Program in accordance with STC 72.

### **6.3.3 State Reporting to External Stakeholders and Stakeholder Engagement**

The State will compile public-facing annual reports of ACO, CP, and statewide investments performance. The report will provide relevant information on the State's progress under the DSRIP program, as determined by the State. Annual public meetings will be held to engage stakeholders on the DSRIP program at large, and allow for discussion, comments, and questions. MassHealth will also post information related to the DSRIP program online. The public will be encouraged to contact MassHealth to provide comments and feedback throughout the Demonstration through a dedicated e-mail address.

## **6.4 Evaluation of the Demonstration**

The State will procure an Independent Evaluator to conduct interim and final evaluations of the DSRIP program per STC 73. The State may utilize the same Independent Evaluator for the Demonstration under STC 87 as it does for the DSRIP program under STC 73.

### **6.4.1 Requirements for Interim Evaluation**

The Independent Evaluator will conduct an interim evaluation of the DSRIP program, in accordance with STC 73(a). The interim evaluation will evaluate the program using quantitative and qualitative methods to determine whether the investments made through the DSRIP program are contributing to achieving the demonstration goals as described in STC 60. The Independent Evaluator may use the data and results from the midpoint assessment to inform the interim and final evaluations.

The DSRIP interim evaluation will cover the time period July 2017 to December 2020, and will be submitted to CMS by the end of June 2021. Notwithstanding STC 73, in the event of a state of emergency declared by the federal or state government, due dates for the interim evaluation report shall be extended by at least a month, as mutually agreed upon by CMS and the State. The DSRIP interim evaluation will be a separate section in the overall waiver interim evaluation. The State will provide the draft evaluation design of the overall waiver (including proposals for evaluation of the DSRIP program) to CMS by June 30, 2018.

### **6.4.2 Final Evaluation**

In contrast to the interim evaluation, 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 contributed to achieving the demonstration goals as described in STC 60. The Independent Evaluator will also be responsible for completing the final evaluation of the DSRIP program in accordance with STCs 73(b) and 88(f). The final evaluation of DSRIP will be a component of the Summative Evaluation submitted to CMS as per the timeline in STC 88(f).

## 6.5 CMS Oversight

### 6.5.1 State Reporting to CMS

The State will compile quarterly and annual reports to submit to CMS consistent with sections IX and X of the approved STCs as part of the broader 1115 demonstration reports. These reports will include an account of all DSRIP payments made in the quarter or year, respectively and include insights and updates from the progress reports collected from ACOs, CPs, and CSAs. The State and CMS will agree upon a reporting template for quarterly and annual reports by the start of the demonstration for the quarterly report and by December 2017 for the annual report. The State and CMS will also use a portion of the Monthly Monitoring Calls for March, June, September, and December of each year for an update and discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.

### 6.5.2 Process for Review, Approval, and Modification of Protocol

The State will work collaboratively with CMS for the review and approval of the DSRIP Protocol. As set forth in STC 61(c), the State may modify the DSRIP Protocol over time, with CMS approval. Reasons for modification may include but are not limited to:

- State decision to change programmatic features that are codified in the Protocol (e.g. change the structure of the outcomes-based payment funding stream for CPs)
- State decision to modify State Accountability Targets during the demonstration period, if the targets are no longer appropriate, or that targets were greatly exceeded or underachieved

State will submit the modification request to CMS, which will have 90 calendar days to review and approve. If CMS does not approve the Protocol, the State and CMS will work collaboratively together to align on appropriate modifications and a timeline for prompt approval.

## Appendix A: Description of ACOs and CPs

### Accountable Care Organizations

To achieve Massachusetts' DSRIP goals as described above, the State is transitioning a significant portion of the delivery system from a fragmented, fee-for-service model to one where providers come together in new partnerships to take financial accountability for the cost and quality of care for populations of members. Massachusetts is launching a new Accountable Care Organization program, has designed three ACO payment models that respond to the diversity of the state's delivery system, and intends to select ACOs across all three models through a competitive procurement.

ACO contracts will have an initial term of five-years and will include significant requirements for ACOs to ensure care delivery in line with the state's delivery system goals, including but not limited to requirements to screen members and connect them to appropriate settings of care; requirements to proactively identify at-risk members, complete comprehensive assessments, and provide them with appropriate care management activities; and requirements to work with Community Partners to integrate behavioral health, LTSS, and medical care. Massachusetts' three ACO models are described in Section 1.

### Procurement Process

Massachusetts intends to select ACOs across all three ACO models as part of a single, competitive procurement. Bidders may bid on more than one model, but a bidder may be selected for, at maximum, one ACO model. The State may re-open the procurement at any time if, in the State's determination, the State has not received sufficient responses, or to otherwise meet the State's delivery system goals.

Bidders will submit responses to the State's procurement by the deadline, after which the responses will be evaluated by the State. The State will select successful ACO bidders to enter into contract negotiation. Through contract negotiation, the State intends to reach successful contract execution with a set of ACOs; although not all ACOs selected for negotiation may ultimately execute contracts with the State (e.g., if an ACO ultimately chooses not to accept final contract terms or rates). The graphic below shows an example process flow:

*Example process flow for procurement: for illustration purposes only:*



The State's current anticipated procurement timeline is as follows:

- Request for responses was posted in September 2016
- Bidders' responses are due mid-February 2017
- Target contract execution in August 2017
- Contracts will be effective the date they are executed, and will have an operational start date (i.e., the date on which members can enroll in ACOs) in December 2017



Further information on the ACO procurement can be found online at the State's public procurement website, [www.commbuys.com](http://www.commbuys.com).

## Community Partners

Community Partners will support members with complex BH and LTSS needs, in coordination with ACOs and other managed care entities, as determined by the State. The focus populations of MassHealth members for the CP program may include, for example, (1) members with diagnoses of serious mental illness and/or substance use disorder who have significant utilization of acute services such as ER visits, inpatient stays, detoxification stays, medication assisted treatment for SUD or co-occurring chronic medical conditions; and/or (2) members with claims for MassHealth State Plan LTSS of more than \$300 per month over at least 3 consecutive months.

MassHealth will selectively procure the following two types of CPs, BH CPs and LTSS CPs (see Sections 1 and 4.3 for additional descriptions of the CP Models).

- **BH CP Model overview:** MCOs and ACOs will delegate comprehensive care management responsibility to the BH CP for enrollees of the BH CP with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD). BH CPs will be required to coordinate care across the full healthcare continuum, including physical and behavioral health, LTSS and social service needs. Because BH CPs will be expected to have experience supporting members with LTSS needs, members with both complex BH and LTSS needs as assigned to a BH CP. BH CPs will be required to meet certain training obligations (e.g., training in person-centered planning, cultural competency, accessibility and accommodations, independent living and recovery principles, motivational interviewing, conflicts of interest and health and wellness principles) and coordination requirements (e.g., providing enrollees with at least two choices of LTSS service providers, assisting the member in navigating and accessing needed LTSS and LTSS-related services, identifying LTSS providers that serve or might serve the member, and coordinating and facilitate communication with LTSS providers) to ensure their capability to support members with both complex BH and LTSS needs.
- **LTSS CP Model overview:** ACOs and MCOs will conduct comprehensive assessments, convene the care teams, and provide care planning and coordination for physical and behavioral health services to enrollees assigned to a LTSS CP. The LTSS CP will review the comprehensive assessment results with the LTSS CP assigned members as part of the person-centered LTSS care planning process and will inform the member about his or her options for specific LTSS services, programs and providers that may meet the member's identified LTSS needs. The LTSS CP is expected to be an integral part of the member's care team, as requested by the member. LTSS CPs may also have the opportunity to participate in an enhanced supports model (anticipated to begin in year 2), where responsibility for the comprehensive assessment and care management will be delegated by the ACO/MCO to the LTSS CP.

CPs will not be able to authorize services for members under either model.

## Procurement Process

MassHealth intends to select BH and LTSS CPs across the State through a competitive procurement. ACOs (and other managed care entities as determined by the state) will be required to partner with CPs in all the regions or services areas in which the ACO operates.

Bidders will submit responses to the State's procurement by the deadline, after which the responses will be evaluated by the State. The State will consider any bid submitted by any entity that meets the minimum bidder qualifications of the procurement. The State will select successful CP bidders to enter into contract

negotiation. Through contract negotiation, the State intends to reach successful contract execution with a set of CPs; although not all CPs selected for negotiation may ultimately execute contracts with the State (e.g., if an CP ultimately chooses not to accept final contract terms or rates). The graphic below shows an example process flow:

*Example process flow for procurement: for illustration purposes only:*



The State’s current anticipated procurement timeline is as follows:

- Request for responses will be posted in February/March 2017
- CP responses are due end of May 2017
- Target contract execution in November 2017
- Contracting between CPs and ACOs & MCOs is targeted to be completed by January-February 2018
- CPs begin enrolling members in June 2018

Further information on the CP procurement can be found online at the State’s public procurement website, [www.commbuys.com](http://www.commbuys.com).

### **Relationships between ACOs and CPs**

Massachusetts has established a framework for ACOs and CPs to form and formalize their relationships. This framework is set forth in the model contracts for ACOs, and Massachusetts intends to similarly incorporate this framework in its model contracts for CPs. The framework delineates areas of delegated and shared responsibility between ACOs and CPs, as follows:

#### **Delegated responsibility to BH CPs**

ACOs must maintain agreements with BH CPs. These agreements will require the BH CP to support the ACO’s care coordination and care management responsibilities, including:

- Working together to improve coordination and integration of BH services and expertise into care, including activities such as but not limited to:
  - Identifying BH providers that serve or might serve enrollees, and coordinating between the ACO and those providers
  - Assisting the ACO’s members to navigate to and access BH and related services
  - Facilitating communication between members and providers

- Coordinating with staff in state agencies that are involved in member care
- Facilitating members' access to peer support services
- Working together to perform outreach and enrollment for members who are eligible for BH CPs
- Providing care management to BH CP-enrolled members, including designated care coordinators/clinical care managers, documented treatment plans, comprehensive transition management, health promotion, and other activities
- Collaborating and establishing mutual policies and procedures to ensure alignment, information sharing, appropriate sign-off, issue resolution, and communication
- Performance measurement and management, including the ACO and CP working together to evaluate performance on key process measures (e.g., outreach and enrollment) and outcome measures (e.g., the state's accountability score measures)

**Delegated responsibility to LTSS CPs**

ACOs must maintain agreements with LTSS CPs. These agreements will require the LTSS CP to support the ACO's care coordination and care management responsibilities, including:

- Working together to improve coordination and integration of LTSS and expertise into physical and behavioral health care, including activities such as but not limited to:
  - Identifying LTSS providers that serve or might serve enrollees, and coordinating between the ACO and those providers
  - Assisting the ACO's members to navigate to and access LTSS and related services
  - Facilitating communication between members and providers
  - Coordinating with staff in state agencies that are involved in member care
  - Providing support during transitions of care for the ACO's members
- Providing information and navigation to LTSS for the ACO's members
- Collaborating and establishing mutual policies and procedures to ensure alignment, information sharing, appropriate sign-off, issue resolution, and communication
- Performance measurement and management, including the ACO and CP working together to evaluate performance on key process measures (e.g., outreach and enrollment) and outcome measures (e.g., the state's accountability score measures)

Exhibit A1 below details the entities performing the comprehensive assessment, care planning and service authorization functions related to LTSS and the target populations for such functions.

**Exhibit A1: LTSS Comprehensive Assessment, Care Planning and Service Authorization**

Activity	Entity Performing Activity	Population
Care Needs Screening	ACO or MCO	ACO and MCO enrollees

<b>Comprehensive Assessment</b>	ACO or MCO	ACO and MCO enrollees assigned to a LTSS CP or with LTSS needs as specified by EOHHS
<b>LTSS segment of Care Planning</b>	ACO or MCO	ACO and MCO enrollees with LTSS needs as specified by EOHHS who are not assigned to LTSS CPs
	LTSS CP	ACO and MCO enrollees assigned to a LTSS CP
<b>Service Authorization</b>	<i>Before LTSS becomes covered services and included in TCOC:</i>	
	MassHealth	ACOs and MCOs enrollees, including LTSS CP engaged enrollees
	<i>After LTSS become covered services and are included in TCOC (~year 3):</i>	
	Accountable Care Partnership Plan	Accountable Care Partnership Plan enrollees, including LTSS CP engaged enrollees
	MCO	MCO-Administered ACO and MCO enrollees, including LTSS CP engaged enrollees
	MassHealth	Primary Care ACO enrollees, including LTSS CP engaged enrollees

### Shared responsibility between ACOs and CPs

Agreements will codify responsibilities of ACOs and CPs and describe additional requirements, including:

- Member assignment to a CP (as applicable)
- Care team roles and participation
- Performance expectations and any associated financial arrangements (beyond DSRIP)
- Shared decision-making and governance
- IT systems and data exchange, including quality and cost reporting

Beyond delineation of roles and responsibilities, contracts between ACOs, CPs, and MCOs must include conflict resolution protocols to handle disputes between the relevant parties. As ACOs and MCOs will not be paying CPs for services provided, a substantial portion of disputes will likely center around member referrals and care plans. If the member believes that the care he or she is receiving is unacceptable, the member will have access to formal grievance processes through the ACO, MCO, and CP entities. Additionally, the member can contact MassHealth’s Ombudsman Patient Protection Program, which is established to explicitly help members work through such issues. Throughout Year 1, the State will monitor disputes as they arise, and at year conclusion, will determine if further conflict resolution protocols are needed.

## Appendix B: Description of Statewide Investments Initiatives

### Student Loan Repayment

The student loan repayment program will repay a portion of a student's loan in exchange for at least an 18 month commitment (or equivalent in part time service) to work as a (1) primary care provider at a community health center or (2) behavioral health professional (e.g., Community Health Worker (CHW), Peer Specialist, Recovery Support Specialist, or Licensed Clinical social worker) in a community setting (e.g., community health center, community mental health center) and/or at an Emergency Service Program (ESP), and/or at any entity participating in a CP or CSA. This program hopes to reduce the shortage of providers and incentivize them to remain in the field long-term. Additionally, increased numbers of providers available to ESPs will help support diversionary strategies to reduce Emergency Department utilization and increase appropriate member placement in other settings.

#### Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the impact of the student loan repayment program on their practice and institutions. Awardees' accountability will be ensured through primary care providers' and behavioral health professionals' attestations that they have remained in the required placement for a minimum of two years or the equivalent in part time service. If a provider fails to fulfill the minimum requirement, the State will determine the appropriate recourse, which may include recoupment of funds paid by the State for student loans.

#### State Management

The State will select the recipients of the awards, and will conduct robust monitoring and assessment of the semi-annual progress reports including reviewing the awardees' progress, successes, and challenges.

### Primary Care Integration Models and Retention

The State will implement a grant program that provides support for community health centers and community mental health centers, and/or any entity participating in a CP or CSA to allow their primary care and behavioral health providers to engage in one-year projects related to accountable care implementation, including improving care coordination and integrating primary care and behavioral health. These projects must support improvements in cost, quality and patient experience through accountable care frameworks and will also serve as an opportunity to increase retention of providers. Community health centers, community mental health centers, and/or entities participating in a CP or CSA will be the primary applicant and will partner with primary care and behavioral health providers to apply for this funding.

#### Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

#### State's Management

The State will select the recipients of this funding, and will conduct robust monitoring and assessment of the semiannual progress reports by reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

## **Investment in Primary Care Residency Training**

In order to increase the number of physicians receiving residency training in community health centers, the State will use DSRIP funding to help offset the costs of community health center and community mental health center residency slots for both community health centers, community mental health centers, and hospitals. Community health centers, community mental health centers, and hospitals will be eligible to apply for this funding.

### **Awardee's Obligations**

Awardees will be required to submit semiannual progress reports to the State that detail the project's progress towards goals and pre-approved accountability measures (e.g., the number of providers remaining in the CHC for the length of the residency program), challenges and plans to address those challenges, and expenditures to date.

### **State's Management**

The State will select the recipients of this award, and will conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures.

## **Workforce Development Grant Program**

The State's payment reform initiatives will introduce new demands and shifting responsibilities for the healthcare workforce. The State will use DSRIP funding to support a wide spectrum of health care workforce development and training to allow for providers to more effectively operate in a new health care system. Entities participating in payment reform (ACOs, Community Partners, and CSAs), or entities in support of ACOs, CPs, and CSAs (e.g. training programs) are eligible to apply for funding.

### **Awardee's Obligations**

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

### **State's Management**

State will select the awardees, and will conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

## **Technical Assistance**

The State will procure vendors to provide technical assistance (TA) to ACOs, CPs and CSAs in a range of knowledge domains in order to help with the implementation of evidence-based interventions. TA may be provided in multiple forms, including but not limited to: individual consultation, learning collaboratives, tools and resources, and webinars. Providers participating in payment reform (ACOs, Community Partners, and CSAs) may be eligible to apply for funding.

Technical assistance may be available in areas such as, but not limited to:

- (1) **Education:** Education on delivery system reform topics, such as governance requirements, shared savings and shared losses; network development; quality and financial management analytics; assistance with health care literacy; and other topics.
- (2) **Actuarial and Financial:** Actuarial consulting to support participation in payment models. Baseline education and readiness assessments that address financial business process changes, patient attribution, budgeting, practice management systems, and other needs.
- (3) **Care Coordination/Integration:** Technical assistance to support, establish, and improve care coordination/integration best practices, including best practices around incorporating community health workers and social workers into practice, among other areas
- (4) **Performance Management:** Technical assistance to support program improvements, project management and provider performance management
- (5) **Health Information Technology:** Consultations to provide insight into what HIT investments and workflow adjustments will be needed to achieve goals regarding data sharing and integration across the delivery system (e.g., establishing clinical or community linkages through an e-Referral system)
- (6) **Accessible and Culturally Competent Care:** Training and support materials to promote best practices for accessibility and for culturally competent care for individuals with limited English proficiency; diverse cultural and ethnic backgrounds; physical, developmental, or mental disabilities; and regardless of gender, sexual orientation, or gender identity.
- (7) **Chronic Conditions Management:** Training, support, and technical assistance on utilizing and implementing evidence-based interventions to manage chronic conditions, among other areas.
- (8) **Behavioral Health Care Treatment and Management:** Training, support, data analytics, and technical assistance in caring for patients with behavioral health needs in the community, among other areas
- (9) **Population Health and Data Analytics:** Training, support, and technical assistance in analyzing data (e.g. raw claims extracts from The State, clinical quality data from EHRs) to help providers make evidence-based decisions, among other items

#### Awardee's Obligations

ACOs, CPs, and CSAs will be eligible to apply for technical assistance. Interested ACOs, CPs, and CSAs will submit a comprehensive TA plan as part of their application, which will be subject to modification and approval by the State. Any TA resources to support the plan must not overlap with TA supported through other funding sources (e.g., federal, state, private sector). Awardees will be required to submit a semiannual progress report discussing the progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

#### Vendor's Obligations

Vendors will work in collaboration with the State, ACOs, CPs, and CSAs to provide TA in a way that optimizes allocated TA resources and supports sustainable TA infrastructure. Vendors will also be required to submit documentation covering the same topics discussed in the awardees' semiannual progress report.

#### State's Management

The State will procure qualified vendor(s) for each TA category. A vendor may be approved for multiple categories. To be considered a qualified vendor, the vendor must demonstrate expertise and capacity for the categories for which it is applying, as well as meet other eligibility criteria set by the State.

The State will conduct robust monitoring and assessment of progress reports submitted by the awardees and TA vendors, which will include reviewing progress, successes, challenges, and accountability measures. Awardee and TA vendor accountability will be based on meeting pre-determined accountability measures, which will focus on whether the awardee was able to meet its technical assistance goals, or whether the vendor provided appropriate TA. If the goals are not met, or performance is inadequate, the State, in consultation with the awardee and/or vendor, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

### **Alternative Payment Methods (APM) Preparation Fund**

The State will use DSRIP funding for an Alternative Payment Methods (APM) Preparation Fund, which will offer up to two years of support to providers that are not yet ready to participate in an APM, but want to take steps towards APM adoption. Funds can be used to develop, expand, or enhance shared governance structures and organizational integration strategies linking providers across the continuum of care. Massachusetts' providers seeking to move towards ACOs or APMs but that are not participating as a MassHealth ACO; and behavioral health providers, BH CPs, LTSS providers and LTSS CPs seeking to enter into APM arrangements with MassHealth managed care entities will be eligible to apply for funding. Funds may also be used to raise awareness about APM among providers not yet engaged in a MassHealth ACO, CP, or CSA.

#### **Awardee's Obligations**

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

#### **State's Management**

The State will select recipients of this funding, and conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

### **Enhanced Diversionary Behavioral Health Activities**

The State will use DSRIP funding to support investment in new or enhanced diversionary strategies or infrastructure to help place members with behavioral health needs in the least restrictive, clinically most appropriate settings and to reduce the incidence of members who are boarded in a hospital emergency department waiting for admission into acute inpatient treatment or diversion to a community setting. Strategies for investment may include:

- Workforce Development
- Urgent care and intensive outpatient program (IOP)
- Community-Based Acute Treatment (CBAT) for adults



- ESP/Mobile Crisis Intervention (MCI) Teams with specific focus on placement in the EDs
- Crisis Stabilization Services (CSS)
- Telemedicine and Tele-psychiatry
- Peer Support models
- Discharge navigation services
- Web-based portal for navigation and data collection of ED boarding and available bed placement
- Care coordination software to better manage members who are boarded in the ED and to prevent such events

ACOs, CPs, CSAs, primary care providers, ESPs, community mental health centers, acute care hospitals, community health centers, psychiatric hospitals, advocacy organizations, provider organizations, vendors, and MCOs may be eligible to apply for funding. ACOs, CPs, or CSAs receiving funding must demonstrate that activities supported through this statewide investment are not duplicative with activities supported through other available funding.

#### Awardee's Obligations

Awardees will submit a semiannual progress report discussing the project's progress to date including activities and progress towards the reduction of ED boarding, goals and accountability measures, challenges and plans to address those challenges, and expenditures to date.

#### State's Management

The State will select recipients for this funding, and conduct robust monitoring and assessment of the semiannual progress and annual reports. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

### **Improved accessibility for people with disabilities or for whom English is not a primary language**

The State will use DSRIP funding to help providers offer necessary equipment and expertise at their facilities to meet the needs of persons with disabilities, or of those for whom English is not a primary language.

Funding would be available to help providers purchase items necessary to increase accessibility for members with disabilities, for accessible communication assistance, and for development of educational materials for providers regarding accessibility for members with disabilities. The State will tailor some of these materials specifically for providers treating members who are vision-impaired, deaf and hard of hearing, or for whom English is not a primary language. Applicants will be required to demonstrate that training is not duplicative of that received under the Technical Assistance statewide investments funding stream.

The State may also utilize this funding to support development of directories or other resources to assist MassHealth members find MassHealth providers by preferred accessibility preferences and to assist providers in identifying the accessibility preferences of their patients.

#### Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

#### State's Management

The State will select funding recipients, and conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

## Appendix C: Example Calculation of State DSRIP Accountability Score by Accountability Domain for BP 4

The following example demonstrates how the State DSRIP Accountability Score will be calculated for Budget Period 4. There are five steps to calculate how much at-risk funding the State earns in a given BP:

- **Step 1:** Calculate the MassHealth ACO/APM Adoption Rate Score
- **Step 2:** Calculate the Reduction in Spending Growth Score
- **Step 3:** Calculate the Overall Statewide Quality Performance Score
- **Step 4:** Using the three scores calculated in Steps 1 through 3 to calculate the State DSRIP Accountability Score
- **Step 5:** Use the State DSRIP Accountability Score to determine earned at-risk funds

### Step 1: Calculate the MassHealth ACO/APM Adoption Rate Score for BP 4

For the ACO/APM Adoption Rate score, the State will earn a 100% score for a given Budget Period if the State meets or surpasses the target for that Budget Period. If the State does not meet the target, then it will earn a 0% score for that Budget Period.

For BP 4, the State must have at least 40% of MassHealth ACO-eligible members who are enrolled in or attributed to ACOs or who receive services from providers paid under APMs, as shown below:

**EXHIBIT A2 – Target ACO/APM Adoption Rates, BP 4**

Target ACO/APM Adoption Rates						
DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
% of MassHealth ACO-Eligible Lives Served by ACOs/ Covered by APMS	NA	25%	30%	35%	40%	45%

For the purpose of this example, assume that the State has a 42% ACO/APM adoption rate in BP 4. Therefore, the State receives an accountability domain score of **100%** in this category.

### Step 2: Calculate the Reduction in Spending Growth Score for BP 4

In accordance with STC 71(f), the State will calculate its performance on reduction in state spending growth compared to the trended PMPM, and the domain score will be determined according to a gap-to-goal methodology for each budget period in accordance with STC 71(g), as follows:

- If Actual Reduction < (50% \* Reduction Target), then Measure Score = 0%
- If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
- 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)) OR the simplified version,

$$\frac{\text{Percent of reduction target achieved} - 50\%}{100\% - 50\%}$$

For BP 4, the Reduction Target is 1.1% off of trended PMPM, as shown in below.

**EXHIBIT A3 – Reduction Targets for ACO-Enrolled PMPMs, BP 4**

Reduction Targets for ACO-Enrolled PMPMs						
DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
% Reduction Target in ACO-enrolled PMPM vs. trended PMPM	NA	NA	NA	0.25% off of trended PMPM	<b>1.1% off of trended PMPM</b>	2.1% off of trended PMPM

For the purpose of this example, assume that the State’s Actual Reduction is 0.9% in BP 4, which is roughly 82% of the Reduction Target, as show below:

$$\text{Percent of reduction target achieved} = \frac{0.9\%}{1.1\%} \approx 82\%$$

Thus, to calculate this State accountability domain score:

$$\frac{82\% - 50\%}{100\% - 50\%} = 64\%$$

Therefore, the State receives an accountability domain score of **64%** in this category.

**Step 3: Calculate the Overall Statewide Quality Performance for BP 4**

In accordance with STC 71, the State will annually calculate the State performance score for each quality domain by aggregating the performance scores of all ACOs. Weighting varies by Budget Period, as shown below:

**EXHIBIT A4 – State Quality Domain Weights**

State Quality Domain Weights				
Quality Domain		Domain Weight: BP 1	Domain Weight: BP 2	Domain Weight: BP 3-5
<i>Clinical Quality Measures</i>				
1	Prevention & Wellness	N/A	85%	45%
2	Care Integration		N/A	40%
<i>Patient Experience Surveys</i>				
3	Overall Rating and Care Delivery	N/A	15%	7.5%

4	Person-centered Integrated Care	N/A	N/A	7.5%
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**STEP 3(a): Scoring for all Domains**

For all domains, domain scores for BP4 are calculated using the following steps:

- Calculate the aggregate domain scores for BP 1-3
- Calculate the pooled aggregate domain scores across the three Budget Periods
- Calculate the aggregate domain scores for BP 4 (our example year) and utilize Wilcoxon-rank sum tests to compare pooled aggregate domain scores from BP 1-3 against the BP4 aggregate domain scores

Domain scores are calculated using Achievement Points and do not include Improvement Points. Calculations for other Budget Periods would follow a similar methodology.

**1. Calculate the aggregate domain scores for BP 1-3**

Assume there are two ACOs (ACO 1 and ACO 2). Assuming ACO 1 receives a score of 30% and ACO 2 receives a score of 40% in the Prevention and Wellness domain for BP 1, the aggregate domain score for BP1 is the median of these two scores, or 35%. This step is repeated for all quality domains in BP 1-3 (see Exhibit A5 for detail).

**2. Calculate the pooled aggregate domain scores for BP 1-3**

The pooled aggregate domain score is then calculated by determining the median value of all scores within the Budget Periods. Assume ACO 1, ACO 2, and ACO 3 demonstrates the following scores in the Prevention and Wellness domain across BP1-3:

ACO 1			ACO 2			ACO 3		
BP1	BP2	BP3	BP1	BP2	BP3	BP1	BP2	BP3
30%	40%	50%	33%	41%	52%	31%	39%	49%

Redistributed from lowest to highest the domain scores appear as:

30%	31%	33%	39%	40%	41%	49%	50%	52%
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As the median score from a distribution is the middle score, then the pooled aggregate domain score across BP1-3 = 40.0%.

**EXHIBIT A5 – ACO Aggregate and Pooled Aggregate Domain Scores, BP 1-3**

Budget Period	BP 1			BP 2			BP 3			BP 1-3
	ACO 1	ACO 2	ACO 3	ACO 1	ACO 2	ACO 3	ACO 1	ACO 2	ACO 3	Total
<b>DSRIP Quality Domains</b>	<b>Domain Scores</b>			<b>Domain Scores</b>			<b>Domain Scores</b>			<b>Aggregate Domain Score</b>
Prevention & Wellness	30%	33%	31%	40%	41%	39%	50%	52%	49%	<b>40.0%</b>

Care Integration	60%	50%	53.3%	70%	50%	63.3%	80%	70%	73.3%	<b>63.3%</b>
PES: Overall Rating and Care Delivery	60%	60%	60%	50%	60%	56.7%	60%	70%	66.7%	<b>60.0%</b>
PES: Person-centered Integrated Care	60%	60%	60%	50%	50%	50%	70%	70%	70%	<b>60.0%</b>

**3. Calculate the aggregate domain scores for BP 4 and run Wilcoxon rank-sum test**

After calculating the BP4 aggregate domain scores using the same method utilized to calculate BP 1-3 domain scores (see above), the State will run a two-tailed, unmatched, Wilcoxon rank-sum test (hereinafter “Wilcoxon test”) to compare each aggregate domain score from BP 4 against its associated pooled aggregate domain score from BP 1-3. The p-value from this test will indicate whether in BP4 the quality domain score is better and statistically significant ( $p < 0.05$ , receives 100% score), worse and statistically significant ( $p < 0.05$ , receives 0% score) or not statistically different ( $p \geq 0.05$ , receives 100% score) from BP 1-3.

**EXHIBIT A6 – Wilcoxon testing of BP 4 Aggregate Domain Scores vs BP 1-2 Pooled Aggregate Domain Scores**

Budget Period	BP 1-2	BP 4				Wilcoxon test comparing BP4 aggregate domain scores vs. pooled aggregate BP 1-2 domain scores		
		ACO 1	ACO 2	ACO 3	Total (BP 4)			
Domains	Pooled Domain Score (BP 1-2)	Domain Scores			Aggregate Domain Score	Result	DSRIP Domain Score	Weight
Prevention & Wellness	40%	60%	70%	75%	70%	<b>Better and Statistically Significant</b>	<b>100%</b>	45%
Care Integration	63.3%	60%	66.7%	70%	66.7%	<b>Not Statistically Different</b>	<b>100%</b>	40%
PES: Overall Rating and Care Delivery	60%	50%	53.3%	60%	53.3%	<b>Worse and Statistically Significant</b>	<b>0%</b>	7.5%
PES: Person-centered Integrated Care	60%	50%	50%	50%	50.0%	<b>Worse and Statistically Significant</b>	<b>0%</b>	7.5%

BP3 domain scores are excluded from the pooled domain score based on concerns about the validity of domain scores in BP3 due to a state of emergency declared by the federal or state government.

**STEP 3(b): Calculating the Overall Statewide Quality Performance**

To calculate the overall Statewide Quality performance, we multiply the domain scores from BP 4 and the weights from BP 4 and obtain the sum:

**EXHIBIT A7 – Calculating the Statewide Quality Score for BP 4**

Domain	BP 4 DSRIP Domain Score	BP 4 DSRIP Domain Weight	Product
Prevention & Wellness	100%	45%	45%
Care Integration	100%	40%	40%
PES: Overall Rating and Care Delivery	0%	7.5%	0%
PES: Person-centered Integrated Care	0%	7.5%	0%
<b>Overall Statewide Quality Performance (sum of the products) =</b>			<b>85%</b>

#### Step 4: Calculate the Overall State DSRIP Accountability Score for BP 4

The State will calculate the State DSRIP Accountability Score by multiplying the Score for each State DSRIP Accountability domain by the associated weight and then summing the totals together.

For this example, the State achieved the following domain scores in BP 4:

- MassHealth ACO/APM Adoption Rate: **100%**
- Reduction in State Spending Growth: **64%**
- ACO Quality Performance: **85%**

Thus, the State DSRIP Accountability Score for BP 4 is **82.75%**, as demonstrated in the table below:

#### EXHIBIT A8 – Calculating the Overall State DSRIP Accountability Score

Example Calculation of State DSRIP Accountability Score for BP 4				
DSRIP Accountability Domain	Domain Weight	State Domain Score	State Accountability Calculations	DSRIP Score
MassHealth ACO/APM Adoption Rate	20%	100%	20% x 100% =	20%
Reduction in State Spending Growth	25%	64%	25% x 64% =	16%
ACO Quality Performance	55%	85%	55% x 85% =	46.75%
<b>State DSRIP Accountability Score =</b>				<b>82.75%</b>

#### Step 5: Determine At-Risk Funds Lost and Earned for BP 4

As noted above, the amount of at-risk State expenditure authority varies by Budget Period. For Budget Period 4, the amount at-risk is \$41.25M.

#### EXHIBIT A9 – Percent of State DSRIP Expenditure Authority At-Risk, BP 4

Percent of State DSRIP Expenditure Authority At-Risk					
DSRIP Budget Period	Prep BP and BP 1	BP 2	BP 3	BP 4	BP 5
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	<b>\$41.25M</b>	\$22.5M

To calculate how much at-risk funding the State has earned for BP 4:

$$\begin{aligned}
 &BP\ 4\ amount\ at-risk \times BP\ 4\ State\ DSRIP\ Accountability\ Score \\
 &\$41.25M \times 82.75\% = \$34.13M
 \end{aligned}$$

To calculate how much at-risk funding the State has lost for BP 4:

$$\begin{aligned}
 &BP\ 4\ amount\ at-risk - BP\ 4\ at-risk\ funding\ earned \\
 &\$41.25M - \$34.13M = \$7.12M
 \end{aligned}$$

Therefore, the State earned \$34.13M and lost \$7.12M of the \$41.25M at-risk in Budget Period 4.



## Appendix D: Measure Tables

### ACO Measure Slate

Note: Where applicable, columns 2019 (Domain 3) and 2020 (Domains 1 and 2) indicate the performance period (e.g., “P (18/19/20)”, “P (19/20)”) from which data, as decided by the State, may be substituted for PY2020 performance rates due to the state of emergency declared by the federal or state government.

#	Measure Name	Measure Description	Data Source	Measure Payment Status (P = Performance, R=Reporting Only; P4R = Pay for Reporting)				
				2018	2019	2020	2021	2022
<b>Domain 1 – Prevention &amp; Wellness</b>								
1	Childhood Immunization Status	Percentage of members who received all recommended immunizations by their 2nd birthday	Hybrid	P4R	P	P (19/20)	P	P
2	Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	Hybrid	P4R	P	P (19/20)	P	P
3	Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	Hybrid	P4R	P	P (19/20)	P	P
4	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	Hybrid	P4R	R	P (19/20)	P	P
5	Comprehensive Diabetes Care: A1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	P4R	P	P (19/20)	P	P
6	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Admin	R	P	P (19/20)	P	P
7	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	Admin	R	P	P (19/20)	P	P
8	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Admin	R	P	P (19/20)	P	P

9	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment**	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 30 days of the initiation visit	Admin	R	P	P (19/20)	P	P
<b>Domain 2 – Care Integration</b>								
10	Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation during the year	Admin	R	R	R	P	P
11	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Hybrid	P4R	R	R	R	P
12	Depression Remission or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score	Hybrid	P4R	R	R	P	P
13	ED Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions	Number of ED visits for members 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	Admin	R	R	R	P	P
14	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge	Admin	R	R	P (19/20)	P	P
15	Hospital Readmissions (Adult)	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age	Admin	R	R	R	P	P
16	Health-Related Social Needs Screening	Percentage of members who were screened for health-related social needs in the measurement year	Hybrid	P4R	R	R	P	P
17	Behavioral Health Community Partner Engagement **	Percentage of members 18 to 64 years of age who engaged with a BH Community Partner and received a treatment plan within 3 months (122 days) of Community Partner assignment	Admin	R	R	R	P	P
18	Long-Term Services and Supports Community Partner Engagement**	Percentage of members 3 to 64 years of age who engaged with an LTSS Community Partner and received a care plan within 3 months (122 days) of Community Partner assignment	Admin	R	R	R	P	P
19	Community Tenure**	The percentage of eligible days that ACO members 18-64 with bipolar disorder, schizophrenia, or psychosis (BSP) diagnoses, and separately, for other members 18-64 who have at least 3 consecutive months of LTSS utilization reside in their home or in a	Admin	R	R	R	P	P

		community setting without utilizing acute, chronic, or post-acute institutional health care services during the measurement year.							
<b>Domain 3 – Patient Experience: Overall Rating and Care Delivery</b>									
21	Overall Rating and Care Delivery**	Composite Related to Communications and Willingness to Recommend (To be finalized)	Survey	R	18/19/20	P (18/19/20)	P	P	
<b>Domain 4 – Patient Experience: Person-Centered Integrated Care</b>									
22	Person-centered Integrated Care**	Composites Related to Care Planning, Self-Management and Integration of Care (To be finalized)	Survey	R	R	R	P	P	

\*Note: The Acute Unplanned Admissions for Individuals with Diabetes measure and corresponding number (#20) were removed from the measure slate.

\*\* Composite measures

**MassHealth DSRIP BH Community Partners Quality Measure Program (Prospective Measures, 2018-2022) – Include Benchmark Timeline**

*Note: Where applicable, Column 2020 indicates the performance period (i.e., “P (19/20)”) from which data, as decided by the State, may be substituted for PY2020 performance rates due to the state of emergency declared by the federal or state government.*

#	Measure Name	Measure Description	Data Source	Benchmark due to CMS	Measure Steward	NQF	Pay for Performance Phase In (P= Performance, R= Reporting)				
							2018	2019	2020	2021	2022
<b>Domain 1: Care Integration</b>											
1	Community Partner Engagement**	Percentage of assigned enrollees 18 to 64 years of age with documentation of engagement within 122 days of the date of assignment to a Community Partner	Admin	Q4 2021	MA EOHHS	N/A	R	R	P (19/20)	P	P
2	Annual Treatment Plan Completion**	Percentage of enrollees 18 to 64 years of age with documentation of a completed Treatment Plan during the measurement year	Admin	Q4 2021	MA EOHHS	N/A	R	P4R	P (19/20)	--	--
2*	Enhanced Person-Centered Care Planning	Percentage of enrollees 18 to 64 years of age with timely completion of a new or	Admin	Q4 2021	MA EOHHS	N/A	--	--	R	P	P

		updated Treatment Plan during the measurement year									
3	Follow-up with BH CP after acute or post-acute stay (3 days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a BH CP within 3 business days of discharge	Admin	Q2 2021	MA EOHHS	N/A	R	R	R	P	P
4	Follow-up with BH CP after ED visit	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within 7 days of the ED visit	Admin	Q2 2021	MA EOHHS	N/A	R	R	R	P	P
<b>Domain 2: Population Health</b>											
5	Annual primary care visit	Percentage of enrollees 18 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Admin	Q4 2021	MA EOHHS	N/A	R	R	P (19/20)	P	P
7	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment**	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 30 days of the initiation visit	Admin	Q2 2021	NCQA	4	R	R	P (19/20)	P	P
9	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Admin	Q4 2021	NCQA	576	R	R	P (19/20)	P	P
10	Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year	Admin	Q4 2021	NCQA	1932	R	R	P (19/20)	P	P

11	Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on antidepressant medication treatment	Admin	Q4 2021	NCQA	N/A	N/A	N/A	R	P	P
<b>Domain 3: Avoidable Utilization</b>											
12	ED Visits for Adults with SMI, Addiction, or Co-occurring Conditions	The rate of ED visits for enrollees 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	Admin	Q4 2021	MA EOHHS	N/A	R	R	P (19/20)	P	P
13	Hospital Readmissions (Adult)	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age	Admin	Q4 2021	NCQA	1768	R	R	P (19/20)	P	P
<b>Domain 4: Member Experience</b>											
	Member Experience**	Composites Related to Member Engagement, Care Planning, and Community Tenure	Survey	Q4 2021	n/a	n/a	R	R	R	P	P

\*Note: The Community Tenure measure and corresponding number (#6) were removed from the measure slate.

\*\* Composite measures

Measure Steward Definitions

- MA EOHHS: Massachusetts Executive Office of Health and Human Services
- NCQA: National Committee for Quality Assurance

**MassHealth DSRIP LTSS Community Partners Quality Measure Program (Prospective Measures, 2018-2022) – Include Benchmark Timeline**

*Note: Where applicable, Column 2020 indicates the performance period (i.e., “P (19/20)”) from which data, as decided by the State, may be substituted for PY2020 performance rates due to the state of emergency declared by the federal or state government.*

#	Measure Name	Measure Description	Data Source	Benchmark due to CMS	Measure Steward	NQF	Pay for Performance Phase In (P= Performance, R= Reporting)				
							2018	2019	2020	2021	2022
<b>Domain 1: Care Integration</b>											
1	Community Partner Engagement**	Percentage of assigned enrollees 3 to 64 years of age with documentation of engagement within 122 days of assignment to a Community Partner	Admin	Q4 2021	MA EOHHS	N/A	R	R	P (19/20)	P	P
2	Annual Care Plan Completion**	Percentage of enrollees 3 to 64 years of age with documentation of a completed Care Plan during the measurement year	Admin	Q4 2021	MA EOHHS	N/A	R	P4R	P (19/20)	--	--
2*	Enhanced Person-Centered Care Planning	Percentage of enrollees 18 to 64 years of age with timely completion of a new or updated Care Plan during the measurement year	Admin	Q4 2021	MA EOHHS	N/A	--	--	R	P	P
3	Follow-up with LTSS CP after acute or post-acute stay (3 days)	Percentage of discharges from acute or post-acute stays for enrollees 3 to 64 years of age that were succeeded by a follow-up with a LTSS CP within 3 business days of discharge	Admin	Q2 2021	MA EOHHS	N/A	R	R	R	P	P
<b>Domain 2: Population Health</b>											
5	Annual primary care visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Admin	Q4 2021	MA EOHHS	N/A	R	R	P (19/20)	P	P

6	Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year	Admin	Q4 2021	DQA	2517	R	R	P (19/20)	P	P
<b>Domain 3: Avoidable Utilization</b>											
7	All-Cause ED Visits	The rate of ED visits for enrollees 3 to 64 years of age	Admin	Q2 2021	MA EOHHS	N/A	R	R	P (19/20)	P	P
8	Hospital Readmissions (Adult)	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age	Admin	Q4 2021	NCQA	1768	R	R	P (19/20)	P	P
<b>Domain 4: Member Experience</b>											
	Member Experience**	Composites Related to Member Engagement Care Planning, and Community Tenure	Survey	Q4 2021	n/a	n/a	R	R	R	P	P

\*Note: The Community Tenure measure and corresponding number (#4) were removed from the measure slate.

\*\* Composite measures

Measure Steward Definitions

- DQA: Dental Quality Alliance
- MA EOHHS: Massachusetts Executive Office of Health and Human Services
- NCQA: National Committee for Quality Assurance

**MassHealth DSRIP Community Service Agency Quality Measure Program (Prospective Measures, 2018-2022) – Include Benchmark Timeline**

*Note: Where applicable, Column 2020 indicates the performance period (i.e., “P (19/20)”) from which data, as decided by the State, may be substituted for PY2020 performance rates due to the state of emergency declared by the federal or state government.*

#	Measure Name	Measure Description	Data Source	Benchmark due to CMS	Measure Steward	NQF	Pay for Performance Phase In (P= Performance, R= Reporting)				
							2018	2019	2020	2021	2022
<b>Domain 1: Care Integration</b>											
1	Annual Physical	Percentage of members 0 to 20 years of age who received an annual physical examination and had documentation of an annual physical in the health record of the CSA provider	Hybrid	Sep 2020	MA EOHHS	N/A	R	P4R	P (19/20)	P	P
<b>Domain 2: Member Experience</b>											
2	Effective Teamwork	WFI-EZ Composite	Survey	Sep 2020	UW	N/A	R	R	R	P	P
3	Outcomes-Based	WFI-EZ Composite	Survey	Sep 2020	UW	N/A	R	R	R	P	P
4	Satisfaction	WFI-EZ Composite	Survey	Sep 2020	UW	N/A	R	R	R	P	P

Measure Steward Definitions

- MA EOHHS: Massachusetts Executive Office of Health and Human Services
- UW: University of Washington Wraparound Fidelity Index, Short Form (WFI-EZ)



**ATTACHMENT N**  
**Safety Net Provider Payment Eligibility and Allocation (Reserved)**

**ATTACHMENT O**  
**Continuous Eligibility Implementation Plan (Reserved)**

**ATTACHMENT P**  
**Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and**  
**Provider Qualifications (Reserved)**

**ATTACHMENT Q**  
**Medicaid Managed Care Plan/ACO Performance Based Incentive Payment Mechanisms**  
**(Reserved)**

## **ATTACHMENT R**

### **Flexible Services Program Protocol**

In accordance with the State's Section 1115 Demonstration Waiver and Special Terms and Conditions 60(b)(ii), this protocol outlines the State's Delivery System Reform Incentive Payment (DSRIP) Program's Flexible Services Program (FSP). Under the FSP, the State will provide eligible MassHealth members with access to Flexible Services, which consist of Tenancy Preservation Services (TPS) and Nutritional Support Services (NSS). This protocol outlines the target criteria, needs based criteria, the covered flexible services, the flexible service planning process, and the payment methodology for covered flexible services under the FSP.

#### **I. Target Criteria**

ACO-enrolled MassHealth members ages 0-64.

#### **II. Needs Based Criteria**

Members who meet the target criteria outlined in Section I must also meet **at least one of** the health needs-based criteria outlined in Section II.A; **and at least one of** the risk factors outlined in Section II.B associated with the need for flexible services covered under the FSP as determined by the Flexible Service Assessment outlined in Section IV.

##### **A. Health Needs-Based Criteria**

1. The individual is assessed to have a behavioral health need (mental health or substance use disorder) requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support)
2. The individual is assessed to have a complex physical health need, which is defined as persistent, disabling, or progressively life-threatening physical health condition(s), requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support);
3. The individual is assessed to have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs);
4. Repeated incidents of emergency department use (defined as 2 or more visits within six months, or 4 or more visits within a year); OR
5. Pregnant individuals who are experiencing high risk pregnancy or complications associated with pregnancy, including:
  - a. Individuals 60 days postpartum;
  - b. their children up to one year of age; and
  - c. their children born of the pregnancy up to one year of age.

##### **B. Risk Factors**

1. Risk Factor 1: The member is homeless as defined by the following:
  - a. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    - i. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

- ii. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low-income individuals); or
- iii. An individual who is exiting an institution where they resided for 90 days or less and who experienced Risk Factor (1)(a)(i) or Risk Factor (1)(a)(ii);
- b. An individual or family who will imminently lose their primary nighttime residence, provided that:
  - i. The primary nighttime residence will be lost within 21 days of the date of Flexible Services Assessment as outlined in Section IV;
  - ii. No subsequent residence has been identified; and
  - iii. The individual or family lacks the resources or support networks, *e.g.*, family, friends, faith-based or other social networks, needed to obtain other permanent housing;
- c. Any individual or family who:
  - i. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, unsafe, or life-threatening conditions that relate to violence, including physical or emotional, against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to or stay in their primary nighttime residence;
  - ii. Has no other residence; and
  - iii. Lacks the resources or support networks, *e.g.*, family, friends, and faith-based or other social networks, to obtain other permanent housing.

2. Risk Factor 2: The member is at risk of homelessness as defined by the following:

- a. Does not have sufficient resources or support networks, *e.g.*, family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation or a safe haven; and
- b. Meets one of the following conditions:
  - i. Has moved because of economic reasons two or more times during the 60 days immediately preceding the Flexible Service Assessment as outlined in Section IV;
  - ii. Is living in the home of another because of economic hardship;
  - iii. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
  - iv. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room;
  - v. Has a past history of receiving services in a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

- vi. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness.
  - a. Characteristics are defined as:
    - i. **Living in housing that is unhealthy** (e.g., the presence of any characteristics that might negatively affect the health of its occupants, including, but not limited to, evidence of rodents, water leaks, peeling paint in homes built before 1978, and absence of a working smoke detector, poor air quality from mold or radon).
    - ii. **Living in housing that is inadequate** as defined as an occupied housing unit that has moderate or severe physical problems (e.g., deficiencies in plumbing, heating, electricity, hallways, and upkeep). Examples of moderate physical problems in a unit include, but are not limited to, two or more breakdowns of the toilets that lasted more than 6 months, unvented primary heating equipment, or lack of a complete kitchen facility in the unit. Severe physical problems include, but are not limited to, lack of running hot or cold water, lack of a working toilet, and exposed wiring.
    - iii. **Rent Arrears (1 or more):** Missing one or more monthly rent payment as well as situations such as receiving a Notice to Quit, being referred to Housing Court, receiving complaints from a property manager/landlord, or failure to have one's lease recertified or renewed
3. **Risk Factor 3:** The member is at risk for nutritional deficiency or nutritional imbalance due to food insecurity, defined as having limited or uncertain availability of nutritionally adequate, medically appropriate, and/or safe foods, or limited or uncertain ability to acquire or prepare acceptable foods in socially acceptable ways.
  - a. Limited or uncertain is defined as reports of:
    - i. Reduced quality, variety, or desirability of diet with little or no indication of reduced food intake; or
    - ii. Multiple indications of disrupted eating patterns and reduced food intake.

### III. **Flexible Services**

The FSP program consists of two services, Tenancy Preservation Supports (TPS) and Nutrition Sustaining Supports (NSS). These services are covered for FSP eligible members when determined necessary through the flexible service planning process described in **Section IV**. ACOs may decide which specific services within TPS and NSS they will make available to members based on needs criteria or funding availability.

In the context of Tenancy Preservation Supports and Nutrition Sustaining Supports “assisting” is defined as: (1) helping a member to locate services; and/or (2) providing support, education, and/or coaching directly to the member in regards to a particular service(s).

#### **A. Tenancy Preservation Supports**

Tenancy Preservation Supports consists of Pre-tenancy Supports, Tenancy Sustaining Supports, and Home Modifications, and as described below.

**1. Pre-tenancy Supports**

Pre-tenancy Supports include one or more of the following:

a. Individual Supports

- i. Assessing and documenting the member's preferences related to the tenancy the member seeks, including the type of rental sought, the member's preferred location, the member's roommate preference (and, if applicable, the identification of one or more roommates), and the accommodations needed by the member.
- ii. Assisting the member with budgeting for tenancy/living expenses, and assisting the member with obtaining discretionary or entitlement benefits and credit (e.g., completing, filing, and monitoring applications to obtain discretionary or entitlement benefits and credit as well as obtaining or correcting the documentation needed to complete such applications).
- iii. Assisting the member with obtaining completing, and filing, applications for community-based tenancy.
- iv. Assisting the member with understanding their rights and obligations as a tenant.
- v. Assisting the member with locating and obtaining services needed to establish a safe and healthy living environment.
- vi. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed.

b. Transitional Assistance

Assisting the member with locating, obtaining, and/or providing the member with one-time household set-up costs and move-in expenses, including but not limited to, first month's rent, security deposit, costs for filing applications and obtaining and correcting needed documentation, and/or purchase of household furnishings needed to establish community-based tenancy.

**2. Tenancy Sustaining Supports**

Tenancy sustaining supports include one or more of the following supports:

- a. Assisting the member with communicating with the landlord and/or property manager regarding the member's disability, and detailing the accommodations needed by the member.
- b. Assisting with the review, update, and modification of the member's tenancy support needs, as documented in the member's Flexible Service Plan, on a regular basis to reflect current needs and address existing or recurring barriers to retaining community tenancy.
- c. Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit, including, but not limited to obtaining, completing, filing, and monitoring applications.



- d. Assisting the member with obtaining appropriate sources of, tenancy training, including trainings regarding lease compliance and household management.
- e. Assisting the member in all aspects of the tenancy, including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during negotiations with a landlord, and directing a member to appropriate sources of legal services.
- f. Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed.
- g. Assisting the member with obtaining or improving the adaptive skills needed to function and live independently and safely in the community and/or family home, including advising the member of the availability of community resources.

### 3. Home Modifications

Home Modifications consist of limited physical adaptations to the member's community-based dwelling, when necessary to ensure the member's health, welfare, and safety, or to enable the member to function independently in a community-based setting (e.g., installation of grab bars and hand showers, doorway modifications, in-home environmental risk assessments, refrigerators for medicine such as insulin, HEPA filters, vacuum cleaners, pest management supplies and services, air conditioner units, hypoallergenic mattress and pillow covers, traction or non-skid strips, night lights, and training to use such supplies and modifications correctly). The State will establish limits within this category, such as:

- a. Excluding those adaptations to the dwelling that are of general utility, and are not of direct medical or remedial benefit to the member.
- b. Excluding adaptations that add to the total square footage of the dwelling except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- c. Excluding adaptations which would normally be considered the responsibility of the landlord.

### B. Nutrition Sustaining Supports

Nutrition Sustaining Supports (NSS) include one or more of the following services:

- 1. The provision of healthy, well-balanced, home-delivered meals for the member.
- 2. Assisting the member with obtaining discretionary or entitlement benefits and credit, including but not limited to, completing, filing, and monitoring applications as well as obtaining and correcting the documentation needed to complete such applications.
- 3. Providing, or assisting with locating nutrition education and skills development.

4. Assisting or providing the member with transportation to any of the nutrition sustaining support services or supporting the member's ability to meet nutritional and dietary needs.
5. Assisting the member with locating, obtaining, and/or providing the member with purchase of household supplies needed to meet nutritional and dietary need.
6. Assisting or providing the member with access to foods that meet nutritional and dietary need that cannot otherwise be obtained through existing discretionary or entitlement programs.
7. Assisting the member in maintaining access to nutrition benefits including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during appeals of benefit actions (e.g., denial, reduction, or termination) and directing a member to appropriate sources of legal services.

### **C. Non-Covered TPS and NSS**

TPS and NSS do not include:

1. Ongoing payment of rent or other room and board costs;
2. Expenses for recurring utilities or other recurring bills not specifically delineated in Section III.A or III.B;
3. Goods and services intended for leisure or recreation; and
4. Services or supports that are duplicative of those offered under other state or federal programs.

## **IV. Flexible Services Assessment and Planning Process**

### **A. Assessment**

An ACO or its designee will perform an assessment that (1) determines a member's eligibility for Flexible Services; and (2) identifies which Flexible Service(s) the member may receive.

1. The assessment may be completed by the ACO or designee of the ACO. Such designees may include, but are not limited to, licensed or unlicensed social workers, case managers, licensed or unlicensed providers, Community Partners staff, Community Health Workers, or an individual appropriately trained by the ACO.
2. Members determined eligible may receive planning for flexible services as described in Section IV.B.

### **B. Flexible Service Planning**

A member and ACO or its designee will create a plan for a member to obtain Flexible Services specific to the member's needs regarding tenancy preservation supports and/or nutrition sustaining supports as determined through the Flexible Service planning process. The Flexible Service Plan will be in writing and agreed to by the member and approved by the ACO or its designee.

1. ACOs may have a designee complete the plan with the member. Such designees may include, but are not limited to, licensed or unlicensed social workers, case managers, licensed or unlicensed providers, Community Partners staff, Community Health Workers or an individual appropriately trained by the ACO.
2. The Flexible Service Plan will include:
  - a. The recommended flexible service(s);
  - b. The units of service(s);
  - c. The goals of the service(s);
  - d. Steps to obtaining the services;
  - e. The follow-up plan; and
  - f. The ACO representative or designee that will be responsible for managing the member's Flexible Service Plan

An ACO or its designee is required to have at least one in-person meeting with the member during the assessment and planning process. The in-person assessment and planning may include assessments and planning performed by telehealth (e.g., telephone/videoconference), in situations when the member has provided informed consent to receive assessments and planning performed by telehealth, that the informed consent is documented by the ACO, and that the member receives the support needed to have the assessment conducted via telehealth (including any on-site support needed by the member). During a state of emergency declared by the federal or state government, the State may temporarily suspend this in-person meeting requirement for the duration of the state of emergency.

### **C. Additional Requirements for Receiving Flexible Services**

To receive Flexible Services, the ACO must confirm that the member is enrolled in MassHealth (1) on the date the Flexible Services Assessment is conducted; (2) on the first date of a Flexible Services episode of care, which is a set of related Flexible Services (e.g. tenancy sustaining supports, home modifications, nutrition sustaining supports); and (3) every subsequent 90 calendar days from the initial date of service of an episode of care until the conclusion of that episode.

### **D. Flexible Services Service Availability**

1. The State reserves the right to roll out the services and member eligibility groups in stages, in accordance with a plan set forth by the State, as well as to set up specific requirements that the Accountable Care Organization must meet before programs and funds will be approved.
2. ACOs may elect to provide flexible services only to members with certain health needs-based criteria or with certain Risk Factors from among those listed in Section II above. ACOs may also restrict the number of members within those categories who will receive services. ACOs may also elect which flexible services they intend to offer. ACOs will be required to submit such plans to the State for approval. The State may require ACOs to maintain a waitlist.

3. ACOs will be required to estimate the number of members they expect to serve each year with the FSP as well as report to the State on the actual number of members they do serve. Due to limited funding and resources, neither the State nor ACOs will be expected to serve all eligible members.
4. A parent, guardian, or caregiver of a child assessed to need TPS and NSS services that resides with the child may receive such services on the child’s behalf when in the best interests of the child as determined through the flexible service plan.

**E. Conflict of Interest**

An entity that performs the Assessment and/or Flexible Service Planning may also provide Flexible Services provided they take appropriate steps to avoid conflict of interest as determined by the State.

**V. Provider Qualifications**

A. Contractors of Flexible Services must possess the following qualifications, as applicable.

Provider Type	Education and Experience	Skills	Services
Tenancy Preservation Services Contractors	Education (e.g., Bachelor’s degree, Associate’s degree, certificate) in a human/social services field or a relevant field, and/or at least 1 year of relevant professional experience; and/or training in the field of service.	Knowledge of principles, methods, and procedures of services included under Tenancy Preservation Services (as outlined above and applicable to the position), or comparable services meant to support a member’s ability to obtain and sustain residency in an independent community setting.	Tenancy Preservation Services, including pre-tenancy supports and tenancy sustaining supports (as outlined above)
Nutritional Support Services Contractors	Education (e.g., Bachelor’s degree, Associate’s degree, certificate) in a human/social services field or a relevant field, and/or at least 1 year of relevant professional experience; and/or training in the field of service.	Knowledge of principles, methods, and procedures of services included under Nutritional Support Services (as outlined above and applicable to the position), or comparable services meant to support a member’s ability to obtain or maintain food security.	Nutritional Support Services (as outlined above)

B. ACOs will be required to ensure that contractors of Flexible Services have and maintain the necessary qualifications as laid out in Section V.A to provide Flexible Services, as applicable.

**VI. Payment Methodology**

## A. Payment

Each ACO with an approved Participation Plan, Budget, and Budget Narrative will be allocated a per-member/per-month (PMPM) amount for the FSP that will be determined by the State. ACOs will be allowed to utilize flexible service funding for two main purposes:

- (1) **ACO administrative costs related to Flexible Services and Social Service Integration (SSI):** prospective funding, up to a certain percentage set by the State, which ACOs may utilize to build the necessary capacity and infrastructure to implement the FSP and to support ongoing administration/overhead of the FSP. This includes but is not limited to personnel for FSP and SSI, Health Information Technology, software, assessments and reporting costs surrounding FSP and SSI. ACOs or the State may also provide portions of this funding to Social Service Organizations (SSOs) to support their administrative and infrastructure costs. In addition, the State may provide up to \$4.5M of the Flexible Services funding over the demonstration period to SSOs to build infrastructure and capacity to better support ACOs in delivering services; and
- (2) **Flexible Services:** prospective funding provided to ACOs, or SSOs through ACOs, for TPS and NSS as laid out in Section III. The State anticipates disbursing funds on a quarterly basis but may choose to do so more frequently.

ACOs may also use Startup/Ongoing funding to pay for administrative costs related to the FSP, but will be required to attest to non-duplication of funding.

## VII. Reporting and Documentation

The ACOs will be required to submit a Flexible Service Program Plan as an additional portion of their Full Participation Plan as set forth in Section 3.2.2 of the DSRIP Protocol. The ACOs will also be required to add FSP spending to their DSRIP Budgets and Budget Narratives submitted in accordance with Section 3.4.4.1 of the DSRIP Protocol.

Budgets and Budget Narratives will detail specific FSP supports that the ACO intends to make available to eligible members through its FSP as well as the estimated numbers of members the ACOs expects to serve. The Budgets and Budget Narratives will also specify the ACO's administrative/infrastructure expenses related to the FSP. The State will review and approve the Budgets and Budget Narratives in accordance with the DSRIP Protocol.

The ACOs will be required to provide updated information regarding such Flexible Services expenditures their DSRIP Semiannual and Annual Progress Reports as laid out in Section 5.5.1 of the DSRIP Protocol. These reports will be used to determine whether FSP spending and activities are in line with the ACO's approved DSRIP Budget, Budget Narrative, and Participation Plan.

The ACOs will also be required to submit to the State detailed information about the flexible services provided to members to inform robust monitoring and evaluation of the Flexible Services program, in a form and format specified by the State.

The ACOs will be required to ensure that FSP contractors meet documentation standards and cooperate in any evaluation activities by the State or CMS. ACOs will be required to have processes in place to ensure that there is no duplication of federal funding or services provided to members.

**ATTACHMENT S**  
**Evaluation Design (Reserved)**

**ATTACHMENT T**  
**HRSN Implementation Plan (Reserved)**

**ATTACHMENT U**  
**Primary Care Payment Protocol (Reserved)**



**ATTACHMENT V**  
**Provider Rate Increase Attestation Table (Reserved)**

**ATTACHMENT W**  
**Monitoring Protocol for Other Policies (Reserved)**