DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

September 25, 2026

Ryan Schwarz
Assistant Secretary for MassHealth
Office of Medicaid
Executive Office of Health and Human Services
One Ashburton Place, 10th Floor
Boston, MA 02108

Dear Assistant Secretary Schwarz:

The Centers for Medicare & Medicaid Services (CMS) is making conforming changes to Massachusetts' "MassHealth Medicaid and Children's Health Insurance Plan (CHIP) Section 1115 Demonstration," (MassHealth) (Project Numbers 11-W-00030/1 and 21-00071/1) to align with recent changes to the Medicaid and Children's Health Insurance Program (CHIP) statutes. In this letter, CMS is also clarifying the applicability of these recent changes and related regulation and policy to the MassHealth demonstration.

Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, made changes to the Medicaid and CHIP provisions of the Social Security Act (the Act), including eligibility and financing changes. CMS has issued regulations and guidance implementing and interpreting many of the Medicaid and CHIP provisions of the WFTC legislation. Some of these statutory and related regulatory changes will affect this demonstration. Therefore, in this action, CMS is making conforming changes and clarifying the applicability of certain of these new requirements to the MassHealth section 1115 demonstration during the current demonstration period.

Specifically, in this action:

- Effective January 1, 2027, we are waiving section 1902(e)(14)(L) of the Act (added by section 71107 of the WFTC legislation) with respect to certain individuals affected by the demonstration through December 31, 2027.
- We are changing the demonstration special terms and conditions (STCs) to conform with sections 1903(v)(5) and 2107(e)(1)(R) of the Social Security Act (the Act) (added and amended, respectively, by section 71109 of the WFTC legislation) and with guidance related to these sections of the Act; these changes are effective October 1, 2026, through December 31, 2027.
- Effective January 1, 2027, we are changing the demonstration STCs to conform with section 1902(xx) of the Act, (added by section 71119 of the WFTC legislation), and regulations and guidance implementing and interpreting that section of the Act; through December 31, 2027.

Unless renewed or amended, all authorities granted to operate this demonstration will expire on December 31, 2027.

The conforming changes to the STCs are authorized under STC 3.3, titled "Changes in Medicaid and CHIP Law, Regulation, and Policy," which provides that 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 the demonstration approval period. Under STC 3.3, CMS may amend the STCs to reflect such changes without requiring the Commonwealth to submit an

amendment. We consider the waiver of section 1902(e)(14)(L) of the Act to be a conforming change permissible under STC 3.3. because it will help to avoid noncompliance with certain newly applicable requirements for a limited period of time, as further explained below. The clarifications are authorized under STC 3.2, which specifies that all requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents, apply to the demonstration.

CMS has determined that this action for the MassHealth demonstration is likely to assist in promoting the objectives of the Medicaid and CHIP statutes by aligning this section 1115 demonstration with new statutory requirements applicable to the Medicaid and CHIP programs and with how CMS has interpreted and implemented those requirements in regulations and guidance. Moreover, this action will provide the Commonwealth with additional time to operationalize changes to comply with section 1902(e)(14)(L) of the Act, given its concurrent work to unwind existing expanded continuous eligibility authority in the demonstration for individuals who are also subject to section 1902(e)(14)(L) of the Act while implementing the community engagement requirements for these individuals, as described in section 1902(xx) of the Act (added by section 71119 of the WFTC legislation). The effective dates of these actions are intended to align with the implementation timelines of these new statutory requirements.

This section 1115(a) demonstration action is subject to the limitations specified in Attachment AD below, which is appended to the demonstration's special terms and conditions (STCs), as amended and restated in our approval on September 10, 2026. Attachment AD makes conforming changes to the demonstration's waivers and STCs as further specified therein, and governs any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The changes in Attachment AD of this letter should be considered as part of the broader set of STCs that were approved on September 10, 2026, for the MassHealth demonstration and will be incorporated into the full STCs at a future approval action for this demonstration.

Program Integrity

As part of this action, CMS would like to remind the Commonwealth about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid and CHIP laws and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity, including processes to identify, investigate, and refer suspected fraud and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement, when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the Commonwealth provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Changes

Section 71107 – Eligibility redeterminations

Section 1902(e)(14)(L) of the Act, added by section 71107 of the WFTC legislation, requires states to conduct renewals of eligibility once every six months (instead of once every 12 months) for two groups of beneficiaries whose financial eligibility is determined using MAGI methodologies. First, this requirement applies to almost all individuals enrolled under the state plan in the Medicaid adult group described at section 1902(a)(10)(A)(i)(VIII) of the Act. Second, this requirement applies to almost all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act who are enrolled in coverage "under a waiver" of the state plan that provides coverage equivalent to minimum essential coverage (MEC) to all individuals described at section 1902(a)(10)(A)(i)(VIII) of the Act. The requirements of section 1902(e)(14)(L) of the Act apply to redeterminations of eligibility scheduled on or after January 1, 2027. On March 6, 2026, CMS issued State Medicaid Director Letter #26-001, which offers implementation guidance to states on this new requirement.[1]

Section 71107 implementation concurrent with expanded continuous eligibility wind down

CMS has approved expenditure authority for expanded continuous eligibility in several demonstrations, including MassHealth. This authority provides Medicaid and CHIP expenditures for continued benefits for certain individuals who would have otherwise lost coverage due to a change in circumstance. On July 17, 2025, CMS issued a Dear Colleague letter indicating that CMS does not anticipate approving new requests for expanded continuous eligibility or renewing existing section 1115 demonstration authority for expanded continuous eligibility, beyond what is required or available under the Medicaid and CHIP statutes, as applicable.[2] CMS has provided technical assistance to assist states as they begin upgrading eligibility systems, notifying beneficiaries, and conducting an orderly phase out of expanded continuous eligibility where it has been approved under section 1115 demonstration authority.

In MassHealth, certain individuals who currently qualify for expanded continuous eligibility will also be subject to the requirements of section 1902(e)(14)(L) of the Act. Massachusetts will need to complete eligibility system upgrades to begin conducting eligibility redeterminations in accordance with requirements of section 1902(e)(14)(L) of the Act at the same time that the Commonwealth is working on beneficiary notices and returning to regular renewal timeframes resulting from the wind-down of the demonstration authority for expanded continuous eligibility. Therefore, in order to ensure that the Commonwealth has adequate time to operationalize both sets of changes in an orderly fashion, CMS is waiving section 1902(e)(14)(L) of the Act for a limited period of time for the populations that are subject both to the demonstration's expanded continuous eligibility provisions and section 1902(e)(14)(L) of the Act. This waiver authority takes effect on January 1, 2027, and will not exceed the end date of the current demonstration period, December 31, 2027.

Section 71109 – Alien Medicaid eligibility

Beginning October 1, 2026, sections 1903(v)(5) and 2107(e)(1)(R) of the Act, as added and amended, respectively, by section 71109 of the WFTC legislation, generally limit federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP), with limited exceptions, to U.S. citizens and U.S. nationals, lawful permanent residents (LPRs), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd26001.pdf
[2] https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf

Section 1903(v)(5) of the Act describes three exceptions to these FFP limitations: (1) care and services necessary for the treatment of an emergency medical condition as described in section 1903(v)(3) of the Act, (often referred to as "emergency Medicaid"), per section 1903(v)(2) of the Act; (2) full Medicaid and CHIP coverage provided to lawfully residing children and pregnant women under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option, per section 1903(v)(4) of the Act, applicable to CHIP through a cross reference at section 2107(e)(1)(Q) of the Act; and (3) Health Services Initiatives (HSIs), which are programs that are designed to improve the health of low-income children, authorized under section 2105(a)(1)(D)(ii) of the Act. Massachusetts elected the CHIPRA 214 option for Medicaid coverage of lawfully residing children and pregnant women, and CHIP coverage of lawfully residing children.

On April 8, 2026, CMS issued State Health Official (SHO) letter #26-001, which provides policy and operational guidance to states related to implementation of the changes made by section 71109 of the WFTC legislation.[3] On August 17, 2026, CMS issued a letter to Massachusetts describing CMS's determination that continuing previously approved policies in section 1115 demonstrations that authorize federal matching funds for expenditures that are subject to the FFP limitations in sections 1903(v)(5) and 2107(e)(1)(R) of the Act would not be likely to promote the objectives of the Medicaid or CHIP statutes, as applicable and as modified by the WFTC legislation.[4] In this action, CMS is making conforming changes to align with, and clarifying the applicability of, sections 1903(v)(5) and 2107(e)(1)(R) of the Act to the STCs of the demonstration. These changes and clarifications, which are further described below, are expected to protect program integrity, ensure accurate eligibility determinations, and ensure proper claiming of FFP.

Aligning section 1115 eligibility policies with section 71109 changes

The MassHealth demonstration STCs currently include references to historical noncitizen eligibility requirements for individuals for whom, beginning October 1, 2026, under the statutory changes made by section 71109 of the WFTC legislation, the Commonwealth is no longer able to claim FFP, unless an exception applies. The demonstration's STCs regarding coverage for these individuals are consistent with historical statutory requirements, but do not align with the new FFP limitations in sections 1903(v)(5) and 2107(e)(1)(R) of the Act. Therefore, CMS is taking action to ensure the demonstration STCs are compliant with sections 1903(v)(5) and 2107(e)(1)(R) of the Act. Specifically, CMS is making conforming changes to STC 10.1 to remove and align language regarding noncitizens with the new statutory restrictions on FFP.

Aligning Designated State Health Programs authority with section 71109 changes

CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide federal matching funds for state expenditures for Designated State Health Programs (DSHP). On April 10, 2025, CMS sent a letter to states explaining that CMS does not anticipate approving new state proposals or renewing existing expenditure authority for section 1115 demonstration expenditure authority for DSHP.[5] In this letter, CMS is clarifying that the time-limited authority in the MassHealth demonstration for DSHP must align with new statutory limitations for FFP in section 1903(v)(5) of the Act that apply beginning October 1, 2026. This includes ensuring that DSHP expenditures are restricted to expenditures for individuals who are U.S. citizens and U.S. nationals, LPRs, Cuban/Haitian entrants, and COFA migrants, unless a limited exception applies, such as expenditures for lawfully residing children and pregnant women in accordance with the Commonwealth's election of the CHIPRA 214 option as described in the state plan.

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf
[4] www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/Massachusetts_71109%20Letter_08.17.26.pdf
[5] https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf

This letter does not change current CMS guidance explaining that section 1115 demonstration expenditure authority for DSHP in the MassHealth demonstration is not expected to be extended beyond the currently approved demonstration period.

Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

As discussed above, CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide expenditure authority for expanded continuous eligibility.

CMS clarified in SHO Letter #26-001 that states must apply the FFP limitations under section 1903(v)(5) of the Act for the following: 1) children in a continuous eligibility period under the state plan or section 1115 demonstrations under section 1902(e)(12) of the Act; 2) individuals covered during a period of continuous postpartum coverage under the state plan or section 1115 demonstrations under section 1902(e)(16) of the Act; and 3) individuals receiving authority for an expanded continuous eligibility period under the terms of a section 1115 demonstration. For Medicaid applicants and current Medicaid beneficiaries who are not U.S. citizens or U.S. nationals, LPRs, Cuban/Haitian entrants, or COFA migrants, and are not lawfully residing children or pregnant women eligible under the Commonwealth's election of the CHIPRA 214 option, FFP remains available for emergency Medicaid coverage for such individuals in accordance with section 1903(v)(5) of the Act beginning October 1, 2026, and for the remainder of the expanded continuous eligibility period.

In this action, consistent with its August 17, 2026, letter to Massachusetts, CMS is making conforming changes to reflect that populations receiving expanded continuous eligibility under section 1115(a)(2) expenditure authority in Massachusetts' MassHealth demonstration are subject to these new requirements beginning October 1, 2026. Specifically, CMS is adding subsection (e) to STC 4.10 to affirm that the FFP limitations under sections 1903(v)(5) and 2107(e)(1)(R) of the Act are applicable to Massachusetts' expanded continuous eligibility authority in the MassHealth demonstration.

Section 71119 – Requirement for states to establish Medicaid community engagement requirement for certain individuals

In this letter, CMS is making conforming changes to the terms of the demonstration to align with section 1902(xx) of the Act (added by section 71119 of the WFTC legislation) and the interim final rule with comment period (IFC) implementing section 1902(xx) of the Act issued in the June 3, 2026, Federal Register (91 FR 33348).[6] Section 1902(xx) of the Act and the IFC require that, beginning no later than January 1, 2027, "applicable individuals" (as defined at section 1902(xx)(9)(A)(i) of the Act) demonstrate, as a condition of their Medicaid eligibility, community engagement (as specified in 42 CFR 435.552) for one to three consecutive months (as specified by the state) before their month of application. Additionally, enrolled applicable individuals must demonstrate community engagement for a number of months specified by the state either between renewals or, if elected by the state, between more frequent verifications of community engagement, as a condition of continued eligibility. Applicable individuals are deemed to demonstrate community engagement for a month if, during such month, they meet the criteria for a mandatory exception or, if elected by the state, an optional short-term hardship exception. Certain individuals who qualify as "specified excluded individuals" (as defined at section 1902(xx)(9)(A)(ii) of the Act) are not applicable individuals and are not subject to the community engagement requirement.

[6] https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals

Aligning section 1115 expanded continuous eligibility authorities with section 71119 requirements

The expanded continuous eligibility expenditure authority in the MassHealth demonstration affects populations that include applicable individuals and lists several circumstances which, should they occur during an applicable individual's designated expanded continuous eligibility period, would necessitate that the individual's Medicaid eligibility be terminated or redetermined, as appropriate. In this action, CMS is adding an applicable individual's failure to demonstrate community engagement to the list of exceptions to expanded continuous eligibility periods in STC 410(b). Section 1902(xx)(10) of the Act prohibits a waiver of the community engagement requirement under section 1902(xx) of the Act in a section 1115(a) demonstration. Beginning January 1, 2027, (or earlier if elected under the state plan) applicable individuals must demonstrate (or be deemed to demonstrate) community engagement at their next renewal. An applicable individual who does not demonstrate (or is not deemed to demonstrate) community engagement at this time will have their Medicaid eligibility terminated, provided they are not eligible under a different eligibility group.

Applicability of section 1902(xx) of the Act to certain individuals covered through section 1115(a)(2) expenditure authority

CMS determined that the MassHealth demonstration provides coverage to populations using section 1115(a)(2) expenditure authority that generally meets the criteria for applicable individuals at section 1902(xx)(9)(A)(i)(II) of the Act and at 42 CFR 435.551(b). In this action, CMS is making a conforming change in Table 3 of the STCs to indicate that the community engagement requirement applies to applicable individuals who are applicants for or beneficiaries enrolled in coverage under the MassHealth section 1115(a)(2) expenditure authorities for Family Assistance-HIV/AIDS, Temporary Assistance for Needy Families (TANF), and Emergency Aid to Elders, Disabled and Children (EAEDC) populations. Massachusetts is required to implement the community engagement requirement for the specified demonstration populations in the MassHealth demonstration not later than January 1, 2027.

Implementation of community engagement in section 1115 demonstrations must be consistent with all applicable regulations, including the use of MAGI-based methodologies for all applicable individuals for purposes of determining whether the applicable individual has demonstrated community engagement on the basis of monthly income or average monthly income for seasonal workers. Even if a state does not have an income test or uses a non-MAGI methodology for determining financial eligibility for a population of applicable individuals eligible only under section 1115 demonstration authority, such as the TANF and EAEDC populations under the MassHealth demonstration, we nevertheless require states to use MAGI-based methodologies for the purpose of determining income under 42 CFR 435.552(f) and (g).

The Commonwealth is required to comply with section 1902(xx) of the Act and implementing regulations with respect to the populations of applicable individuals in the demonstration. In the Commonwealth's community engagement state plan amendment (SPA) submission, Massachusetts will be asked to specify that it operates a demonstration that has applicable individuals eligible and enrolled in coverage authorized only by expenditure authority under section 1115(a)(2) of the Act.

Budget Neutrality

There are no changes to budget neutrality or allotment neutrality for this action.

Monitoring and Evaluation

Massachusetts is required to conduct systematic monitoring and evaluation in accordance with the demonstration STCs and to incorporate, as appropriate, the conforming changes and clarifications specified in

this letter and attachment into these activities. Monitoring and evaluation should identify and describe any observed changes in metrics or outcome measures, including relevant context, as well as associated operational updates. In addition to other required content, these activities—including required deliverables and monitoring calls—should address any anticipated or actual challenges, risks, and program integrity considerations related to implementation of the conforming changes and clarifications in this letter and attachment.

Other Information

This action for the demonstration project is conditioned upon compliance with the previously approved waivers, expenditure authorities, and STCs (as modified as stated in this letter and attachment AD) which set forth in detail the nature, character and extent of anticipated federal involvement in the project. In addition, this action is subject to CMS receiving written acceptance within 30 days of the date of this letter. Your project officer is Rabia Khan, who is available to answer any questions concerning your section 1115 demonstration. Ms. Khan's 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, MD 21244-1850
Email: rabia.khan1@cms.hhs.gov

If you have questions regarding this action, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely

[redacted]

Dr. Mehmet Oz

Enclosure

Cc: John Dedrick, State Lead, Medicaid and CHIP Operations Group

ATTACHMENT AD
CONFORMING CHANGES TO SPECIAL TERMS AND CONDITIONS

This Attachment AD makes conforming changes to the STCs that were approved on September 28, 2022, and amended and restated on September 10, 2026, as follows. Language CMS is newly adding is in red text. Language CMS is removing is in red text and struck through.

Edit to add new waiver: Section 71107 implementation in demonstrations with expanded continuous eligibility authorities

Title XIX Waiver Authority:

Frequency of Eligibility Renewals **Section 1902(e)(14)(L)**

To the extent necessary to enable Massachusetts to complete an orderly transition from expanded continuous eligibility policy by allowing the Commonwealth to defer implementation of six-month renewals for individuals who are covered by expanded continuous eligibility and are enrolled in the Medicaid state plan eligibility group under section 1902(a)(10)(A)(i)(VIII) of the Act, as otherwise required under section 1902(e)(14)(L) of the Act, until the end of the currently approved demonstration period, December 31, 2027.

Edits to STC 4.10.b: Aligning section 1115 expanded continuous eligibility authorities with section 71119 requirements

STC 4.10.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, re-determined, or have medical assistance limited, 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. Beginning January 1, 2027, the individual is an applicable individual who does not demonstrate, or is not deemed to demonstrate, community engagement under section 1902(xx) of the Act and 42 CFR 435.550 through 435.563.

Edits to STC 4.10.e: Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

STC 4.10.e: **Expanded Continuous Eligibility for Noncitizens Ineligible for FFP**. For current Medicaid beneficiaries in an expanded continuous eligibility period, beginning October 1, 2026, the Commonwealth must apply the FFP limitations under section 1903(v)(5) of the Act. FFP is limited to payment for emergency Medicaid coverage during the remainder of the expanded continuous eligibility period for such Medicaid beneficiaries who are not U.S. citizens or nationals, Lawful Permanent Residents (LPRs), Cuban/Haitian entrants, or Compact of Free Association (COFA) migrants and are not eligible as a child or pregnant woman who is lawfully residing in the U.S. under the Commonwealth's election of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option in accordance with section 1903(v)(4) of the Act.

Edits to Table 3 of the STCs: Specifying section 71119 applicable individuals in the demonstration

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. The Commonwealth is required to comply with all requirements specified in section 1902(xx) of the Act and 42 CFR 435.550 through 435.563, with respect to this population of applicable individuals in the demonstration.	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. Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.
TANF/EAEDC	Individuals who receive Temporary Assistance for Needy Families (TANF) and Emergency Aid to Elders, Disabled and Children (EAEDC). Individuals in this eligibility group are eligible for MassHealth Standard based on receipt of TANF and/or EAEDC benefits, not an income determination. The Commonwealth is required to comply with all requirements specified in section 1902(xx) of the Act and 42 CFR 435.550 through 435.563, with respect to this population of applicable individuals in the demonstration.	MassHealth Standard

Edits to STC 10.1: Aligning section 1115 eligibility policies with section 71109 changes

STC 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 500 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 500 percent of the FPL; and (3) who are eligible to purchase subsidized health insurance through the Health Connector under state regulations. The Commonwealth may implement an income threshold below 500 percent of the FPL, but no lower than 300 percent of the FPL, following 90 days advance notice to CMS. Individuals receiving premium and cost sharing subsidies must be notified of any changes in accordance with 45 CFR 155.310(g), and as applicable 45 CFR 156.1255 and 45 CFR 147.106.

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, for up to 100 days. 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 noncitizens~~ 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~~ U.S. citizens, nationals, and individuals who have satisfactory immigration status for full Medicaid benefits, pursuant to sections 1137(d) and 1902(a)(46)(B) of the Act, and for whom federal financial participation is available pursuant to section 1903(v)(5) of the Act.

c. **Reporting for ConnectorCare.** 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.

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, State, or Commonwealth) to operate the MassHealth Medicaid and CHIP Section 1115 Demonstration. These waivers are effective beginning October 1, 2022 through December 31, 2027 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 4, 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 Accountable Care Organization (PCACO) 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.

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.

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. Effective no later than January 1, 2026, individuals 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, and this waiver authority ends for the demonstration.

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. **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 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 herein as the state, State, or 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. **TANF and EAEDC Recipients.** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not based on an income determination.

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 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.

    c. For expenditures related to 1905(z)(2) expansion state individuals in the Adult Group aged 19 and over who are eligible for continuous eligibility based on both MAGI and non-MAGI eligibility criteria, the state shall make a downward adjustment by claiming 2.6 percent of expenditures at the state's regular FMAP instead of at the 1905(z)(2) expansion state increased FMAP.

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. **Diversionary 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 not more than the limits established under the state plan for Medicare Savings Programs, and for monthly Medicare Part B premiums, including through the Qualifying Individual program, for MassHealth Standard members with incomes less than those established under the state plan for Medicare Savings Programs, who are also eligible for Medicare.

    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 up to 135 percent FPL.

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 500 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 500 percent of the FPL. The income ceiling for eligibility may be reduced to a threshold no lower than 300 percent of the FPL subject to the terms in STC 10.1.

    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 500 percent of the FPL. The income ceiling for eligibility may be reduced to a threshold no lower than 300 percent of the FPL subject to the terms in STC 10.1.

    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 STC 8.8(a).

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.

29. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries if not for their

incarceration status for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail or house of correction, or youth correctional facility.

30. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of the Reentry initiative.

31. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, described in these STCs (Section 23), which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. This authority is contingent upon adherence to the requirements within Section 21 of the STC, as well as all other applicable STCs.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services

32. **Statewideness** **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying beneficiaries on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

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

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that is different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration.

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

To enable the state to require qualifying beneficiaries to receive pre-release services, as authorized under this demonstration, through only certain providers.

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

35. **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.

36. **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.

37. **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.

38. **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.

39. **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.

40. **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 15 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:

41. **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.

42. **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.

43. **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:

44. **Resource Limits** **Section 1902(a)(10)(E)**

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

To enable Massachusetts to make monthly premium assistance payments for individuals who would otherwise not be eligible as Qualifying Individuals due to Medicaid State Plan eligibility.

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.

45. **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:

46. **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).

47. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying demonstration beneficiaries who would be eligible for the CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

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 (referred to herein as the state, State, or Commonwealth) waivers of requirements under section 1902(a) and 2102(b)(2) of the Social Security Act ("the 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. Reentry Demonstration Initiative
23. Designated State Health Programs
24. 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
Attachment E. Safety Net Care Pool Payments
Attachment F. SMI/SED Implementation Plan
Attachment G. SUD and SMI/SED Monitoring Protocol
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
Attachment K. Monitoring Protocol for Other Policies (Reserved)
Attachment L. Pricing Methodology for Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs)
Attachment M. DSRIP Protocol
Attachment N. Safety Net Hospital Provider Payment Eligibility and Allocation Protocol
Attachment O. Retired
Attachment P. Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications
Attachment Q. Medicaid Managed Care Entity/ACO Performance-Based Payment Mechanisms
Attachment R. DSRIP Flexible Services Protocol
Attachment S. Evaluation Design
Attachment T. HRSN Implementation Plan
Attachment U. Primary Care Payment Protocol
Attachment V. Provider Rate Increase Attestation Table
Attachment W. Reentry Demonstration Initiative Services
Attachment X. Reentry Demonstration Initiative Implementation Plan
Attachment Y. Reentry Demonstration Initiative Reinvestment Plan (Reserved)

Attachment Z. Approved Designated State Health Programs (DSHP) List
Attachment AA. DSHP Claiming Protocol
Attachment AB. DSHP Sustainability Plan (Reserved)
Attachment AC. Waiver Authorities for the Consolidated Appropriations Act, 2023 Demonstration Amendment

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 care 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.**

a. Retroactive eligibility is provided in accordance with STC 8.13 and Table 9, except for pregnant individuals and children up to the age of 19, of any eligible income level, who 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.

b. Beginning no later than January 1, 2026, individuals of all remaining eligible populations who meet the criteria in 42 CFR 435.915(a) will be eligible for retroactive coverage up to the first day of the third month prior to the date of application.

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. **TANF and EAEDC) Recipients.** The Medicaid agency shall extend MassHealth eligibility to individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. MassHealth eligibility for individuals in this demonstration population does not involve an income determination, but is based on receipt of TANF/EAEDC benefits. Individuals in this demonstration population would not

be described in the 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 their TANF/EAEDC eligibility, then they 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 on the first day of the month 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 days of retroactive coverage prior to the date of application 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 days of the 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 on the first day of the month the application is received at the MEC, 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, SMI/SED services described in section 7, HRSN services described in section 15, and pre-release services described in section 22 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 except for individuals eligible for cost sharing assistance in accordance with STCs 5.3(c) and 5.6(a).

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. The Commonwealth may opt to implement this authority for non-MAGI no sooner than July 1, 2025.

iii. For all adults age 19 and over whose Medicaid eligibility is based on either MAGI or non-MAGI eligibility criteria, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR §435.915, or the effective date of the most recent renewal of eligibility and extends 12 months (except as provided under STC 4.10(b)). The Commonwealth may opt to implement this authority no sooner than July 1, 2025.

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.

Except as specified in subparagraph (b), continuous eligibility applies to individuals in all eligibility categories who meet the criteria in this table:

Table 1: Eligible Populations and Associated Duration for Continuous Eligibility	
Population	**Duration of Continuous Eligibility**

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 Executive Office of Housing and Liveable Communities Emergency Assistance shelter system for families experiencing homelessness)	24 months
Individuals age 19 and over whose eligibility is determined using MAGI or non-MAGI methodologies who no longer would be eligible for Medicaid or CHIP if subject to redetermination but are still within a 12-month continuous eligibility period.	12 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. **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.

4.11. **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.

4.12. **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 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					
Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
AFDC-Poverty Level infants	< Age 1: 0 through 185%	Title XIX	Base Families	Standard	
Medicaid Expansion infants	< Age 1: 185.1 through 200%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application, as a Medicaid Expansion Child • Funded through title XIX if title XXI is exhausted	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	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**
	regard to income or assets Former Foster Care Children up to age 26 without regard to income or assets				
AFDC-Poverty Level Children Medicaid Expansion Children I	Age 6 - 17: 114.1% through 133% Age 18: 0 through 133%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application as a Medicaid Expansion Child • Funded through title XIX if title XXI is exhausted	Base Families Base Fam 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.
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of	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.

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**
		application, as a Medicaid expansion child • Funded through title XIX if title XXI is exhausted			
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	

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**
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 Base Disabled 1902(r)(2) Children 1902(r)(2) Disabled New Adult Group	Limited	Member eligible for emergency services only under the state Plan and the demonstration. Members who meet the definition and are determined to have a disability are included in the Base Disabled EG Members who are determined eligible via 1902(r)(2) criteria are included in the 1902(r)(2) EG
Disabled adults ages 19 through 64	114.1 through 133%	Title XIX	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	Title XIX	Base Disabled	Standard	Income and assets of their parents are not considered in determination of eligibility

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**
	• $0 through $2,000 in assets				
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
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	• 0 through 300% SSI Federal Benefits Rate • $0 through $2,000 in assets	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	• Ages 19 and 20: 0 through 133% • Individuals with HIV or breast or cervical cancer: 0 through 133% • Individuals receiving services or on a waiting list to receive services through the Department of Mental Health: 0 through 133%	Title XIX	New Adult Group	Standard (Alternative Benefit Plan) CarePlus (Alternative Benefit Plan)	Ages 19 and 20 treated as children and entitled to EPSDT Individuals exempt from mandatory enrollment in an Alternative Benefit Plan may enroll in Standard

Table 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**
	• Adults ages 21-64: 0 through 133%				
TANF	Referred eligibility	Title XIX	Base Families	Standard	

Table 3: Demonstration Expansion Populations		
Population Name	**Population Description**	**Benefits**
CommonHealth Adults	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). 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 >$2,000.	CommonHealth benefits as 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). Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

Table 3: Demonstration Expansion Populations		
Population Name	**Population Description**	**Benefits**
CommonHealth Children	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. Higher income children with disabilities if insured at the time of application or when Title XXI funding is exhausted: • < Age 1: 200.1% through 300% FPL • Ages 1 - 18: 150.1% through 300% FPL Higher income children (above 300% FPL) with disabilities ages 0 through 18	CommonHealth benefits as described in the CHIP state plan and benefits described in these STCs. 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. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

Table 3: Demonstration Expansion Populations		
Population Name	**Population Description**	**Benefits**
Out-of-state Former Foster Care Youth	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.	MassHealth Standard benefits, as described in the Medicaid state plan and Section 5 of these STCs.
Family Assistance Children	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. • Children ages 1 through 18: above 150% through 300% FPL • Children less than age 1: Above 200% through 300% FPL	Family Assistance benefits as described in the CHIP state plan and Section 5 of these STCs. 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. A benefit wrap is provided for MassHealth covered services not provided through the ESI

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.	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. Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.
TANF/EAEDC	Individuals who receive Temporary Assistance for Needy Families (TANF) and Emergency Aid to Elders, Disabled and Children (EAEDC). Individuals in this eligibility group are eligible for MassHealth Standard based on receipt of TANF and/or EAEDC benefits, not an income determination.	MassHealth Standard
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.	Benefits are based on self-attested information

Table 3: Demonstration Expansion Populations		
Population Name	**Population Description**	**Benefits**
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		
Population Name	**Population Description**	**Benefits**
Continuous Eligibility	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. Individuals age 19 and over whose eligibility is determined using MAGI or non-MAGI methodologies who no longer would be eligible for Medicaid or CHIP if subject to redetermination but are still within a 12-month continuous eligibility period. 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.	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 who are also eligible for Medicare, (1) payment of monthly Medicare Part B premiums, including through the Qualifying Individual program for individuals with incomes not more than the limits established in the state plan for Medicare Savings Programs (2) payment of hospital insurance premiums under Medicare Part A for individuals with incomes not more than the limits established in the state plan for Medicare Savings Programs; and, (3) payment of deductibles and co-insurance under Medicare Part A and B for individuals with incomes not more than the limits established in the state plan for

Medicare Savings Programs. 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 up to 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.**

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

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

Table 4: Summary of MassHealth Direct Coverage Benefits				
Benefits	**Standard/ Standard ABP**	**CommonHealth**	**Family Assistance**	**CarePlus**
Skilled Nursing Facility	X	X	Limited	Limited
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
Chart Notes				
****Adult Foster Care Services:** These services are state plan services and the definition of these services may vary contingent upon the approved state plan. In general, the services are assistance with activities of daily living and instrumental activities daily living, supportive services, nursing oversight and care management provided in a qualified private home by a principal caregiver who lives in the home. Adult foster care is furnished to adults who receive the services in conjunction with residing in the home. The number of individuals living in the home unrelated to the principal caregiver may not exceed three. Adult foster care does not include payment for room and board or payments to spouses, parents of minor children and other legally responsible relatives.				
*** **Chapter 766 Home Assessments:** These services may be provided by a social worker, nurse or counselor. The purpose of the home assessment is to identify and address behavioral needs that can be obtained by direct observation of the child in the home setting.				
**** **Day Habilitation Services:** These services are state plan services and the definition of these services may vary contingent upon the approved state plan. In general, the services are assistance with skill acquisition in the following developmental need areas: self-help, sensorimotor, communication, independent living, affective, behavior, socialization and adaptive skills. Services are provided in non-residential settings or Skilled Nursing Facilities when recommended through the PASRR process. Services include nursing, therapy and developmental skills training in environments designed to foster skill acquisition and greater independence. A day habilitation plan sets forth measurable goals and objectives, and prescribes an integrated program of developmental skills training and therapies necessary to reach the stated goals and objectives.				

5.11. **Diversionary Behavioral Health Services.** Diversionary behavioral health services are home and community-based mental health and substance use disorder (SUD) services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and SUD services in more community-based, less structured environments. Diversionary services are also provided to support an individual's return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary 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 diversionary 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, 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.

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration

Diversionary Behavioral Health	Setting	Description of Services
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	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. 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 SUD and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to

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

		children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting.
		
		Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.
		
		When provided to chronically homeless individuals or individuals with justice involvement living in the community[1], CSP services fall into the following domains, as applicable to the individual's needs:
		
		• Assisting Members in enhancing daily living skills;
		  ○ Identifying and addressing barriers to attaining and maintaining community tenure
		  ○ 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
		  ○ Coaching members on budget strategies and/or supporting Members to connect with money management services, including financial counselors and representative payees
		  ○ Support to gather documentation such as government identification documents, medical records
		  ○ Linkages to education, vocational training/services
		• Providing service coordination and linkages;
		  ○ Referrals to healthcare providers
		  ○ Providers make reasonable efforts to assist Members identify and/or facilitate transportation options, including

[1] 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**
		community-based transportation resources, such as public transportation and/or community- or publicly-subsidized transportation options o 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. o Discharge planning that involves collaterals as appropriate. Collaterals include state agencies, community-based programs, criminal justice entities, and other non-health care community supports o Provider coordinates care with Members' primary care providers to be knowledgeable of medical conditions, to assess Members' compliance with medical treatment, and to assist with mitigating related barriers • Assisting Members with obtaining benefits, housing, and health care; o Providers work with housing agencies to obtain documentation of housing status o Working with Members to identify transitional supports for move-in o Connecting Members to housing search assistance, and helping to coordinate search(es) o Linkages to primary and preventive health services Linkages to behavioral health and substance use disorder treatment o 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 o Working with Member to identify resources for home modifications as needed

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

		• Developing a crisis plan in the event of a psychiatric crisis;
		  ○ Refer the Member to outpatient provider
		  ○ Refer the Member to an ESP
		  ○ Implement other interventions such as Member's safety plan
		  ○ Collaborate with providers (including ESPs) and natural supports
		• Providing prevention and intervention;
		  ○ 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
		  ○ Developing a service plan/treatment plan (linkages to health, behavioral health, and substance use treatment; and addressing criminogenic needs)
		  ○ Assisting Members to prepare for transition to permanent supportive housing by linking Members to entities that provide transitional assistance resources. This may include referrals to houses of worship, local housing authorities and non-profit agencies. Transitional assistance includes non-recurring household set-up expenses
		  ○ Discharge planning that involves collaterals
		  ○ Early intervention for potential issues/behavior intervention affecting tenancy or community tenure
		• Fostering empowerment and recovery, including linkages to peer support and self-help groups

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	**Setting**	**Description of Services**
		○ Recovery, wellness and empowerment principles and practices are incorporated in service delivery, trainings, and quality improvement activities ○ 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 ○ Provider educates Members and their natural supports about substance use and psychiatric disorders, recovery and medications, and links with regular health services
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 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

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	**Setting**	**Description of Services**
		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 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	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. 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.

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	**Setting**	**Description of Services**
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, will 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

Service for People with SUD	Population	Setting	Definition of Service
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-	All MassHealth members, except those in	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

Table 6: SUD Services			
Service for People with SUD	**Population**	**Setting**	**Definition of Service**
hour Transitional Support Services)	MassHealth Limited		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.
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-

Table 6: SUD Services			
Service for People with SUD	**Population**	**Setting**	**Definition of Service**
			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; 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)
Chart Notes			
MassHealth Members receiving services on a FFS basis will receive all medically necessary Transitional Support Services (TSS), and up to the first 90 days of a medically necessary stay in Residential Rehabilitation Services (RRS). MassHealth Members who are enrolled in an MCO, ACO			

Table 6: SUD Services			
Service for People with SUD	**Population**	**Setting**	**Definition of Service**
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/OUD.** 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/OUD.** 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).[2]

    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.[3] 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.

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[2] 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.
[3] *Ibid*.

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.[4]

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/).
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

[4] 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.

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.[5] 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 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-

[5] 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).

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 SUD and SMI/SED 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 (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. On December 8, 2023, CMS approved a transition period extension until January 1, 2025 for the one remaining facility in the Commonwealth to receive accreditation status.

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.

Table 7: Overview of Managed Care Delivery Systems			
PCCM and PCCM entity delivery systems		**MCO-based delivery systems**	
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. See Attachment L and Attachment U for additional detail on the pricing methodology for Primary Care ACOs.

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 L. 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.[6]

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 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. While the Commonwealth is permitted to implement the program as reflected in each protocol revision prior to CMS approval, the Commonwealth may be subject to deferrals or disallowances if it makes claims for payments inconsistent with the protocol ultimately approved by CMS.

[6] APM Framework: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

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[7]. 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

[7] See Appendix C of MassHealth MCO and ACPP contracts for a discussion of 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 competitively procures MCOs. 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 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 competitively procures Partnership Plans. 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.

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(c) to CMS for review and approval, at 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(c).

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.

iv. STC 8.6(c)(i), 8.6(c)(ii), and 8.6(c)(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 prior demonstration increasing their scope of responsibilities to align with the 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 rations, 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.

b. Subject to the total payments of $20 million in this demonstration period described in STC 8.8(a), the State may carry forward prior year LTSS CP enhanced care coordination expenditure authority from one year to the next. The State must notify CMS of any changes to annual amounts from STC 19.4 in the quarterly and annual monitoring reports.

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:

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***
*Standard/Standard ABP**					
Individuals with no third-party liability (TPL)	Managed Care (PCC Plan, MCO, Primary Care ACO (PCACO) or Accountable Care	X		X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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*** **
	Partnership Plan (ACPP))** Certain services provided via FFS				
Adults with TPL	Receive wrap benefits via FFS			X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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 available; all other services		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." Title IV-E adoption assistance - start date of adoption

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*** **
	are offered via Managed Care or FFS.				
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

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*** **
	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	First day of the month of application if citizenship/immigration status is verified
Individuals in the Breast and Cervical Cancer Demonstration Program without TPL	Managed Care	X			First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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.
*CommonHealth**					
Individuals with no TPL	Managed Care ** (PCC Plan, MCO, PCACO, or ACPP)** Certain services provided via FFS	X		X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) whose start date of coverage may be up to the first day of the

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*** **
					third month prior to the date of application.)
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	X		X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) whose start date of coverage may be up to the first day of the third month prior to the date of application.)
*Family Assistance for HIV/AIDS**					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP) ** Certain services provided via FFS	X		X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) whose start date of coverage may be up to the first day of the third month prior to the date of application.)
*Family Assistance for Children**					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP) ** ** Certain services provided via FFS	X		X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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				First day of the month of application (except for populations listed in STC 4.2(a) and (b) whose start date of coverage may be up to the first day of the third month prior to the date of application.)
*CarePlus**					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP) **	X		X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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*** **
	Certain services provided via FFS				
Individuals with TPL	Receive wrap benefits via FFS			X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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	First day of the month of application (except for populations listed in STC 4.2(a) and (b) whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Limited					
Individuals receiving emergency services only	FFS			X	First day of the month of application (except for populations listed in STC 4.2(a) and (b) 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
Chart Notes					
*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 500 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 500 percent of the FPL; and (3) who are eligible to purchase subsidized health insurance through the Health Connector under state regulations. The Commonwealth may implement an income threshold below 500 percent of the FPL, but no lower than 300 percent of the FPL, following 90 days advance notice to CMS. Individuals receiving premium and cost sharing subsidies must be notified of any changes in accordance with 45 CFR 155.310(g), and as applicable 45 CFR 156.1255 and 45 CFR 147.106.

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, for up to 100 days. 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 also 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.

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 11.4, 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 11.4. The DSH-like 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, referred to interchangeably herein as "UC Application" or "application") 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:

i. Any UC Payment applications submitted by eligible providers; and

ii. 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 $759.6 million (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. 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 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 – B of Attachment E.** The Commonwealth must submit to CMS for approval, updates to Charts A – B of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Years (SFYs) 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-B of Attachment E that are in excess of the approved projected SNCP payments and expenditures by a variance greater than 10 percent. Any variance in SNCP payments and expenditures must adhere to the SNCP expenditure limits pursuant to STC 11.4 The Commonwealth must submit to CMS for approval updates to Charts A – B that include these variations in projected SNCP payments and expenditures. CMS shall approve the Commonwealth's revised projected SNCP payments and expenditures within 30 business days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 11.4.

c. The Commonwealth must submit to CMS for approval updates to Charts A – B of Attachment E that reflect actual payments and expenditures for each SFY, within 180 calendar days after the close of the SFY. CMS shall approve the Commonwealth's actual SNCP expenditures within 45 business days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in STC 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 - B in Attachment E, with the exception of any new types of payments or expenditures in Charts A - B, 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 12.12(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.

Table 10: DSRIP Funding Allocation Total Computable (in millions)							
	DY 27	**DY 28**	**DY 29**	**DY 30**	**DY 31**	**DY 32**	**Total**
Total	$45.7M	$124.2M	$48.6M	$34.2M	$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 8.4 and 8.6 above and in MassHealth's prior demonstration.

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 12.11).

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:

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. No new DSRIP funding is authorized in this demonstration period, therefore, as authorized in the prior demonstration period, the total Budget Period 5 funds will be at-risk in accordance with the table below:

Table 11: Budget Period 5 At-Risk Funds	
DSRIP Budget Period	**January 1, 2022–March 31, 2023**
% of Expenditure Authority At- Risk	20%
Actual Expenditure Authority At- Risk	$22.5M

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: percent reduction = (trended PMPM minus actual PMPM) / (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% * Reduction Target), then Measure Score = 0%

   ii. If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%

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

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

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 $131,500 per residency slot to allow Community Health Centers (CHCs) to support FNP residency slots during the demonstration period. The Commonwealth may adjust the individual awards to providers as necessary to reflect the impact of inflation, subject to the total funding for the initiative detailed in STC 13.8. 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 Programs, for each individual round of awarded practitioners, the managing vendor will make payments in one or two 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.

Table 12: Workforce Funding by Initiative (in millions)

	DY 28	DY 29	DY 30	DY 31	DY 32	Total
Behavioral Health Student Loan Repayment	$0M	$3.30M	$17.70M	$0M	$0M	$20.00M
Primary Care Student Loan Repayment	$0M	$3.10M	$15.30M	$0M	$0M	$18.40M
Nurse Practitioner Residency	$1.21M	$1.21M	$1.21M	$1.21M	$0M	$4.84M
Total	$1.21M	$7.61M	$34.21M	$1.21M	$0M	$43.24M

13.9. Subject to the total funding for each initiative in STC 13.8, the State may carry forward prior year workforce expenditure authority from one year to the next. The State must notify CMS of any changes to annual amounts in the quarterly and annual monitoring reports.

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 DY 27-28) 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.

Table 13: Annual Expenditure Limits (in millions, total computable)

	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Private Acute Hospitals	$80M	$320M	$400M	$400M	$400M	$400M
CHA	$22.5M	$90M	$90M	$90M	$90M	$90M

Table 13: Annual Expenditure Limits (in millions, total computable)						
	DY 27	**DY 28**	**DY 29**	**DY 30**	**DY 31**	**DY 32**
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, 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 Quality and Access

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 language access needs; 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 PY 3 (DY 30), 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 language, disability status, sexual orientation and gender identity) by the end of PY 5 (DY 32), 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 PY 5 (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 language access needs 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 language access needs, 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 PY 3 (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/or 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:

Table 14: Expenditure Authority Annual Allocation by Domain

	Domain 1: Demographic and Health-Related Social Needs Data Collection	**Domain 2: Equitable Quality and Access**	**Domain 3: Capacity and Collaboration**
% 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 (DY 27 and DY 28) 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 DY 32 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 PY 2, PY 3, and PY 4 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 PY 4 to reflect baseline health disparity data collected during the initial years of the Hospital Quality and Equity Initiative. The Commonwealth must submit these updates in the monitoring reports described in STC 16.5.

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. Measure technical specifications must be submitted for CMS review and approval as a separate document from the Implementation Plan. Following CMS approval, the Commonwealth must publish the approved technical specifications for transparency. Updates to approved technical specifications shall not require CMS approval insofar as the updates do not alter the intention of measures, but must be documented in Monitoring Reports and the technical specifications documents, as appropriate.

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 and/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 DY 27 and DY 28, 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.

Table 15: Funding At-Risk by Demonstration Year

	DY 27-28	DY 29	DY 30	DY 31	DY 32
Funding at risk for statewide achievement	5 percent	15 percent	20 percent	25 percent	25 percent

Table 15: Funding At-Risk by Demonstration Year					
	DY 27-28	**DY 29**	**DY 30**	**DY 31**	**DY 32**
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 DY 27/DY 28 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 with 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 addendum to the Hospital Quality and Equity Initiative Implementation Plan.

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 the CHA 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).

Table 16: CHA Expenditure Authority Allotments (total computable)

	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
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 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 addendum to the Hospital Quality and Equity Initiative Implementation Plan. The addendum describing PY 1 (DY 27 – DY 28) of the initiative must be submitted to CMS by January 30, 2023. Descriptions of activities occurring in PYs 2 through 5 (DY 29 – 32) must be included in the Implementation Plan addendum due no later than six months prior to PY 2, as defined in STC 14.8. 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 approved technical specifications shall not require CMS approval insofar as the updates do not alter the intention of measures, but must be documented in Monitoring Reports and the technical specifications documents, 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 CHA addendum to 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 performance 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 Specialized Community Support Programs) 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 15.8 through STC 15.11, and 15.14(b) and (c) 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 flexible services. 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 15.7 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.

vii. Short-term pre-procedure and/or post-hospitalization housing, with room and board, for individuals experiencing homelessness, involving a lower-intensity care setting for individuals who would otherwise lack a safe option for discharge or recovery or who would require a hospital stay. Additional requirements for this service are listed in STC 15.4.

viii. Rent/short-term post transition temporary housing, with room and board, for up to 6 months for pregnant individuals and families with children who are experiencing homelessness, and participating in the Massachusetts Emergency Assistance Family Shelter Program as described in STC 15.6(c). Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.

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 (CSP-JI).

c. Standalone nutrition supports outside of joint room and board interventions.

i. Nutrition counseling and education, including on healthy meal preparation.

ii. Home delivered meals, tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions, and/or specifically for children or pregnant individuals. Up to 3 meals a day may be delivered in the home or private residence, for up to 6 months. This intervention may be renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria. Additional meal support is permitted when provided to the household of a child identified as high risk or a pregnant individual, as defined in the risk and needs-based criteria in Attachment P. Beneficiaries who receive delivered meals cannot concurrently receive nutrition prescriptions.

iii. Nutrition prescriptions (e.g., fruit and vegetable prescriptions, protein box) tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months. This intervention may be renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria. Additional support is permitted when provided to the household of a child identified as high risk or a pregnant individual, as defined in the risk and needs-based criteria in Attachment P. Beneficiaries who receive delivered food prescriptions cannot concurrently receive meals.

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. **Short-Term Pre-procedure and Post-Hospitalization Care**

a. Short-term post hospitalization housing settings provide a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of utilizing other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits, to receive treatment on a short-term basis. Pre-procedure housing is for individuals that are experiencing homelessness and are scheduled for a colonoscopy that has been indicated as needing preparation by a medical professional. Short-term pre-procedure and post hospitalization housing settings must offer transitional supports to help enrollees secure stable housing and avoid future readmissions. The combination of pre-procedure and post-hospitalization housing may not exceed 6 months, once every 12 months. Pre-procedure stays are limited to two full calendar days. Qualified providers will implement pre-procedure care, and short-term post-hospitalization housing in accordance with the detailed service definitions, standards and requirements in Attachment P.

b. The HRSN Services Protocol, described in STC 15.7, must include a description of the state's documented process to authorize Short-Term Pre-procedure and Post Hospitalization Housing Services for beneficiaries for whom there is an assessed risk of a need for other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This process must document that a provider using their professional judgement has determined it to be medically appropriate for the specific beneficiary as provision of the Short-Term Pre-procedure and Post Hospitalization Housing Service is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, states may also impose additional provider qualifications or other limitations and protocols, and these must be documented within the managed care plan contracts, HRSN Services Protocol, and state guidance.

c. Eligible settings for short-term pre-procedure and post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

15.5. **Excluded HRSN Services and Infrastructure.** Excluded items, services, and activities that are not covered as HRSN services or infrastructure 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.

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, except those HRSN-related case management services provided as part of an approved reentry demonstration initiative.

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.

15.6. **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 STC 15.2, 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. For individuals receiving services through the Emergency Assistance Family Shelter Program, the state may determine medical appropriateness using claims data. 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 Specialized 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.

c. Emergency Assistance Family Shelter Program. Pregnant individuals and/or families that are enrolled in the full MassHealth benefit and have been determined eligible for temporary housing assistance under the Massachusetts Emergency Assistance (EA) Family Shelter Program. For a pregnant individual or family to be enrolled in the EA Family Shelter Program, they must meet the Commonwealth's criteria, which includes experiencing homelessness as defined by 24 CFR 91.5. Beneficiaries must also demonstrate clinical need for the service as described in 15.2 and 15.6. The state may determine clinical need using claims data. A pregnant or postpartum individual experiencing homelessness or nutrition insecurity would by definition constitute a high-risk pregnancy because they have defined adverse health outcomes.

d. **Short-term Post-Hospitalization Housing.** MassHealth members must be currently experiencing homelessness as defined by 24 CFR 91.5; have a primary acute medical issue that is not yet resolved but no longer requires or does not require a hospital level of care and does not meet a skilled nursing facility level of care; and is being discharged from a hospital after an inpatient stay or from an emergency department visit. This service is available to all MassHealth members (other than MassHealth limited) who meet the criteria in STC 15.4.

e. Pre-Procedure Housing. MassHealth members must be currently experiencing homelessness as defined by 24 CFR 91.5, who do not have consistent access to a private bathroom, and have a colonoscopy procedure scheduled that has been indicated as needing preparation by a medical professional. This service is available to all eligible MassHealth members (other than MassHealth limited).

15.7. **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 service 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.

a. No later than 90 days after the approval of an amendment to the demonstration that adds new HRSN services, the Commonwealth must submit revisions to the Protocol to CMS. The revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population for each new service, the process by which that criteria will be applied including service plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, if different than previously submitted, and provider qualification criteria for each new service.

15.8. **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 15.6) 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, in accordance with STC 15.1. The Commonwealth may submit this process to CMS at 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 15.9.

iii. The Commonwealth may allow Primary Care ACOs and Accountable Care Partnership Plans to offer the Flexible Services HRSN services 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 January 1, 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. The state may elect to require the BH PIHP to pay for Flexible Services HRSN for Primary Care ACO enrollees.

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).

15.9. **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, BH PIHP, 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, BH PIHP, 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).

15.10. **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.

15.11. **Compliance with Federal Requirements.** The Commonwealth shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

15.12. **Person Centered Plan**. As of January 1, 2025, the Commonwealth shall ensure there is a 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.

15.13. **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.

15.14. **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.

15.15. **Maintenance of Effort (MOE).** The Commonwealth must maintain a baseline level of state funding for ongoing social services related to the categories of housing transition supports and nutrition supports comparable to those authorized under this demonstration,

for the populations authorized under this demonstration, and for the duration of this demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 16.6, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

15.16. **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.

15.17. **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.

15.18. **HRSN Infrastructure Investments: HRSN Infrastructure Fund**

a. Up to $25 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 HRSN 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 HRSN 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 Infrastructure funding retrospectively to the beginning of the extension approval date.

15.19. **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, the Commonwealth'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, no later than 150 days after approval of the demonstration, 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, HRSN, reentry demonstration initiative, and premiums). The Commonwealth must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol for Other Policies will be incorporated in the STCs as Attachment K. 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, language (e.g., preferred language and language access needs), 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 and reentry demonstration 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), (4) social needs screening results from electronic health records, health plans, or other partner agencies as applicable, and (5) data related to carceral status Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community, 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.

The Commonwealth will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and to develop an appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals

and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the Monitoring Protocol for Other Policies.

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 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, DSHP-funded initiatives, and reentry demonstration initiatives. 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 be limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, enrollment by premium payment status, 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, language (e.g., preferred language and language access needs), 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; these metrics are specifically relevant for the Commonwealth's HRSN initiatives and the DSHP-funded initiatives.

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. The Commonwealth's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the newly approved reentry demonstration initiative. In addition, the Commonwealth is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones and goals of the reentry demonstration initiative. CMS expects such metrics to include, but not be limited to: utilization of applicable pre-release and post-release services (e.g., case management, medication-assisted treatment data [MAT], clinical/behavioral health assessment pre-release and primary and behavioral health services post-release), provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among

participating carceral settings. In addition, the Commonwealth is expected to monitor the number of beneficiaries served and types of services rendered under the demonstration. Also, in alignment with the Commonwealth's Reentry Initiative Implementation Plan, the Commonwealth must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and plans for addressing them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

vii. For the presumed eligibility policies, the Commonwealth must, at a minimum, collect performance metrics that establish the rates of presumed eligible beneficiaries eventually found to be eligible and ineligible and the types and counts of services rendered to beneficiaries during the presumed eligibility period.

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. **Reentry Demonstration Initiative Mid-Point Assessment.** The Commonwealth must contract with an independent entity to conduct a mid-point assessment of the reentry demonstration initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment Report.

The Mid-Point Assessment Report must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the reentry demonstration initiative. The report must be completed by the end of the third year of demonstration implementation. In the event that the reentry demonstration initiative is implemented at a

timeline within the demonstration approval period, such as not to provide adequate implementation period to contribute toward a meaningful mid-point assessment, the report may be completed during a future extension of the demonstration, assuming it would also extend the authority for the reentry demonstration initiative. In the event that CMS and the Commonwealth do not extend the reentry demonstration initiative beyond the demonstration's approval period ending on December 31, 2027, the mid-point assessment must be completed and the report submitted to CMS no later than when the demonstration's Summative Evaluation Report is due to CMS, which is 18 months after the end of the demonstration approval period. If requested, 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.

The Commonwealth must require the independent assessor to provide a draft of the Mid-Point Assessment Report to the Commonwealth that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the midpoint assessment, the Commonwealth must require that the independent assessor consult with key stakeholders including, but not limited to: pre- and post- release providers participating in the Commonwealth's reentry demonstration initiative, eligible and participating beneficiaries, and other key partners in carceral and community settings. For milestones and measure targets at medium to high risk of not being achieved, the Commonwealth must submit to CMS modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol for ameliorating these risks subject to CMS approval.

Elements of the Mid-Point Assessment Report must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of 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;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the Commonwealth's Reentry Initiative Mid-Point Assessment Report.

16.7. **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.

16.8. **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.

16.9. **Post-Award Forum.** Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the Commonwealth shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the Commonwealth must publish the date, time and location of the forum in a prominent location on its website. The Commonwealth must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the Commonwealth must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

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), the Commonwealth must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. 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. Any modifications to an existing approved Evaluation Design will only affect the modified sections and will not otherwise affect previously established requirements and timelines for report submission for the demonstration, if applicable. 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, the HRSN demonstration components, reentry demonstration initiatives, 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, language (e.g., preferred language and language access needs), 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, other DSHP-funded initiatives, 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 (e.g., short-term pre/post-hospitalization services, nutrition services, and temporary housing services) 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.

In addition, in accordance with the approved Evaluation Design, the Commonwealth must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the Commonwealth must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

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.** For the duration of the policy implementation during the demonstration approval period, the Commonwealth should provide—to the extent possible—hypotheses for the waiver of retroactive eligibility that 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. **DSHP-Funded Initiatives**. The Commonwealth's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the Commonwealth's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN, reentry and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing certain home-and-community-based services or services to address HRSN or behavioral health.

j. **Reentry Demonstration Initiative.** Evaluation of the reentry demonstration initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and the provision of efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the reentry demonstration initiative in the Commonwealth, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between carceral and community services; access to and quality of care in carceral and community settings; preventive and routine physical and behavioral health care utilization; nonemergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

   The Commonwealth must also provide a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release—to the extent feasible, and discuss in the evaluation any relationship identified between the provision and timing of

particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the Commonwealth is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the Commonwealth might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include an examination of carceral provider qualifications and standards, as well as the experiences of carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, similar to the Commonwealth's HRSN initiative, the Commonwealth must conduct a comprehensive cost analysis to support developing estimates of implementing the reentry demonstration initiative, including covering associated services.

k. **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. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

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. Unless otherwise agreed upon in writing by CMS, the Commonwealth must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

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.

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
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.
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.

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
e-HIV/FA	Main	X		X	Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance.
e-HIV/FA Hypo	Hypo 9	X		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.
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	Main			X	Expenditures for Safety Net Provider Payments, as referenced on Attachment E item 8

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Payments					
New Adult Group	Hypo 2	X		X	Report for all expenditures for the Affordable Care Act (ACA) 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.
Marketplace Subsidies Expansion	Hypo 3	X		X	Expenditures for premium and cost sharing subsidies for individuals whose income is between 300 and 500 percent of the FPL.
Provisional Eligibility	Main			X	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority consistent with STC 4.7.
TANF/EAEDC	Main			X	Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and 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 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.

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
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	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 (i.e. Part A and B assistance for individuals with income at or below 133 percent of the FPL; Part B assistance for individuals with income at or below 165 percent of the FPL).
Medicare Cost Sharing Assistance	Main			X	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 (i.e., Part A and B assistance for individuals with income above 133 percent of the FPL and up to the MSP state plan limit; Part B assistance for individuals with income above 165 percent of the FPL and up to the MSP state plan limit.)
Diversionary BH	Main			X	All expenditures for Diversionary BH Services

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
LTSS 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.
HRSN STPHH	Capped Hypo		X	X	All expenditures for short-term pre-procedure and post-hospitalization housing.
HRSN EA Family	Capped Hypo		X	X	All expenditures for the Emergency Assistance (EA) Family Shelter program.
HRSN Infrastructure Expansion	Capped Hypo		X	X	All expenditures for expanded HRSN infrastructure supports.
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 continued benefits for Formerly Incarcerated individuals who are defined as Base Families during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
CE Formerly Incarcerated/ Base Disabled	Hypo 7	X		X	All expenditures for continued benefits for Formerly Incarcerated individuals who are defined as Base Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE Homeless/Base Families	Hypo 7	X		X	All expenditures for continued benefits for Homeless individuals who are defined as Base Families during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE Homeless/Base Disabled	Hypo 7	X		X	All expenditures for continued benefits for Homeless individuals who are defined as Base Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE Homeless/ 1902(r)2 Children	Hypo 7	X		X	All expenditures for continued benefits for Homeless individuals who are defined as 1902(r)2 Children during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE Homeless/ 1902(r)2 Disabled	Hypo 7	X		X	All expenditures for continued benefits for Homeless individuals who are defined as 1902(r)2 Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE Homeless/ 1902(r)2 BCCDP	Hypo 7	X		X	All expenditures for continued benefits for Homeless individuals who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/CommonHealth	Hypo 7	X		X	All expenditures for continued benefits for adults and homeless individuals who are defined as

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					CommonHealth Adults during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/New Adult	Hypo 7	X		X	All expenditures for continued benefits for adults who are defined as the ACA New Adult group during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/Base Families	Hypo 7	X		X	All expenditures for continued benefits for adults and homeless individuals over age 65 who are defined as Base Families during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/Base Disabled	Hypo 7	X		X	All expenditures for continued benefits for adults who are defined as Base Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/1902(r)2 Children	Hypo 7	X		X	All expenditures for continued benefits for adults who are defined as 1902(r)2 Children during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/1902(r)2 Disabled	Hypo 7	X		X	All expenditures for continued benefits for adults who are defined as 1902(r)2 Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/1902(r)2 BCCDP	Hypo 7	X		X	All expenditures for continued benefits for adults who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.
CE/e-HIV/FA	Hypo 7	X		X	All expenditures for continued benefits for adults who are defined as e-HIV during the Continuous Eligibility

Table 17: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					period and who would otherwise lose coverage during an eligibility determination.
CE/FFS and Duals	Hypo 7	X		X	All expenditures for continued benefits for adults and homeless individuals who are defined as FFS or Medicare-Medicaid dually eligible individuals in a Senior Care Options plan, Program of All-Inclusive Care for the Elderly (PACE) plan, and One Care Plan during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination. This group also includes non-duals in SCO and PACE.
Reentry Services	Hypo 8	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state prisons, county jails and houses of correction, or youth correctional facilities.
Reentry Non-Services	Hypo 8		X	X	Expenditures for planning and supporting the reentry demonstration initiative.
DSHP	Main			X	All expenditures for DSHP described in Section 23.
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**
Base Families	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/Date of Payment	MAP	Y	7/1/97	12/31/27
Base Disabled	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/Date of Payment	MAP	Y	7/1/97	12/31/27

1902(r)(2) Children	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/Date of Payment	MAP	Y	7/1/97	12/31/27
1902(r)(2) Disabled	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/Date of Payment	MAP	Y	7/1/97	12/31/27
BCCDP	Report all medical assistance expenditures for individuals eligible under the Breast and Cervical Cancer Demonstration Program who are		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	7/1/97	12/31/27

	enrolled in MassHealth Standard.							
CommonHealth	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/Date of Payment	MAP	Y	7/1/97	12/31/27
e-Family Assistance	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/Date of Payment	MAP	N	7/1/97	12/31/27
e-HIV/FA	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/Date of Payment	MAP	Y	7/1/17	4/18/24
e-HIV/FA Hypo	Report all medical assistance expenditures for Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27

	enrolled in Family Assistance.							
SNCP-DSRIP	Report expenditures for Delivery System Reform Payments (DSRIP). This should be inclusive of SNCP-DSRIP-ACO, SNCP-DSRIP-CP, SNCP-DSRIP-SWI, SNCP-DSRIP-Operations.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment/Date of Payment	ADM	N	7/1/17	12/31/27
SNCP-PHTII	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
SNCP-DSH-HSNTF	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
SNCP-DSH-IMD	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

SNCP-DSH-CPE	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
SNCP-UCC	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
SNCP-OTHER	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
SNCP - Safety Net Provider Payments	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

New Adult Group	Report for all expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	7/1/97	12/31/27
Marketplace Subsidies	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	10/1/22	12/31/27
Marketplace Subsidies Expansion	Report expenditures for premium and cost sharing subsidies for individuals whose income is between 300 and 500 percent of the FPL.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	4/19/24	12/31/27
Provisional Eligibility	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/Date of Payment	MAP	N	7/1/17	12/31/27
TANF/EAEDC	Report all medical assistance expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	N	7/1/17	12/31/27

	Elders, Disabled and Children.							
End of Month Coverage	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/Date of Payment	MAP	N	7/1/17	12/31/27
FFCY	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 (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		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	7/1/97	12/31/27

	demonstration at any time during the foster care period in which they aged out.							
SUD	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/Date of Payment	MAP	Y	10/1/22	12/31/27
SMI IMD Services	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 prohibition under the state plan as described in Expenditure Authority #15.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	8/11/22	12/31/27

Medicare Savings Program (MSP) Expansion	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, (i.e., Part A and B assistance for individuals with income at or below 133 percent FPL; Part B assistance for individuals with income at or below 165 percent FPL).		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	N	8/11/22	12/31/27
Medicare Cost Sharing 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, (i.e., Part A and B assistance for individuals with income above 133 percent of the FPL and up to the state plan		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	N	4/19/24	12/31/27

	limit; Part B assistance for individuals with income above 165 percent of the FPL and up to the state plan limit.)							
Diversionary BH	All expenditures for Diversionary BH Services		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	N	10/1/22	12/31/27
LTSS CP Enhanced Care Coordination	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
Hospital Quality and Equity Initiative	Report all expenditures for the Hospital Quality and Equity Initiative.		Follow standard CMS 64.10- Category of Service Definitions	Date of payment	ADM	N	10/1/22	12/31/27
Workforce Initiative	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

HRSN Services	Report all expenditures for approved HRSN initiatives.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	10/1/22	12/31/27
HRSN STPHH	Report all expenditures for short-term pre-procedure and post-hospitalization housing		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	4/19/24	12/31/27
HRSN EA Family	Report all expenditures for the Emergency Assistance (EA) Family Shelter program.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	4/19/24	12/31/27
HRSN Infrastructure	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
HRSN Infrastructure Expansion	Report all expenditures for expanded HRSN infrastructure supports.		Follow standard CMS 64.10 Category of Service Definitions	Date of service/Date of payment	ADM	N	4/19/24	12/31/27

Flexible Services: Transportation	Report all expenditures for the transportation benefit under the Flexible Services Program.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	10/1/22	12/31/27
Flexible Services: Cooking Supplies	Report all expenditures for the cooking supplies benefit under the Flexible Services Program.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	10/1/22	12/31/27
CE Formerly Incarcerated/ Base Families	All expenditures for continued benefits for Formerly Incarcerated individuals who are defined as Base Families during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	10/1/22	12/31/27
CE Formerly Incarcerated/ Base Disabled	All expenditures for continued benefits for Formerly Incarcerated individuals who are defined as Base Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	10/1/22	12/31/27

	eligibility determination.							
CE Homeless/Base Families	All expenditures for continued benefits for Homeless individuals who are defined as Base Families during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	10/1/22	12/31/27
CE Homeless/Base Disabled	All expenditures for continued benefits for Homeless individuals who are defined as Base Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	10/1/22	12/31/27
CE Homeless/ 1902(r)2 Children	All expenditures for continued benefits for Homeless individuals who are defined as 1902(r)2 Children during the Continuous Eligibility period and who would otherwise lose coverage during		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	10/1/22	12/31/27

	an eligibility determination.							
CE Homeless/ 1902(r)2 Disabled	All expenditures for continued benefits for Homeless individuals who are defined as 1902(r)2 Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	10/1/22	12/31/27
CE Homeless/ 1902(r)2 BCCDP	All expenditures for continued benefits for Homeless individuals who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	10/1/22	12/31/27
CE/ CommonHealth	All expenditures for continued benefits for adults and homeless individuals who are defined as CommonHealth Adults during the Continuous Eligibility period and		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27

	who would otherwise lose coverage during an eligibility determination.							
CE/New Adult	All expenditures for continued benefits for adults who are defined as the ACA New Adult group during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27
CE/Base Families	All expenditures for continued benefits for adults and homeless individuals over age 65 who are defined as Base Families during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27
CE/Base Disabled	All expenditures for continued benefits for adults who are defined as Base Disabled during the Continuous Eligibility period and who would otherwise lose coverage during		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27

	an eligibility determination.							
CE/1902(r)2 Children	All expenditures for continued benefits for adults who are defined as 1902(r)2 Children during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27
CE/1902(r)2 Disabled	All expenditures for continued benefits for adults who are defined as 1902(r)2 Disabled during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27
CE/1902(r)2 BCCDP	All expenditures for continued benefits for adults who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27

CE/e-HIV	All expenditures for continued benefits for adults who are defined as e-HIV/FA individuals during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27
CE/FFS and Duals	All expenditures for continued benefits for adults and homeless individuals who are defined as FFS or Medicare-Medicaid dually eligible individuals in a Senior Care Organization, Program of All-Inclusive Care for the Elderly (PACE) plan, and One Care Plan during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination. This group also includes non-duals in SCO and PACE.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	N	4/19/24	12/31/27

Reentry Services	Report expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state prisons, county jails and houses of correction, or youth correctional facilities.		Follow standard CMS-64.9 Category of Service Definitions	Date of service/Date of Payment	MAP	Y	4/19/24	12/31/27
Reentry Non-services	Report expenditures for planning and supporting the Reentry demonstration initiative.		Follow standard CMS-64.10 Category of Service Definitions	Date of service/Date of Payment	ADM	Y	4/19/24	12/31/27
DSHP	Report all DSHP expenditures.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	6/25/24	12/31/27
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described		Follow standard CMS 64.10 Category	Date of payment	ADM	N	10/1/22	12/31/27

	elsewhere and are not subject to budget neutrality.		of Service Definitions					

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.

Table 19: Demonstration Years		
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.[8]

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

[8] 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.

expenditures or the next best available data, that the data are allowable in accordance 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	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Base Families	PC	Both	4.80%	$451.74	$465.17	$487.50	$510.90	$535.42	$561.12
Base Disabled	PC	Both	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	4.80%	$460.97	$474.68	$497.46	$521.34	$546.36	$572.59
1902(r)(2) Disabled	PC	Both	4.80%	$586.71	$604.16	$633.16	$663.55	$695.40	$728.78
BCCDP	PC	Both	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	N/A	The Commonwealth must have savings to offset these expenditures.					
e-HIV/FA	N/A	WW Only	N/A	The Commonwealth must have savings to offset these expenditures.		N/A			

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SNCP-DSRIP	Agg	WW Only	N/A	$45,662,216	$124,247,201	$48,632,098	$34,186,080	$502,625	-
SNCP-PHTII	Agg	WW Only	N/A	-	$6,350,000	-	-	-	-
SNCP-DSH-HSNTF	Agg	WW Only	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	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	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	N/A	-	$100,000,000	$100,000,000	$100,000,000	$100,000,000	$100,000,000
SNCP-OTHER	Agg	WW Only	N/A	$5,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SNCP - Safety Net Provider Payments	Agg	WW Only	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	N/A	The Commonwealth must have savings to offset these expenditures.					
TANF/EAEDC	N/A	WW Only	N/A	The Commonwealth must have savings to offset these expenditures.					
End of Month Coverage	N/A	WW Only	N/A	The Commonwealth must have savings to offset these expenditures.					
Medicare Savings Program (MSP) Expansion	N/A	WW only	N/A	The Commonwealth must have savings to offset these expenditures.					
Medicare Cost Sharing Assistance	N/A	WW only	N/A	-	-	The Commonwealth must have savings to offset these expenditures.			
Diversionary BH	N/A	WW only	N/A	The Commonwealth must have savings to offset these expenditures.					

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
LTSS CP Enhanced Care Coordination	Agg	WW only	N/A	-	$4,000,000	$4,000,000	$4,000,000	$4,000,000	$4,000,000
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	-	$1,210,000	$7,610,000	$34,210,000	$1,210,000	$0
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

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
DSHP	Agg	WW only	N/A	N/A	N/A	The Commonwealth must have savings to offset these expenditures.			

*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	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Common Health	PC	Both	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	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
New Adult Group	PC	Both	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	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Marketplace Subsidies	PC	Both	5.60%	$170.96	$176.88	$186.79	$197.25	$208.29	$219.96
Marketplace Subsidies Expansion	PC	Both	5.60%	-	-	$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	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
FFCY	PC	Both	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	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SUD	PC	Both	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	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SMI IMD Services	PC	Both	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.

Table 27: Hypothetical Budget Neutrality Test 7

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
CE Formerly Incarcerated/ Base Families	PC	Both	4.80%	-	$465.17	$487.50	$510.90	$535.42	$561.12
CE Formerly Incarcerated/ Base Disabled	PC	Both	4.80%	-	$1,354.45	$1,419.47	$1,487.60	$1,559.01	$1,633.84
CE Homeless/ Base Families	PC	Both	4.80%	-	$465.17	$487.50	$510.90	$535.42	$561.12

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
CE Homeless/ Base Disabled	PC	Both	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	4.80%	-	$474.68	$497.46	$521.34	$546.36	$572.59
CE Homeless/ 1902(r)2 Disabled	PC	Both	4.80%	-	$604.16	$633.16	$663.55	$695.40	$728.78
CE Homeless/ 1902(r)2 BCCDP	PC	Both	5.50%	-	$2,197.58	$2,318.45	$2,445.96	$2,580.49	$2,722.42

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
CE/ CommonHealth	PC	Both	4.80%	-	-	$550.62	$577.05	$604.75	$633.78
CE/New Adult	PC	Both	5.50%	-	-	-	$799.74	$843.72	$890.13
CE/Base Families	PC	Both	4.80%	-	-	$487.50	$510.90	$535.42	$561.12
CE/Base Disabled	PC	Both	4.80%	-	-	-	$1,487.60	$1,559.01	$1,633.84
CE/1902(r)2 Children	PC	Both	4.80%	-	-	-	$521.34	$546.36	$572.59
CE/1902(r)2 Disabled	PC	Both	4.80%	-	-	-	$663.55	$695.40	$728.78
CE/1902(r)2 BCCDP	PC	Both	5.50%	-	-	-	$2,445.96	$2,580.49	$2,722.42

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
CE/e-HIV	PC	Both	4.60%	-	-	-	$1,682.95	$1,760.37	$1,841.35
CE/FFS and Duals	PC	Both	4.60%	-	-	$2,858.67	$2,990.17	$3,127.72	$3,271.60

19.13. **Hypothetical Budget Neutrality Test 8: Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. 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 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 28: Hypothetical Budget Neutrality Test 8

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Reentry Services	PC	Both	4.90%	-	-	-	$1,090.83	$1,144.28	$1,200.35

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Reentry Non-Services	Agg	Both	N/A	-	-	$7,000,000	$28,000,000	$28,000,000	$7,000,000

19.14. **Hypothetical Budget Neutrality Test 9: e-HIV/FA.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 9. 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 9 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 29: Hypothetical Budget Neutrality Test 9

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
e-HIV/ FA Hypo	PC	Both	4.60%	-	-	$1,608.94	$1,682.95	$1,760.37	$1,841.35

19.15. **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.

19.16. **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 30: 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 STPHH	Agg	Both	-	-	-	$2,007,500	$2,586,938	$3,621,713
HRSN EA Family	Agg	Both	-	-	$190,000,000	$152,500,000	$152,500,000	$152,500,000
HRSN Infrastructure	Agg	Both	-	-	$8,000,000	-	-	-
HRSN Infrastructure Expansion	Agg	Both	-	-	$4,500,000	$12,500,000	-	-

19.17. **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.

19.18. **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.

19.19. **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.

19.20. **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.

Table 31: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
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 the Hospital Quality and Equity Initiative, DSHP and HRSN expenditure authorities, as referenced in expenditure authorities #25, #31, and #22, respectively.

21.2. As a condition of approval and ongoing provision of FFP for the Hospital Quality and Equity Initiative, DSHP, 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. If the Commonwealth's Medicaid rates already exceed 80 percent of Medicare in any of these three categories for either fee-for-service or managed care, for such categories it will at least sustain rates at existing levels for the remainder of the demonstration period.

21.3. 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.

21.4. 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.

21.5. 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.

21.6. 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.

21.7. 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).

21.8. 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.

21.9. 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 21.3.

21.10. If the Commonwealth uses a managed care delivery system for any of the service categories defined in STC 21.3, 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 21.3.

21.11. 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.

21.12. 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.

21.13. 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.

21.14. 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:

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

In accordance with STCs 21.1 through 21.14, 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*].

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.

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.

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 21.3 will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]
☐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*]

☐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*].
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 DSHP and 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 DSHP and 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 21.11 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 21.10, 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. REENTRY DEMONSTRATION INITIATIVE

22.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medicaid and CHIP beneficiaries and demonstration beneficiaries who would be eligible for CHIP except for their incarceration status, who are residing in state prisons, county jails or houses of correction, or youth correctional facilities, as specified by the implementation timeline in STC 22.8 and the implementation plan in STC 22.9. The objective of this component of the demonstration is to facilitate beneficiaries' access to certain healthcare services and case management, provided by Medicaid participating providers or CHIP participating providers, while beneficiaries are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins prior to release and is expected to promote continuity of care and improve health outcomes for justice-involved individuals. Further, coverage beyond 30 days (for up to 90 days immediately before the expected date of release) is expected to provide a longer runway for enrollees to identify and begin to receive needed services, contribute to a reduction in post-release acute care utilization, and lead to a reduction in health crises, overdoses, and overdose-related deaths. The purpose of this reentry demonstration initiative is to provide short-term Medicaid and CHIP enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death in the near-term post-release.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings prior to release.

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release.

c. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.

d. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings, and in the community to maximize successful reentry post-release.

e. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs.

f. Reduce all-cause deaths in the near-term post-release.

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

22.2. **Qualifying Criteria for Pre-Release Services.** In order to qualify to receive services under this component of the demonstration, a beneficiary must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a state prison, county jail or house of correction, or youth correctional facility as defined in STC 22.4;

b. Be enrolled in Medicaid or CHIP, or otherwise eligible for CHIP if not for their incarceration status.

22.3. **Scope of Pre-Release Services.** The pre-release services authorized under the reentry demonstration initiative include the following services, which are further described in Attachment W. Contingent upon CMS's approval of the state's Reentry Demonstration Initiative Implementation Plan (see STC 22.9), the state may begin claiming FFP for services covered through the initiative at the time of inclusion of this STC, expected to begin no later than July 1, 2025.

a. The pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and HRSN;

ii. MAT for all types of SUD as clinically appropriate, with accompanying counseling;

iii. Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;

iv. Medications and medication administration;

v. Laboratory and radiology services; and

vi. A minimum 30-day supply of all covered prescription medications and prescription over-the-counter drugs (as clinically appropriate) and durable medical equipment and supplies, provided to the beneficiary immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.

b. The expenditure authority for pre-release services through this initiative comprises a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Massachusetts Medicaid or CHIP State Plans, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT benefit for qualifying Medicaid beneficiaries under age 21) are not available to qualifying beneficiaries through the reentry demonstration initiative.

22.4. **Participating Facilities.** The pre-release services will be provided at state prisons, county jails and houses of correction, and youth correctional facilities, or outside of the correctional facility with appropriate transportation and security oversight provided by the carceral facility, subject to the Commonwealth's approval of a facility's readiness, according to the schedule described in STC 22.8. Services cannot be provided in facilities that meet the definition of an IMD.

22.5. **Participating Providers.**

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Massachusetts state scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and enrolled as a MassHealth provider.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional-facility based providers.

c. All participating providers and provider staff, including carceral providers, shall have necessary experience and receive appropriate training, as applicable to a given carceral facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community based or carceral providers who have expertise working with justice-involved individuals.

22.6. **Suspension of Coverage.** Upon entry of a Medicaid or CHIP beneficiary into a participating correctional facility, the Commonwealth must not terminate and generally shall suspend their Medicaid or CHIP coverage, as described in the Reentry Demonstration Initiative Implementation Plan.

a. If an individual is not enrolled in Medicaid or CHIP when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid or CHIP and with submitting an application to MassHealth, unless the individual declines such assistance or wants to decline enrollment.

22.7. **Coverage of Individuals Otherwise Eligible for CHIP During Incarceration.** If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status, and they qualify to receive pre-release services per STC 22.2, pre-release services will be covered under this demonstration's expenditure authority.

22.8. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating state prisons, county jails and houses of correction, and youth correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying beneficiaries who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Commonwealth will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;

i. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. Massachusetts may allow participating facilities to select a level of services for initial implementation. The first services level must be structured with at least the minimum benefit package for pre-release coverage: case management services to assess and address physical and behavioral health needs and HRSN; MAT services for all types of SUD as clinically appropriate, with accompanying counseling; and a minimum of 30-day supply of all prescription medications provided to the beneficiary immediately upon release from the correctional facility. The Commonwealth may define such levels of services, describe how a participating facility may move between levels of services, and the timeline for initial implementation and shifting, if any, between levels of service in its Implementation Plan. The Commonwealth may define such levels of services, describe how a participating facility may move between levels of services, and the timeline for initial implementation and shifting, if any, between levels of service in its Implementation Plan, including the implications for evaluation.

b. Coordination amongst partners with a role in furnishing health care and HRSN services to beneficiaries, including, but not limited to, state health and human services agencies, ACOs, managed care plans, and community-based providers.

c. Appropriate reentry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and behavioral health providers and their managed care plan, and making referrals to care management and community supports providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and prescribed over-the-counter drugs (a minimum 30-day supply as clinically appropriate), consistent with approved Medicaid and CHIP state plan coverage authority and policy;

d. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

e. A data exchange process to support the care coordination and transition activities described in (d) and (e) of this subsection;

f. Reporting of requested data from the Commonwealth to support program monitoring, evaluation, and oversight; and

g. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers that the correctional facilities will partner with for the provision of pre-release services.

22.9. **Reentry Demonstration Initiative Implementation Plan.** The Commonwealth is required to submit a Reentry Demonstration Initiative Implementation Plan to describe, at a minimum, the Commonwealth's approach to implementing the reentry demonstration initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Commonwealth must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The Commonwealth must submit any required clarifications or revisions to their draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment X and may be further altered only with CMS approval.

In the Implementation Plan, the Commonwealth is expected only to provide additional details regarding the implementation of the reentry demonstration initiative that are not already captured in the STCs (including any other attachments). CMS will provide the state with a template to support developing and obtaining approval of the Implementation

Plan. Contingent upon CMS's approval of the Commonwealth's Implementation Plan, and the Commonwealth's determination that participating facilities have demonstrated readiness, the Commonwealth may begin claiming FFP for services provided through the reentry demonstration initiative at the time of inclusion of this STC, expected to begin no later than July 1, 2025.

The Reentry Demonstration Initiative Implementation Plan must describe the implementation settings, the time period that pre-release services are available, and the Commonwealth's approach to implementing levels of services, including whether facilities may opt into each and identification of each. The Implementation Plan should further describe the Commonwealth's approach for handling facilities that may be allowed to opt into a level of services after the initial implementation of the demonstration has begun. Other than providing such contextual information, the core requirement of the Implementation Plan is for the Commonwealth to describe the specific processes, including timelines and programmatic content where applicable, for meeting the below milestones, such as to remain on track to achieve the key goals and objectives of the program. For each milestone—and specifically for any associated actions that are integral aspects for attaining the milestone—the Implementation Plan must document the current state of affairs, the intended end state to meet the milestone, the date by which the milestone is expected to be achieved, and the activities that must be executed by that date for the milestone to be achieved. Furthermore, for each milestone, the Implementation Plan must identify the main anticipated implementation challenges and the Commonwealth's specific plans to address these challenges. The Implementation Plan is also required to document the state's strategies to drive positive changes in health care quality for all beneficiaries, thereby reducing disparities and improving health equity. The Commonwealth will be required to provide the following information related to, but not limited to, the following milestones and actions.

a. **Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.** The state must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid and CHIP eligible individuals or individuals who would be eligible for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid and CHIP application, enrollment, and renewal processes. Additionally, the state must describe how it will notify individuals of any Medicaid and CHIP eligibility determinations or actions. Other aspects to be included in the Implementation Plan related to this milestone include the state's plan to make available a Medicaid and CHIP and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid and CHIP application, including providing information about where to complete the Medicaid and CHIP

application for another state (e.g., relevant state Medicaid agency website) if the individual will be moving to a different state upon release.

b. **Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.** The state must detail how the Medicaid agency and the carceral facilities will ensure that beneficiaries can access the pre-release benefit package, as clinically appropriate. The state must describe its approach and plans for implementing processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release.

c. **Milestone 3: Promoting continuity of care.** The state must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, including HRSN and LTSS, as applicable. The state must detail its plans and timeline for implementing state policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. The state must describe its processes for promoting and ensuring collaboration between case managers, providers of pre-release services, and providers of post-release services, to ensure that appropriate care coordination is taking place. As applicable, the state must also describe the planning or projected activities to ensure that Medicaid and CHIP managed care plan contracts include requirements and processes for transfer of relevant health information from the carceral facility, community-based providers, and/or state Medicaid agency to the managed care plan to support continuity and coordination of care post-release.

d. **Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.** The state must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate timeframe. The Implementation Plan must also capture how the state will monitor and adjust, as needed, ongoing post-release case management and describe its process to help ensure the scheduling and receipt of needed services. The state must describe how it will connect demonstration beneficiaries to other services needed to address HRSN, LTSS, and other social supports as identified in the development of the person-centered care plan. Additionally, the state must describe how it will ensure that case managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.

e. **Milestone 5: Ensuring cross-system collaboration**. The state must provide an assessment that outlines how MassHealth and participating correctional systems will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to how correctional facilities will facilitate access to incarcerated beneficiaries for community health care providers, including case managers, either in person or via telehealth. The state must also document its plans for establishing communication, coordination, and engagement between corrections systems, community supervision entities, health care provider and provider organizations, the Commonwealth Medicaid agency, and supported employment and supported housing organizations. The Commonwealth must also develop a system (for example, a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release, and identify anticipated challenges and potential solutions. Further, the Commonwealth must develop and share its strategies to improve awareness and education about Medicaid/CHIP coverage and health care access among stakeholders, including those who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).

22.10. **Reentry Initiative Reinvestment Plan.** To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries, the Commonwealth must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries prior to the individual facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing

the HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

iv. Improved health information technology and data sharing;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the HRSN of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. Within 6 months of amendment approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan as part of the implementation plan referred to in STC 22.9 for CMS approval that memorializes the Commonwealth's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment Y.

22.11. **Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid and CHIP pre-release application and suspension/unsuspension planning and purchase of certified electronic health record technology to support Medicaid and CHIP pre-release applications. Reentry demonstration initiative planning and implementation funds will provide funding over the course of the MassHealth demonstration to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among MassHealth, carceral facilities participating in the reentry demonstration initiative (e.g., state prisons, county jails and houses of correction, youth correctional facilities), community-based providers, Probation Offices, community health workers, managed care plans, Sheriff's Offices, and state health and human services agencies, and

others. The specific use of this funding will be proposed by the Qualified Applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the carceral facility) and must be properly cost-allocated to Medicaid or CHIP, as necessary, and once finalized will be included in the Reentry Demonstration Initiative Implementation Plan at Attachment X within the STCs. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid and CHIP application and enrollment for demonstration coverage (e.g., for inmates who would be eligible for CHIP but for their incarceration status) and coordinating pre-release and post-release services for enrollees. This includes the development of electronic interfaces for prisons, jails, and youth correctional facilities to communicate with Medicaid and CHIP IT systems to support Medicaid and CHIP enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with correctional facilities, state health and human services agencies, and others, such as managed care plans and community-based providers, in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid/CHIP enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology**. Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems**. Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures**. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid and CHIP enrollment process and suspension and unsuspension process for eligible individuals and coordination of a period for up to 90 days immediately prior to the expected date of release and reentry planning

services for individuals qualifying for reentry demonstration initiative services.

vi. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration among the Commonwealth's correctional institutions (county jails and houses of correction, youth correctional facilities, and state prisons), correctional agencies (e.g., Massachusetts Department of Corrections, Sheriff's Offices, Probation Offices, etc.), community-based organizations, state health and human services agencies, managed care plans, community-based providers and others involved in supporting and planning for the reentry demonstration initiative. This may include conferences and meetings convened with the agencies, organizations, and stakeholders involved in the initiative.

vii. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identify uninsured who are potentially eligible for Medicaid and CHIP; (2) assist with the completion of an application; (3) submit an application to MassHealth or coordinating suspension/unsuspension; reentry planning in a period for up to 90 days immediately prior to the expected date of release; (4) deliver necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (5) establish on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 32. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 32: Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 29	DY 30	DY 31	DY 32
Total Computable Expenditures	$7,000,000	$28,000,000	$28,000,000	$7,000,000

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

22.12. **Qualified Applicants**. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program may include correctional institutions (county jails and houses of correction, youth correctional facilities, and state prisons), the Massachusetts Department of Corrections, the Department of Youth Services, other state health and human services agencies supporting carceral health and HRSNs, Probation Offices, Sheriff's Offices, community-based providers, community-based organizations, managed care plans, and other entities as relevant to the needs of justice-involved individuals as approved by MassHealth.

23. DESIGNATED STATE HEALTH PROGRAMS

23.1. **Designated State Health Programs (DSHP).** The Commonwealth may claim FFP for designated state health programs (DSHP), subject to the limits described in this Section 23. DSHP are specific state programs that: (1) are population- or public health-focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the DSHP will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. This DSHP authority will enable the state to use state dollars that it otherwise would have spent on the DSHP specified in the Approved DHSP List (Attachment Z), for which it may claim and use FFP as specified in this Section 23, on demonstration expenditures to support DSHP-funded initiatives, as described in STC 23.3(c). This DSHP authority will be available from DY 29 - DY 32.

a. The DSHP will have an established limit in the amount of $647,500,000 total computable expenditures, in aggregate, for DY 29 - DY 32.

b. The Commonwealth may claim FFP for up to the annual amounts outlined in the table below, plus any unspent amounts from prior years. In the event the Commonwealth does not claim the full amount of FFP for a given demonstration year, the unspent amount will roll over to one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year. The total amount of DSHP FFP that the state may claim in DY 29 - DY 32 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives.

Table 33: Annual Limits of Total Computable Expenditures for DSHP				
	DY 29	**DY 30**	**DY 31**	**DY 32**
Total Computable Expenditures	$259,000,000	$194,250,000	$129,500,000	$64,750,000

c. The Commonwealth must contribute $57,132,353 in original, non-freed up DSHP funds, for the remaining demonstration period towards its initiatives described in STC 23.3. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of nonfederal share, which may be subject to CMS financial review.

e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the amendment approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public heath- focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage for services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. The state is not eligible to claim FFP for DSHP expenditures until the list is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. The Approved DSHP List will be appended to the STCs as Attachment Z and thereafter may be changed or updated only with CMS approval.

23.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, or the Centers for Disease Control and Prevention) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 4.4 percent of total provider expenditures or claims through DSHP identified as described in STC 23.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the Approved DSHP List (Attachment Z) for applicable programs. Therefore, the Commonwealth can claim up to the program limits in the Approved DSHP List.

c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

    i. Bricks and mortar;

    ii. Shelters, vaccines, and medications for animals;

    iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

    iv. Revolving capital funds; and

    v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

23.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs, for which the state may claim FFP in accordance with STC 23.1 and 23.2 to fund the DSHP-funded initiatives as specified in STC 23.3(c).

b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. Funding for DSHP-funded initiatives specifically associated with infrastructure or start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

   i. Reentry Initiative;

   ii. Medicare cost sharing assistance expansion;

   iii. Marketplace subsidy expansion for individuals with income between 300 percent of the FPL and 500 percent of the FPL;

   iv. HRSN Short-term post-hospitalization and pre-procedure housing;

   v. HRSN infrastructure expansion; and

   vi. Continuous eligibility for adults.

23.4. **DSHP Claiming Protocol.** The state will develop and submit to CMS within 150 calendar days of the approval of this amendment, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP on DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to claim FFP for DSHP expenditures until the protocol is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. Once approved by CMS, the protocol becomes Attachment AA to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

   a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

      i. Certification or attestation of expenditures.

      ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 23.2.

   b. The state will claim FFP for DSHP quarterly based on actual expenditures.

23.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of nonfederal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the CMS-approved DSHP Claiming Protocol in Attachment AA.

23.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than the end of December 31, 2025, after the approval of this authority. Upon CMS approval, the plan will become Attachment BB to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

24. 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.

Date – Specific	Deliverable	STC/Section Reference
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

Date – Specific	Deliverable	STC/Section Reference
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 date of SMI/SED amendment to this Demonstration	SMI/SED Implementation Plan (including Health IT Plans and Financing Plan)	STC 7.2
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 7.2
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, 2025	SMI/SED Mid-Point Assessment	STC 7.8
150 calendar days after approval of the demonstration	SUD Monitoring Protocol	STC 6.5
60 calendar days after receipt of CMS comments on SUD Monitoring Protocol	Revised SUD Monitoring Protocol	STC 6.5
No later than 60 calendar days after September 30, 2025	SUD Mid-Point Assessment	STC 6.6
No later than 60 days after demonstration effective date	SUD HIT Plan	STC 6.3
Prior to claiming UC FFP	UC Payment Protocol	STC 11.3
Prior to claiming FFP	Hospital Quality and Equity Implementation Plan	STC 14.8
By July 1, 2023	Assessment of beneficiary-reported demographic and health-related social needs data adequacy and completeness	STC 14.3(a)

Date – Specific	Deliverable	STC/Section Reference
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 15.7
90 calendar days after demonstration effective date	HRSN Implementation Plan	STC 15.17
60 calendar days after receipt of CMS comments on HRSN Implementation Plan	Revised HRSN Implementation Plan	STC 15.17
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	STC 21.5
150 days after approval of the demonstration	Monitoring Protocol for Other Policies	STC 16.4
60 calendar days after receipt of CMS comments on Monitoring Protocol for Other Policies	Revised Monitoring Protocol for Other Policies	STC 16.4
120 calendar days after approval date	Reentry Demonstration Initiative Implementation Plan	STC 22.9
6 months after approval date	Reentry Demonstration Initiative Reinvestment Plan	STC 22.10
No later than 60 days after the third year of the demonstration implementation.	Reentry Demonstration Initiative Mid-Point Assessment	STC 16.6
150 calendar days after approval date	DSHP Claiming Protocol	STC 23.4
No later than December 31, 2025	DSHP Sustainability Plan	STC 23.6
Annually		
90 days after the end of each DY	Annual Monitoring Report (including Q4 monitoring information and budget neutrality)	STC 16.5

Date – Specific	Deliverable	STC/Section Reference
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	STC 11.6
No later than 90 days after the end of each DY	Report of actual UC payments	STC 11.3
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	STC 11.6
Updated at least annually	Update to Primary Care Payment Protocol	STC 8.5
Quarterly		
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	STC 16.5
60 days following the end of the quarter, except for Q4 which is submitted with Annual Report	Quarterly Budget Neutrality Report	STC 16.5

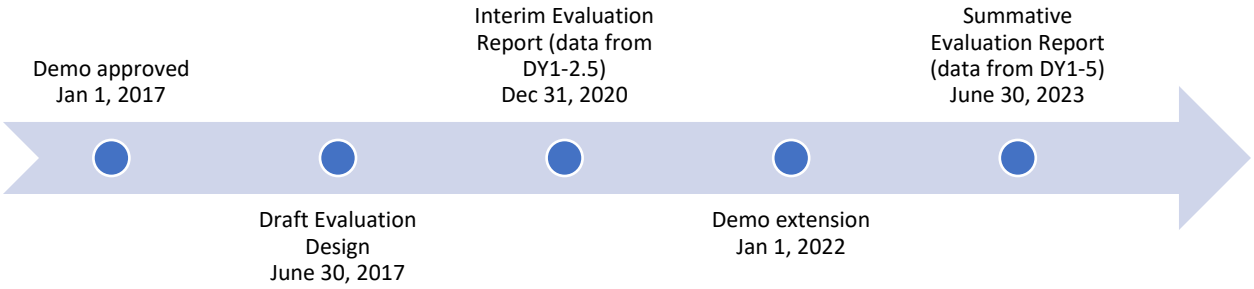
ATTACHMENT A
Preparing the Evaluation Design

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/hciatwoaimsdrvrs.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
Hypothesis 1				
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
Hypothesis 2				
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.

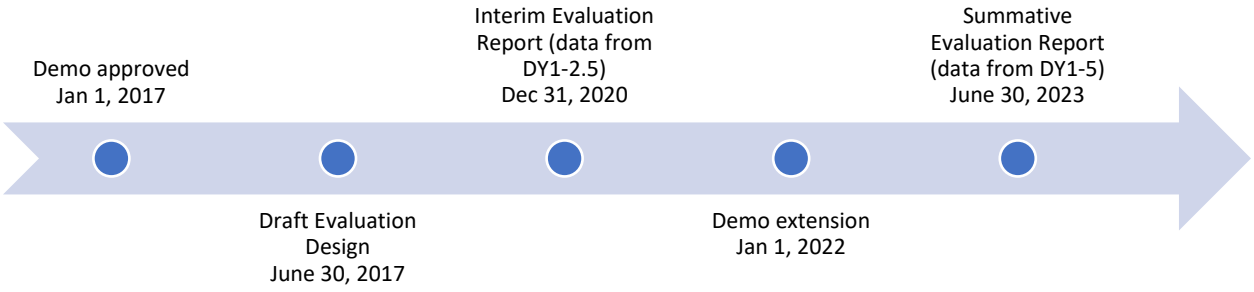
E. Attachments

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 coverage types and by Federal Poverty Level (FPL). However, no co-payments are charged for any individuals or services identified at 42 CFR 447.56(a), including individuals under age 21, pregnant individuals receiving pregnancy-related services, individuals living in an institution or receiving hospice, and American Indian/Alaska Natives who have received or are eligible to receive services through Indian health care provider or through referral under contract health services. Furthermore, co-payments for individuals with income at or less than 50% of the FPL are set to an amount of $0.

Consistent with 42 CFR 447.55(a), no premiums are charged to any individual enrolled in the demonstration whose gross income is less than 150% of the FPL. Additionally, premiums are not charged for any individuals identified at 42 CFR 447.56(a), including any American Indian/Alaska Natives who receive services through an Indian health care provider or through referral under contract health services. 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 is 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.

Consistent with the limitation on Medicaid premiums and cost sharing set forth in 42 CFR 447.56(f), MassHealth premiums and cost sharing incurred by all individuals in the Medicaid or CHIP household do not exceed an aggregate limit of 5% of the family's income on a monthly basis.

Table 1: MassHealth Premiums and Co-payments by Coverage Type

Coverage Type	MassHealth Premiums (only for persons with family income above 150% FPL)	MassHealth Co-payments
MassHealth Standard/Standard ABP	$0	All MassHealth co-payments and co-payment caps are specified in the Medicaid state plan
MassHealth CarePlus	$0	All MassHealth co-payments and co-payment caps are specified in the Medicaid state plan
MassHealth Breast and Cervical Cancer Treatment Program	See Table 2: $15-$72 depending on income	All MassHealth co-payments and co-payment caps are specified in the Medicaid state plan

Table 1: MassHealth Premiums and Co-payments by Coverage Type		
Coverage Type	**MassHealth Premiums (only for persons with family income above 150% FPL)**	**MassHealth Co-payments**
MassHealth CommonHealth	See Table 3: $15 and above depending on income and family group size See Table 4: Supplemental Premium Formula for members with TPL	All MassHealth co-payments and co-payment caps are specified in the Medicaid state plan
CommonHealth Children through 300% FPL Children with income above 300% FPL adhere to the regular CommonHealth schedule in Table 3	See Table 5: $12-$84 depending on income and family group size	N/A as children are exempt from MassHealth copayments
MassHealth Family Assistance: HIV/AIDS	See Table 6: $15-$35 depending on income See Table 7: Supplemental Premium Formula for members with TPL	All MassHealth co-payments and co-payment caps are specified in the Medicaid state plan
MassHealth Family Assistance for children	See Table 5: $12 - $28 per child, $36 - $84 max per family group depending on income	N/A as children are exempt from MassHealth copayments
All coverage types with TPL	Member is responsible for any premiums required under private insurance but may qualify for MassHealth premium assistance	Member is responsible for any co-payments required under private insurance

Table 2: Breast and Cervical Cancer Treatment Program Premium Schedule	
Percent of FPL	**Premium Cost**
Above 150 to 160	$15
Above 160 to 170	$20
Above 170 to 180	$25
Above 180 to 190	$30
Above 190 to 200	$35
Above 200 to 210	$40
Above 210 to 220	$48
Above 220 to 230	$56
Above 230 to 240	$64
Above 240 to 250	$72

Table 3: CommonHealth Full Premium Schedule for Young Adults and Adults above 150% FPL and Children above 300% FPL		
Base Premium	**Additional Premium Cost**	**Range of Premium Cost**
Above 150% FPL—start at $15	Add $5 for each additional 10% FPL until 200% FPL	$15 - $35
Above 200% FPL—start at $40	Add $8 for each additional 10% FPL until 400% FPL	$40 - $192
Above 400% FPL—start at $202	Add $10 for each additional 10% FPL until 600% FPL	$202 - $392
Above 600% FPL—start at $404	Add $12 for each additional 10% FPL until 800% FPL	$404 - $632
Above 800% FPL—start at $646	Add $14 for each additional 10% FPL until 1000% FPL	$646 - $912
Above 1000% FPL—start at $928	Add $16 for each additional 10% FPL	$928 - greater

Table 4: CommonHealth Supplemental Premium Schedule for young adults, adults and children with income above 300% FPL who have TPL and do not receive MassHealth premium assistance	
% of FPL	**Premium requirement**
Above 150% to 200%	60% of full premium per listed premium costs above
Above 200% to 400%	65% per above
Above 400% to 600%	70% per above
Above 600% to 800%	75% per above
Above 800% to 1000%	80% above
Above 1000%	85% above

Table 5: Full Premium Formula for CommonHealth Children between 150% and 300% FPL and Family Assistance Children	
% of FPL	**Monthly Premium Cost**
Above 150% to 200%	$12 per child ($36 Premium Billing Family Group (PBFG) maximum)
Above 200% to 250%	$20 per child ($60 PBFG maximum)
Above 250% to 300%	$28 per child ($84 PBFG maximum

Table 6: Family Assistance for HIV+ Adults Premium Formula	
% of FPL	**Monthly Premium Cost**
Above 150% to 160%	$15
Above 160% to 170%	$20
Above 170% to 180%	$25
Above 180% to 190%	$30
Above 190% to 200%	$35

Table 7: Family Assistance for HIV+ Adults Supplemental Premium Formula for members with TPL and who do not receive MassHealth Premium Assistance	
% of FPL	**Monthly Premium Cost**
Above 150% to 200%	60% of full premium

Attachment D
SUD Health Information Technology (IT) Plan

Section I

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs (PDMP), in the SMD #17-003, states with approved Section 1115 SUD demonstrations are generally required to submit an SUD Health IT Plan as described in the STCs for these demonstrations within 90 days of demonstration approval.

In completing this plan, the following resources are available to the state:

a. Health IT.Gov in "Section 4: Opioid Epidemic and Health IT."[1]
b. CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" and, specifically, the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.[2]

As the state develops its SUD Health IT Plan, it may also request technical assistance to conductan assessment and develop its plan to ensure it has the specific health IT infrastructure with regards to the state's PDMP plan and, more generally, to meet the goals of the demonstration. Contacts for technical assistance can be found in the guidance documents.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e. PDMP functionalities, PDMP query capabilities, supporting prescribing clinicians with using and checking the PDMPs, and masterpatient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State").

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state's PDMP.

[1] Available at https://www.healthit.gov/playbook/opioid-epidemic-and-health-it.
[2] Available at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html.

The state should provide CMS with an analysis of the current status of its health IT infrastructure/"ecosystem" to assess its readiness to support PDMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressedover the course of the demonstration—or the assurance described above.

The SUD Health IT Plan should detail the current and planned future state for each functionality/capability/support—and specific actions and a timeline to be completed over thecourse of the demonstration—to address needed enhancements. In addition to completing the summary table below, the state may provide additional information for each Health IT/PDMP milestone criteria to further describe its plan.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to support its PDMP; and* *--Enhance and/or support clinicians in their usage of the state's PDMP.*	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionalityto achieve the goals ofthe PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancementsto support clinicians'use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identifiedin the first column. Include persons or entities responsible for completion of each action item.* *Include timeframe for completion of each action item*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	Interstate data sharing is already in place with all but 12 states, including sharing with all New England states and NY.	Initiatives in process include: 1. Adding a 'date sold' column in patients' rx history to flag when prescriptions were picked	The state attests that this milestone is completed.,

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		up at a pharmacy. 2. Implementing a Mandatory Use Compliance module that provides both the PDMP administrators and the end users with detailed information regarding the practitioner's compliance with the state's requirement to utilize the PDMP prior to issuing a prescription for a Sch. II-III opioids or a benzodiazepine. 3. Implementation of a Buprenorphine Therapy Interruption alert, that will alert practitioners and/or their team that a patient has failed to pick up a prescription for Suboxone or other buprenorphine-based treatment drug. Additionally, stakeholder engagement has begun regarding a Non-Fatal Overdose flag that would utilize ADT feeds collected from Emergency Rooms across the state.	
Enhanced "ease of use" for prescribers and other state and federal stakeholders	Series of enhancements since PDMP 'go live' have been implemented to improve usability. Enhancements for establishing clinician delegates are in place. Ability to perform 'bulk patient		The state attests that this milestone is completed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	search' has been implemented. Public-facing reporting of state and county level is accessible for state and federal stakeholders and includes: - Total Schedule II Opioid Prescriptions - Total Number of Schedule II Opioid Solid Dosage Units - Individuals Receiving Schedule II Opioid Prescription - % of Individuals Receiving Schedule II Opioid Prescription (of total population) - Individuals with Activity of Concern - Rate of Individuals with Activity of Concern (per 1,000) - Numbers of prescriptions, individuals receiving prescriptions, and number of PDMP searches since Q1 2015		
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	The Commonwealth of Massachusetts has robust adoption of Health Information Technology by health plans and providers. The state operates a statewide electronic health information exchange (HIE), called the Mass HIway, through the Direct Standard. HIway Direct Messaging allows providers to securely communicate with messages to one another regardless of technology. All Massachusetts acute care hospitals, community health centers, and large provider organizations are able to use direct messaging and have access to the Mass HIway for sending and receiving messages, including for accessing public health reporting such as the PDMP, Syndromic Surveillance, and Electronic Lab Reporting.		The state attests that this milestone is completed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns3 (see also "Use of PDMP" #2 below)	PDMP dashboards include 2-year history of Narcotic, Sedative, and Stimulant prescriptions, identify risk indicators, and assign an overdose risk score. Quarterly reports are posted to prescribers' PDMP dashboards on a quarterly basis. Reports specific to opioids include Prescriptions per Patient; Daily MME per Patient; Average Quantity per Patient; Average Duration per Patient; Unique Patients; and Unique Patients in Peer specialty group. Prescriber reports also flag patients 'at risk' due to Dangerous Combination Therapy; Patients Exceeding Multiple Provider Thresholds; and Patients Exceeding Daily MME Thresholds.		The state attests that this milestone is completed.
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	Prescriptions for opioids and other controlled substances are accessible through the state's PDMP.		The state attests that this milestone is completed.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	EHR integration and enhancements for establishing clinician delegates are in place. Ability to perform 'bulk patient search' has been implemented as well.		The state attests that this milestone is completed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	Advanced patient support tool Visano has been implemented. In addition to the existing PDMP functionality, Visano also offers a representation of the data in an interactive format to help prescribers, pharmacists, and care teams access and more quickly and easily comprehend the data to aid in clinical decisions and provide improved patient safety and outcomes. Visano also provides tools and resources that support patients' needs and connects them to treatment, when appropriate.		The state attests that this milestone is completed.
Master Patient Index / Identity Management			
Overall Objective for Enhancing PDMP Functionality & Interoperability	The Center for Health Information and Analysis (CHIA) maintains the MA All Payer Claims Database (APCD) Master Patient Index and reports on Massachusetts health insurance coverage, access, and use of health care services including mental health and substance use disorder services. All payments for prescriptions to providers and retail pharmacies are part of the APCD which allows for the relationship between prescriptions and SUD care to be captured.		The state attests that this milestone is completed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	1. In addition to the above overview and as part of the Commonwealth's comprehensive response to the opioid epidemic, the following protocols and controls have been implemented, including under Massachusetts General Law c.94C:Requirement that the PDMP must be checked prior to each time a prescription for Schedule II or III narcotic or benzodiazepine is issued. 2. Requirement that pharmacies must submit data for all controlled substances dispensed. 3. Establishment of a Prescription Monitoring Program Medical Review Group where MassHealth representatives attend. The Medical Review Group reports to the MA Department of Public Health Drug Control Program and includes physicians, APRNs, physician assistants, dentists, and pharmacists. The group convenes when PDMP staff identify outlier prescribers or receive a complaint about a prescriber. MassHealth convenes an opioid workgroup every 2 weeks to review cases and, additionally, MassHealth's Program Integrity Unit initiates investigations into patterns of over prescribing or inappropriate prescribing practices.		The state attests that this milestone is completed. The Commonwealth pays for the PDMP System without CMS FFP funding. The PDMP meets all Federal and State security, privacy, and operational requirements.

[3] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health ITPlan.

Name and Title: Tracey Nicolosi, Director of Addiction Services
Telephone Number: (978) 518-5310
Email Address: tracey.e.nicolosi@mass.gov

Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the SUD Health IT Plan.

105 CMR 700.00: Implementation of MGL c.94C | Mass.gov
Massachusetts Prescription Awareness Tool (MassPAT) | Mass.gov

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

The following charts reflect approved payments under the Safety Net Care Pool (SNCP) for the period from July 1, 2022 through December 31, 2027* unless otherwise specified in STCs 11.2, 11.3, and 11.4, consistent with and pursuant to section 11 of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section 11 of the STCs. This chart shall be updated pursuant to the process described in STC 11.6.

Chart A: Approved SNCP Payments for the period from July 1, 2022 through December 31, 2027, unless otherwise specified in STCs 11.2, 11.3, and 11.4 (projected and rounded in millions).

*Attachment E includes the temporary extension period of July 1, 2022 – September 30, 2022 (Demonstration Year (DY) 26) and the current demonstration period of October 1, 2022 – December 31, 2027 (DYs 27 – 32).

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Applicable Footnotes
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
	System Transformation Incentive Based Pools												
1	Delivery System Reform Incentive Payments (DSRIP)	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$55.0	$45.7	$74.4	$0.0	$0.0	$0.0	$0.0	$120.1	(1)
2	Delivery System Reform Incentive Payments (DSRIP) Closeout	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$0.0	$0.0	$49.8	$48.6	$34.2	$0.5	$0.0	$133.1	(1)
3	Public Hospital Transformation and Incentive Initiatives (PHTII) Closeout payments	N/A		Cambridge Health Alliance	$0.0	$0.0	$6.4	$0.0	$0.0	$0.0	$0.0	$6.4	
	System Transformation Incentive Based Pools Subtotal				***$55.0***	***$45.7***	***$130.6***	***$48.6***	***$34.2***	***$0.5***	***$0.0***	***259.6***	
	Disproportionate Share Hospital (DSH) Pool												
4	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$5.0	$5.0	$20.0	$20.0	$20.0	$20.0	$20.0	$105.0	(2)
5	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101 CMR 613.00, 614.00	All acute hospitals and CHCs	$56.7	$56.7	$236.0	$236.0	$236.0	$236.0	$236.0	$1,236.7	(3)
6	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101 CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$8.1	$8.1	$30.0	$30.0	$30.0	$30.0	$30.0	$158.1	(4)

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Applicable Footnotes
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
7	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$11.7	$11.7	$46.8	$49.5	$49.5	$49.5	$49.5	$256.5	(5)
8	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$27.3	$27.3	$109.2	$115.5	$115.5	$115.5	$115.5	$598.5	(5)
9	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$62.5	$74.8	$299.0	$299.0	$299.0	$299.0	$299.0	$1,569.8	
10	Safety Net Provider Payments Closeout Activities	DSH		Eligible hospitals outlined in Attachment N	$0.0	$0.0	$17.0	$30.4	$0.0	$0.0	$0.0	$47.4	
	Disproportionate Share Hospital (DSH) Pool Subtotal				***$171.3***	***$183.6***	***$758.0***	***$780.4***	***$750.0***	***$750.0***	***$750.0***	***$3,972.0***	
	Uncompensated Care (UCC) Pool												
11	Health Safety Net Trust Fund Safety Net Care Payment	UCC		All acute hospitals and CHCs	$0.0	$0.0	$10.0	$10.0	$10.0	$10.0	$10.0	$50.0	(3)
12	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$0.0	$0.0	$27.0	$27.0	$27.0	$27.0	$27.0	$135.0	(5)
13	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$0.0	$0.0	$63.0	$63.0	$63.0	$63.0	$63.0	$315.0	(5)
	Uncompensated Care (UCC) Pool Subtotal				***$0.0***	***$0.0***	***$100.0***	***$100.0***	***$100.0***	***$100.0***	***$100.0***	***$500.0***	
	ConnectorCare Subsidies												

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Applicable Footnotes
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
14	***DSHP- Health Connector Premium and Cost Sharing***	N/A		N/A	$17.7	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	(6)
	Connector Care Subsidies Subtotal				***$17.7***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	
	Total				**$244.0**	**$229.3**	**$988.6**	**$929.0**	**$884.2**	**$850.5**	**$850.0**	**$4,731.6**	
	**Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.												

The following notes are incorporated by reference into Chart A:

(1) The Delivery System Reform Incentive Payments and Delivery System Reform Incentive Closeout Payments will be distributed to participating ACOs, CPs and for other approved uses pursuant to STC 12 and the DSRIP Protocol.

(2) The provider-specific Public Service Hospital Safety Net Care payments are approved by CMS. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. The Commonwealth may decrease these payment amounts based on available funding without a demonstration amendment; any increase will require a demonstration amendment.

(3) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, actual total and provider- specific payment amounts may vary depending on volume, service mix, rates, and available funding. Only payments for care provided to eligible uninsured patients may be claimed in line 9, under the UC Pool. Expenditures for dental services that wrap to the MassHealth State plan benefit through the HSNTF are inclusive of amounts included in capitation payments to One Care plans for One Care enrollees for dental services beyond those available in the MassHealth State plan.

(4) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD category: inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification centers.

(5) Expenditures for DPH and DMH hospitals in Chart A are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth. Only uninsured costs may be claimed in lines 10-11 under the UC Pool.

(6) Expenditures for DSHP - Health Connector Premium and Cost Sharing Subsidies are approved based on actual enrollment and premium assistance and cost sharing subsidy costs, and HSN Health Connector gap coverage subsidies are approved based on actual enrollment and gap coverage costs. Consequently, the amount of total expenditures may vary. Health Connector Subsidies are not subject to the aggregate SNCP cap or any sub-cap.

Chart B: Sources of funding for approved SNCP payments for July 1, 2022 through December 31, 2027*, unless otherwise specified in STCs 11.2, 11.3, and 11.4 (projected and rounded in millions).

*Attachment E includes the temporary extension period of July 1, 2022 – September 30, 2022 (DY 26) and the current demonstration period of October 1, 2022 – December 31, 2027 (DYs 27 – 32).

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Source of non-federal share
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
	System Transformation Incentive Based Pools												
1	Delivery System Reform Incentive Payments (DSRIP)	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$55.0	$45.7	$74.4	$0.0	$0.0	$0.0	$0.0	$120.1	General Fund, including provider assessment funding in the DSRIP Trust Fund
2	Delivery System Reform Incentive Closeout Payments (DSRIP)	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$0.0	$0.0	$49.8	$48.6	$34.2	$0.5	$0.0	$133.1	General Fund, including provider assessment funding in the DSRIP Trust Fund
3	Public Hospital Transformation and Incentive Initiatives (PHTII) Closeout payments	N/A		Cambridge Health Alliance	$0.0	$0.0	$6.4	$0.0	$0.0	$0.0	$0.0	$6.4	Intergovernmental Transfer
	System Transformation Incentive Based Pools Subtotal				***$55.0***	***$45.7***	***$130.6***	***$48.6***	***$34.2***	***$0.5***	***$0.0***	***259.6***	
	Disproportionate Share Hospital (DSH) Pool												
4	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$5.0	$5.0	$20.0	$20.0	$20.0	$20.0	$20.0	$105.0	General Fund
5	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101 CMR 613.00, 614.00	All acute hospitals and CHCs	$56.7	$56.7	$236.0	$236.0	$236.0	$236.0	$236.0	$1,236.7	General Fund, including provider assessment funding in the Health Safety Net Trust Fund
6	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101 CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$8.1	$8.1	$30.0	$30.0	$30.0	$30.0	$30.0	$158.1	General Fund

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Source of non-federal share
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
7	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$11.7	$11.7	$46.8	$49.5	$49.5	$49.5	$49.5	$256.5	Certified Public Expenditure
8	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$27.3	$27.3	$109.2	$115.5	$115.5	$115.5	$115.5	$598.5	Certified Public Expenditure
9	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$62.5	$74.8	$299.0	$299.0	$299.0	$299.0	$299.0	$1,569.8	General Fund, including provider assessment funding in the Safety Net Provider Trust Fund
10	Safety Net Provider Payments Closeout Activities	DSH		Eligible hospitals outlined in Attachment N	$0.0	$0.0	$17.0	$30.4	$0.0	$0.0	$0.0	$47.4	General Fund
	Disproportionate Share Hospital (DSH) Pool Subtotal				***$171.3***	***$183.6***	***$758.0***	***$780.4***	***$750.0***	***$750.0***	***$750.0***	***$3,972.0***	
	Uncompensated Care (UCC) Pool												
11	Health Safety Net Trust Fund Safety Net Care Payment	UCC		All acute hospitals and CHCs	$0.0	$0.0	$10.0	$10.0	$10.0	$10.0	$10.0	$50.0	General Fund, including provider assessment funding in the Health Safety Net Trust Fund
12	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$0.0	$0.0	$27.0	$27.0	$27.0	$27.0	$27.0	$135.0	Certified Public Expenditure
13	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center	$0.0	$0.0	$63.0	$63.0	$63.0	$63.0	$63.0	$315.0	Certified Public Expenditure

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Source of non-federal share
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
				Taunton State Hospital Worcester Recovery Center and Hospital									
	Uncompensated Care (UCC) Pool Subtotal				***$0.0***	***$0.0***	***$100.0***	***$100.0***	***$100.0***	***$100.0***	***$100.0***	***$500.0***	
	ConnectorCare Subsidies												
14	***DSHP-Health Connector Premium and Cost Sharing***	N/A		N/A	$17.7	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	Certified Public Expenditure and General Fund, including provider assessment funding in the Health Safety Net Trust Fund
	Connector Care Subsidies Subtotal				***$17.7***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	
	Total				**$244.0**	**$229.3**	**$988.6**	**$929.0**	**$884.2**	**$850.5**	**$850.0**	**$4,731.6**	
	**Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this section 1115 demonstration, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.												

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

The following charts reflect approved payments under the Safety Net Care Pool (SNCP) for the period from July 1, 2022 through December 31, 2027* unless otherwise specified in STCs 11.2, 11.3, and 11.4, consistent with and pursuant to section 11 of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section 11 of the STCs. This chart shall be updated pursuant to the process described in STC 11.6.

Chart A: Approved SNCP Payments for the period from July 1, 2022 through December 31, 2027, unless otherwise specified in STCs 11.2, 11.3, and 11.4 (projected and rounded in millions).

*Attachment E includes the temporary extension period of July 1, 2022 – September 30, 2022 (Demonstration Year (DY) 26) and the current demonstration period of October 1, 2022 – December 31, 2027 (DYs 27 – 32).

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Applicable Footnotes
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
	System Transformation Incentive Based Pools												
1	Delivery System Reform Incentive Payments (DSRIP)	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$14.3	26.5	$61.5	$0.0	$0.0	$0.0	$0.0	$88.0	(1)
2	Delivery System Reform Incentive Payments (DSRIP) Closeout	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$0.0	$0.0	$34.2	$28.3	$41.3	$0.0	$0.0	$103.8	(1)
3	Public Hospital Transformation and Incentive Initiatives (PHTII) Closeout payments	N/A		Cambridge Health Alliance	$0.0	$0.0	$3.8	$0.0	$0.0	$0.0	$0.0	$3.8	
	System Transformation Incentive Based Pools Subtotal				***$14.3***	***$26.5***	***$99.5***	***$28.3***	***$41.3***	***$0.0***	***$0.0***	***$195.6***	
	Disproportionate Share Hospital (DSH) Pool												
4	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$0	$0	$20.0	$20.0	$20.0	$20.0	$20.0	***$100.0***	(2)
5	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101 CMR 613.00, 614.00	All acute hospitals and CHCs	$57.7	$53.7	$225.9	$213.0	$313.0	$336.0	$336.0	***$1,477.6***	(3)

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Applicable Footnotes
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
6	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101 CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$8.8	$9.5	$34.5	$44.6	$10.0	$10.0	$10.0	***$118.6***	(4)
7	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$11.7	$19.9	$84.9	$74.0	$49.5	$49.5	$49.5	***$327.3***	(5)
8	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$27.3	$49.8	$205.6	$154.8	$115.5	$115.5	$115.5	***$756.7***	(5)
9	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$0.0	$74.7	$238.5	$242.8	$299.0	$299.0	$299.0	***$1,453.0***	
10	Safety Net Provider Payments Closeout Activities	DSH		Eligible hospitals outlined in Attachment N	$0.0	$0.0	$17.0	$25.6	$0.0	$0.0	$0.0	***$42.6***	
	Disproportionate Share Hospital (DSH) Pool Subtotal				***$105.5***	***$207.6***	***$826.4***	***$774.8***	***$807.0***	***$830.0***	***$830.0***	***$4,275.8***	
	Uncompensated Care (UCC) Pool												
11	Health Safety Net Trust Fund Safety Net Care Payment	UCC		All acute hospitals and CHCs	$0.0	$0.0	$0.0	$0	$0	$10.0	$10.0	***$20.0***	(3)
12	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$0.0	$0.0	$0.0	$0	$0	$27.0	$27.0	***$54.0***	(5)
13	State-Owned Non-Acute Hospitals	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center	$0.0	$0.0	$0.0	$0	$0	$63.0	$63.0	***$126.0***	(5)

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Appli-cable Foot-notes
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
	Operated by the Department of Mental Health			SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital									
	Uncompensated Care (UCC) Pool Subtotal				***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$100.0***	***$100.0***	***$200.0***	
	ConnectorCare Subsidies												
14	***DSHP- Health Connector Premium and Cost Sharing***	N/A		N/A	$0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	(6)
	Connector Care Subsidies Subtotal				***$0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	
	Total				**$119.8**	**$234.1**	**$925.9**	**$803.1**	**$848.3**	**$930.0**	**$930.0**	**$4,671.4**	
	**Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.												

The following notes are incorporated by reference into Chart A:

(1) The Delivery System Reform Incentive Payments and Delivery System Reform Incentive Closeout Payments will be distributed to participating ACOs, CPs and for other approved uses pursuant to STC 12 and the DSRIP Protocol.

(2) The provider-specific Public Service Hospital Safety Net Care payments are approved by CMS. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. The Commonwealth may decrease these payment amounts based on available funding without a demonstration amendment; any increase will require a demonstration amendment.

(3) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, actual total and provider- specific payment amounts may vary depending on volume, service mix, rates, and available funding. Only payments for care provided to eligible uninsured patients may be claimed in line 9, under the UC Pool. Expenditures for dental services that wrap to the MassHealth State plan benefit through the HSNTF are inclusive of amounts included in capitation payments to One Care plans for One Care enrollees for dental services beyond those available in the MassHealth State plan.

(4) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD category: inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification centers.

(5) Expenditures for DPH and DMH hospitals in Chart A are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth. Only uninsured costs may be claimed in lines 10-11 under the UC Pool.

(6) Expenditures for DSHP - Health Connector Premium and Cost Sharing Subsidies are approved based on actual enrollment and premium assistance and cost sharing subsidy costs, and HSN Health Connector gap coverage subsidies are approved based on actual enrollment and gap coverage costs. Consequently, the amount of total expenditures may vary. Health Connector Subsidies are not subject to the aggregate SNCP cap or any sub-cap.

Chart B: Sources of funding for approved SNCP payments for July 1, 2022 through December 31, 2027*, unless otherwise specified in STCs 11.2, 11.3, and 11.4 (projected and rounded in millions).

*Attachment E includes the temporary extension period of July 1, 2022 – September 30, 2022 (DY 26) and the current demonstration period of October 1, 2022 – December 31, 2027 (DYs 27 – 32).

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Source of non-federal share
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
	System Transformation Incentive Based Pools												
1	Delivery System Reform Incentive Payments (DSRIP)	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$14.3	$26.5	$61.5	$0.0	$0.0	$0.0	$0.0	$88.0	General Fund, including provider assessment funding in the DSRIP Trust Fund
2	Delivery System Reform Incentive Closeout Payments (DSRIP)	N/A		Participating ACOs, CPs and other uses as specified in STC 12.1-4	$0.0	$0.0	$34.2	$28.3	$41.3	$0.0	$0.0	$103.8	General Fund, including provider assessment funding in the DSRIP Trust Fund
3	Public Hospital Transformation and Incentive Initiatives (PHTII) Closeout payments	N/A		Cambridge Health Alliance	$0.0	$0.0	$3.8	$0.0	$0.0	$0.0	$0.0	$3.8	Intergovernmental Transfer
	System Transformation Incentive Based Pools Subtotal				***$14.3***	***$26.5***	***$99.5***	***$28.3***	***$41.3***	***$0.0***	***$0.0***	***$195.6***	
	Disproportionate Share Hospital (DSH) Pool												
4	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$0	$0	$20.0	$20.0	$20.0	$20.0	$20.0	***$100.0***	General Fund

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Source of non-federal share
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
5	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101 CMR 613.00, 614.00	All acute hospitals and CHCs	$57.7	$53.7	$225.9	$213.0	$313.0	$336.0	$336.0	***$1,477.6***	General Fund, including provider assessment funding in the Health Safety Net Trust Fund
6	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101 CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$8.8	$9.5	$34.5	$44.6	$10.0	$10.0	$10.0	***$118.6***	General Fund
7	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$11.7	$19.9	$84.9	$74.0	$49.5	$49.5	$49.5	***$327.3***	Certified Public Expenditure
8	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$27.3	$49.8	$205.6	$154.8	$115.5	$115.5	$115.5	***$756.7***	Certified Public Expenditure
9	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$0.0	$74.7	$238.5	$242.8	$299.0	$299.0	$299.0	***$1,453.0***	General Fund, including provider assessment funding in the Safety Net Provider Trust Fund
10	Safety Net Provider Payments Closeout Activities	DSH		Eligible hospitals outlined in Attachment N	$0.0	$0.0	$17.0	$25.6	$0.0	$0.0	$0.0	***$42.6***	General Fund
	Disproportionate Share Hospital (DSH) Pool Subtotal				***$105.5***	***$207.6***	***$826.4***	***$774.8***	***$807.0***	***$830.0***	***$830.0***	***$4,275.8***	
	Uncompensated Care (UCC) Pool												
11	Health Safety Net Trust Fund Safety Net Care Payment	UCC		All acute hospitals and CHCs	$0.0	$0.0	$0.0	0.0	$0.0	$10.0	$10.0	***$20.0***	General Fund, including provider assessment funding in the Health Safety Net Trust Fund

#	Payment Types	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per DY							Total DY 27-32	Source of non-federal share
					DY 26	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32		
12	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$0.0	$0.0	$0.0	$0.0	$0.0	$27.0	$27.0	***$54.0***	Certified Public Expenditure
13	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$0.0	$0.0	$0.0	$0.0	$0.0	$63.0	$63.0	***$126.0***	Certified Public Expenditure
	Uncompensated Care (UCC) Pool Subtotal				***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$100.0***	***$100.0***	***$200.0***	
	ConnectorCare Subsidies												
14	***DSHP-Health Connector Premium and Cost Sharing***	N/A		N/A	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	Certified Public Expenditure and General Fund, including provider assessment funding in the Health Safety Net Trust Fund
	Connector Care Subsidies Subtotal				***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	***$0.0***	
	Total				**$119.8**	**$234.1**	**$925.9**	**$803.1**	**$848.3**	**$930.0**	**$930.0**	**$4,671.4**	
	**Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this section 1115 demonstration, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.												

Attachment F
Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Emily Bailey
Telephone Number: 857-260-7574
Email Address: emily.r.bailey@mass.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Massachusetts*
Demonstration name	*"MassHealth" (Project Number 11-W-00030/1)*
Approval date	*08/11/2022*
Approval period	*08/11/2022 – 12/31/2027*
Implementation date	*3/1/2023*

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status:* All participating psychiatric hospitals must be licensed by the MA Department of Mental Health (DMH) and comply with DMH regulations for licensure (104 CMR 27: https://www.mass.gov/doc/104-cmr-27-licensing-and-operational-standards-for-mental-health-facilities/download). Hospitals must also be accredited by the Joint Commission or other nationally recognized accreditation agency approved by the Department utilizing the applicable standards as promulgated by said Joint Commission or agency.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* DMH has established licensing requirements for psychiatric hospitals. The licensing division of DMH conducts in-person site visits every 2 years as a condition of licensure and conducts unannounced site visits at any time to ensure compliance with standards. In addition, all psychiatric inpatient hospitals participating in MassHealth must comply with the MassHealth regulations, including, but not limited to, MassHealth regulations at 130 CMR 425.000 (https://www.mass.gov/doc/psychiatric-inpatient-hospital-services-regulations-1/download) and 130 CMR 450.000: Administrative and Billing Regulations (https://www.mass.gov/doc/administrative-and-billing-regulations-for-all-masshealth-providers-0/download). MassHealth conducts unannounced site visits and requires regular reporting (such as adverse incident reporting), to ensure compliance with its regulations.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status*: MassHealth maintains admission and ongoing stay requirements for members through its regulations. MassHealth reviews medical records to evaluate compliance with these requirements, for example through site visits to providers. In addition, MassHealth's contracted health plans conduct utilization review (UR) and have standard processes in place to ensure that members are receiving medically necessary treatment. Timing of the UR varies across each health plan. Additionally, prior to inpatient admissions, members may receive services from the Emergency Services Program (ESP)/Mobile Crisis Intervention (MCI) providers, who provide crisis intervention, assessment, and treatment of members and assist members in accessing appropriate levels of care.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* MassHealth and DMH regulations outline provider requirements which assist in assuring program integrity and quality compliance, including fraud detection and investigation, the prevention of improper payments, and provider participation. MassHealth and its contracted health plans also conduct record reviews to detect fraud, waste, and abuse.

Prompts	Summary
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* MassHealth members are screened for co-morbid conditions, Substance Use Disorders (SUDs), and suicidal ideation by the ESP/MCI providers prior to recommendation for placement in an inpatient psychiatric setting. Upon admission to an inpatient psychiatric setting, MassHealth regulations require that treatment plans be generated based on diagnostic evaluations. All DMH-licensed psychiatric hospitals are required to meet standard clinical competencies, such as screening for suicidal ideation, and treating psychiatric patients with co-occurring medical conditions and co-occurring SUD as well as facilitate access to treatment for those conditions.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* Massachusetts psychiatric hospitals participate in a quality incentive program, reporting results of select quality measures such as evidence of appropriate justification for multiple anti-psychotic medications at discharge, and submission of restraint and seclusion data. In addition, psychiatric hospitals are required to report adverse incidents.
	Future Status: The state anticipates continuing the quality incentive program and reporting requirements. Performance metrics will incorporate appropriate discharge planning and community-based referrals post discharge.
	Summary of Actions Needed: None.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include	*Current Status:* MassHealth requires all inpatient psychiatric hospitals to begin discharge planning on the day of admission, which includes coordination of care and triage support to community-based transitions. Massachusetts has a compliance process that includes site visits and documentation reviews. Psychiatric hospitals are also incentivized to complete timely and robust transition records under the quality incentive program for psychiatric hospitals, described

Prompts	Summary
community-based providers in care transitions.	above. Additionally, managed care entities are required to support member pre-discharge planning in collaboration with psychiatric hospitals and residential settings.
	Future Status: As Massachusetts introduces enhanced community-based services in January 2023, discharge planning expectations will reflect the requirements for hospitals and residential settings to be working closely with local Community Behavioral Health Centers.
	Summary of Actions Needed: Finalize referral reporting metrics in Q1 2023 to ensure our goals for future-state are met.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* MassHealth issued guidance in September 2021 to Managed Care Entities, Acute Inpatient Hospitals, and Psychiatric Hospitals to clarify activities that need to be completed by MCEs and hospitals as part of discharge planning for inpatients who are experiencing or at risk of homelessness. This guidance requires that hospitals: assess the patients current housing situation within 24 hours of admission and commence working on discharge planning activities within 3 working days of admission. These discharge planning activities include communication with (as applicable) the MCE, local shelter, PCP, state human service agencies, family/friends, etc. and submitting applications (as applicable) for state housing and service programs. This guidance has been incorporated into relevant contracts with MCEs and hospitals. Working with the state housing agency that funds shelters and the state Interagency Council on Housing and Homelessness, MassHealth created a website that includes tools and resources for hospital discharge staff and for shelters. In addition, MassHealth and EOHHS staff provide ongoing technical assistance and training to individual hospitals as requested. Furthermore, pursuant to state licensing regulations, licensed behavioral health facilities are required to make efforts to avoid discharging individuals to a shelter or the street by identifying and offering alternative options, and documenting such measures. These facilities must also track all discharges to a shelter or the street and report to the licensing entity.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g.,	*Current Status:* Massachusetts does not currently have any requirements that psychiatric hospitals contact beneficiaries post discharge. The discharge planning process described in 2.a, which begins on the day of admission, is designed to transition care to community-based providers post-discharge, including care coordination or case management as needed by the individual.
	Future Status: Massachusetts is engaging with hospital providers and Managed Care Entities throughout Q1 and Q2 2023 to determine most effective means of patient follow up within 72 hours post discharge for all members, with a goal of implementing changes in the contract year 2024 managed care entity contracts and/or hospital contracts to

Prompts	Summary
email, text, or phone call within 72 hours post discharge	require follow up activities. Effective early 2023, Massachusetts is implementing additional expectations for hospitals to communicate with Community Behavioral Health Centers (CBHCs) via agreed upon workflows and data exchange processes to support warm hand off post discharge.
	Summary of Actions Needed: Engage with MCE and hospitals to determine most effective means of follow-up. Development and compliance oversight of discharge information in agreed upon workflows and data exchanges will be outlined and subsequently monitored.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* In 2018, Massachusetts implemented the Expedited Psychiatric Inpatient Admission (EPIA) Policy. EPIA is a process by which the emergency department (ED) or ESP/MCI staff, MCEs, and psychiatric hospitals work together to place individuals who need inpatient level of care as quickly as possible. If placement has not been identified in a timely manner, a set of escalation steps are followed until admission to an appropriate level of care. Escalation steps include DMH intervention and assistance in finding appropriate placement. Massachusetts is in the process of procuring a vendor to build an online platform to facilitate transparent and expedient hospital admissions in two phases. Phase one (2023) will include technology enhanced clinical data exchange to better facilitate clinical review for inpatient psychiatric admissions. Phase two will be further outlined in 2023, to support ongoing process efficiency. Massachusetts is also working with the ESP/MCI teams and EDs to encourage diversion to community-based services, when appropriate, instead of inpatient admission. Massachusetts is working with providers to expand specialized psychiatric inpatient bed capacity for populations shown to have greater average lengths of stay in ED settings while awaiting psychiatric inpatient placements (such as individuals with Autism Spectrum Disorder, children, geriatric patients, individuals with SMI/SED, and individuals experiencing homelessness) due to the need for specialized services to address complex needs.
	Future Status: Massachusetts intends to continue to work closely to assess the current lengths of stays in EDs and divert members into appropriate community-based services. Effective early 2023, Massachusetts will implement a network of CBHCs that will expand urgent outpatient mental health and addiction treatment as well as enhance access to community-based crisis intervention services utilizing the new federal option, as described in State Health Official Letter #21-008. Introduction of the above-described technology-enabled platform connecting EDs to inpatient facilities for more efficient clinical data exchange, is anticipated to occur in 2023. MassHealth is also implementing rate

Prompts	Summary
	enhancements for inpatient episodes, including for individuals with complex needs, to support services that address the needs of key populations who are shown to have longer wait times in ED settings.
	Summary of Actions Needed: Massachusetts will implement changes to the crisis and outpatient systems, including implementation of CBHCs which are hubs for integrated outpatient, urgent, and crisis behavioral health care. Massachusetts will implement and monitor effectiveness of the technology enabled platform as described above.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status*: MassHealth has implemented Behavioral Health Community Partners (CPs), community-based entities that work with the MassHealth Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs) to provide care management and coordination to certain members with significant behavioral health needs, including SMI and SUD. Youth with SED are eligible for Intensive Care Coordination through the Children's Behavioral Health Initiative.
	Future Status: As part of Massachusetts' work to improve the behavioral health crisis and outpatient systems mentioned in 2.d., Massachusetts is introducing new CBHCs that may serve as the behavioral health care coordination entity for certain members, which will also include coordination with medical providers. CBHCs will include peers, recovery coaches, and other supportive professionals to improve care coordination and connections to community-based care.
	Summary of Actions Needed: MassHealth will implement changes to the crisis and outpatient systems as described above to provide additional support to beneficiaries in the community.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists,	*Current Status:* Massachusetts completed the initial assessment as part of the SMI-SED Demonstration Amendment Request.

Prompts	Summary
other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment	*Future Status*: Massachusetts will complete the required annual assessment.
	Summary of Actions Needed: Massachusetts will continue to complete the annual assessment and use results to monitor provider availability on an annual basis.
3.b Financing plan	*Current Status:* See Topic 5 for additional information on the state's financing plan.
	Future Status: See Topic 5 for additional information on the state's financing plan.
	Summary of Actions Needed: See Topic 5 for additional information on the state's financing plan.
3.c Strategies to improve state tracking of availability of	*Current Status:* The state contracts for the operation of a Massachusetts Behavioral Health Access (MABHA) website. The MABHA website captures provider availability, including inpatient and crisis stabilization beds.

Prompts	Summary
inpatient and crisis stabilization beds	*Future Status:* As described in 2.d. above, Massachusetts is in the process of procuring a technology solution, which will be implemented in two phases. Phase two will allow for automated updating of certain provider availability, such as 24-hour levels of care and to incorporate the capacity to conduct real-time bed-finding from a centralized perspective.
	Summary of Actions Needed: Procurement expected to be complete in late 2022. Vendor contracting and implementation activities to begin early 2023 for phase one, and phase two will be further outlined in 2023.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* MassHealth providers conduct clinical assessments using nationally recognized criteria sets, including ASAM and CANS for children, and standardized assessment tools for adults such as ASAM, PHQ-9, GAD-7, and Columbia Suicide Severity Rating Scale.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* Massachusetts currently has a full continuum of behavioral health services including community crisis stabilization services for covered individuals 18+ and specialized services for youth under the age of 21 through the Children's Behavioral Health Initiative and designated crisis response teams through the ESP/MCI providers.
	Future Status: Massachusetts is implementing a system-wide strategy to increase access to treatment across the continuum, which includes promoting integration of behavioral and physical health, mental health and addiction treatment, as well as increasing the capacity for crisis intervention across all levels of care. Included in this expansion is the addition of new youth community crisis stabilization (YCCS) units.
	Summary of Actions Needed: New CBHCs and YCCS will be implemented in early 2023.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	

Prompts	Summary
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment	*Current Status:* MassHealth MCEs conduct health needs assessments to identify members with resource gaps, inclusive of education and employment, and who may have emerging risks and need additional supports. MassHealth also recently introduced a preventive behavioral health service for members under age 21. MassHealth has developed a phased implementation plan for primary care integration. In Phase 1, MassHealth has instructed managed care plans to pay for certain behavioral health integration services not previously reimbursed in the primary care setting at designated rates. Phase 2 is described below.
	Future Status: Massachusetts has developed a system-wide strategy to improve the behavioral health continuum of care, including integrating behavioral health into primary care via a tiered sub-capitation payment model to be implemented in spring 2023. The tiers will be determined by the degree of BH integration, among other standards, and each tier will have a higher per-member per-month rate. As part of this integration, individuals with SED/SMI may be identified earlier and connected into services in collaboration with their primary care provider. Additionally, primary care integration and the implementation of Community Behavioral Health Centers will offer referral and care coordination for SED/SMI individuals to ensure connection to appropriate services, including supported education, supported employment and referral to services within the Department of Mental Health as appropriate.
	Summary of Actions Needed: In Phase 2 of the implementation plan for primary care integration, the state will implement the primary care sub-capitation model as described above to further support integration. Additionally, MassHealth will expand access to community-based outpatient treatment through CBHCs, including for those members at risk for SMI/SED, effective early 2023.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* See section 4.a.
	Future Status: See Section 4.a.
	Summary of Actions Needed: See Section 4.a.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status*: MassHealth offers a robust array of children's behavioral health services for youth ages 0-20. This includes required BH screening at well child visits, preventive behavioral health services, traditional outpatient BH services, Mobile Crisis Intervention, In-home Therapy, Therapeutic Mentoring, In-home Behavioral Services, Family Partner Services and Intensive Care Coordination (ICC), using high fidelity, wrap-around care approach for youth with SED. 24-hour levels of treatment are also available to youth in the community through Community Based Acute Treatment (CBAT).

Prompts	Summary
	Future Status: The new CBHCs will offer services specifically for youth with clinicians trained to work with youth and using youth-specific evidence-based practices, as well as family-support professionals. These services will include access to urgent care, crisis evaluation, intervention and Youth Community Crisis Stabilization services, as well as ongoing treatment services to complement the existing continuum of care. These centers are anticipated to support enhanced behavioral health integration into pediatric primary care through increased medical screening capacity and coordination with primary care providers.
	Summary of Actions Needed: MassHealth will implement changes to the crisis and outpatient systems, via regulation and MCE contracts, to provide additional support to beneficiaries in the community, effective early 2023.
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* MassHealth has a robust BH screening program for youth, with a designated set of standardized BH screening tools and required BH screening of all members, 0-20, at well child visits for early identification of youth who may need BH support. MassHealth also provides preventive behavioral health services to members under the age of 21.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that	*Current Status:* MassHealth has a state-wide network of ESP/MCI services to provide crisis stabilization and intervention services on a 24-7-365 basis. MassHealth also has a state-wide network of community crisis stabilization service providers, providing 24-hour crisis stabilization services to members ages 18 and older.

Prompts	Summary
involves collaboration with trained law enforcement and other first responders.	
	Future Status: As described above, Massachusetts is implementing a system-wide strategy in early 2023 to improve the behavioral health continuum of care, including the development of new CBHCs that will provide urgent behavioral health services as well as enhanced crisis intervention and stabilization services. Crisis service providers will provide services 24/7 to maximize diversion from inpatient settings, where clinically appropriate, and will provide crisis stabilization services for both youth and adults, with clinical staffing capable of addressing both mental health and SUD. Massachusetts is also implementing a 24-7 Behavioral Health Help Line in early 2023, which will offer real-time clinical triage and service navigation to help individuals and families access the range of treatment for mental health and addiction offered in the Commonwealth, including outpatient, urgent and immediate crisis intervention. Massachusetts has committed to significant investments in the behavioral health system through rate increases and additional investments in the new CBHCs and 24-7 Behavioral Health Helpline. To increase available financing options, MassHealth will draw on funding available through the American Rescue Plan Act of 2021 (ARPA) for an 85 percent enhanced federal matching rate for qualifying mobile crisis services for three years of state coverage. Massachusetts will begin claiming the enhanced FMAP in early 2023 with the implementation of the enhanced crisis intervention and stabilization services and use the additional FMAP to fund crisis intervention services. Massachusetts also has an approved Advance Planning Document that provides enhanced federal funding for certain components of the Behavioral Health Help Line.
	Summary of Actions Needed: MassHealth will implement provider rate increases through regulations and accompanying state plan amendments and will add a CBHCs as a new provider type to deliver an array of behavioral health services, including urgent and enhanced crisis intervention and stabilization services. MassHealth will begin claiming enhanced FMAP on its mobile crisis intervention services in early 2023.
F.b Increase availability of on-going community-based services, e.g., outpatient, community	*Current Status:* As discussed in responses to Topic 1-4 above, as part of the development of system-wide strategies to improve the behavioral health continuum of care, there are significant ongoing efforts to assess community needs and increase the availability of on-going community-based services.

Prompts	Summary
mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Future Status:* As described above, Massachusetts is implementing the system-wide strategy to improve the behavioral health continuum of care to deliver high-quality community-based behavioral health services on an urgent and ongoing basis. MassHealth will implement a new payment model for CBHCs to support flexible, person-centered treatment, including enhanced, encounter and bundled payment models. In addition to investment in the implementation of CBHCs and enhanced crisis intervention and stabilization services, MassHealth has committed significant resources to enhancing access to community-based services through rate increases for a broad range of behavioral health services, and the expansion of coverage of Community Support Program services, PACT services, and for services provided by solo practitioner psychologists and licensed independent clinical social workers to fee-for-service members. Additionally, MassHealth is implementing enhanced rates for services provided by mental health centers designated as behavioral health urgent care providers.
	Summary of Actions Needed: Massachusetts is implementing the system-wide improvements and investments to the behavioral health continuum of care through contract actions and regulatory actions, anticipated to be effective in Q1 of calendar year 2023.
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	The Commonwealth of Massachusetts has robust adoption of Health Information Technology by health plans and providers. The state operates a statewide electronic health information exchange (HIE), called the Mass HIway, through the Direct Standard. HIway Direct Messaging allows providers to securely communicate with messages to one another regardless of technology. All Massachusetts acute care hospitals, CHCs, and large provider organizations are able to use Direct Messaging and have access to the Mass HIway for sending and receiving messages, including for public health reporting such as Syndromic Surveillance and Electronic Lab Reporting. The HIway provides technical assistance to providers to adopt HIway Direct Messaging. The Mass HIway includes Direct Message webmail capability allowing for smaller providers to have access to secure messaging regardless of their implemented EHRs. Health plans support the Commonwealth's efforts by having policies and procedures in place aimed at increasing their capabilities to share information among providers, by facilitating sharing between enrollees and providers, and by increasing the connection rates of their network providers to the Mass HIway.
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	The Commonwealth of Massachusetts submitted a SUD Health IT plan in October 2022 that is in alignment with the State Medicaid Health IT Plan.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and,	MassHealth intends to assess and align with the ISA and 45 CFR 170 Subpart B. MassHealth recognizes and supports the need for a standards-based approach to interoperability. Currently, MassHealth, like all other required CMS-regulated payers, is embarking on the path toward developing and implementing FHIR APIs pursuant to the recent Interoperability and Patient Access Final Rule (CMS-9115-F). Mass

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	HIway uses the Orion Healthcare's Communicate platform for Direct Messaging implemented in accordance with federal standards like 45 CFR 170.202. MassHealth's managed care contracts (including MCOs and ACOs) require contractors to establish and implement policies and procedures to increase the contractor's capabilities to share information among providers involved in enrollees' care, including increasing connection rates of network providers to the Mass HIway, adopting and integrating interoperable certified Electronic Health Records (EHR) technologies (such as those certified by the Office of the National Coordinator (ONC)), enhancing interoperability, and increasing the use of real time notification of events in care (such as but not limited to admission of an enrollee to an emergency room or other care delivery setting).
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* The Mass HIway does not maintain a central data repository; in its federated model, the provider organizations retain ownership of the data and exchange electronic health information point-to-point. For this reason, MassHealth and the Mass HIway do not have the ability to determine which messages exchanged between providers are for any specific use case, such as referrals. Data from 2019 indicates that approximately 27% of behavioral health providers have acquired EHR systems; and current data show that 73 behavioral health organizations are connected to

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.
[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

Prompts	Summary
	the Mass HIway for electronic health exchange, either with a Mass HIway connection or through another HISP. Currently 49% of those behavioral health organizations are actively exchanging messages with other organizations and most report that their primary usage is for care coordination. Some of those behavioral health organizations have notified the Mass HIway when they have implemented specific use cases, including implementing closed-loop referrals.
	Future State: MassHealth and the Mass HIway continue to encourage the expanded use of point-to-point communications like HIway Direct Messaging and other methods of health information exchange. For behavioral health providers, closed-loop referrals is a key use case.
	Summary of Actions Needed: HIway communications to providers will include items focused on behavioral health providers and how to arrange support for implementing closed-loop referrals, such as the availability of HIT programs and opportunities for the BH provider community.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* Please see the response to 1.1, above.
	Future State: See above.
	Summary of Actions Needed: See above.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State:* Please see the response to 1.1, above.
	Future State: See above.
	Summary of Actions Needed: See above.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* The MCOs, ACOs and providers are able to create and use electronic health records (EHR), which include members' electronic care plans (e-care plans). While the use of EHRs is not mandated, the MCOs and ACOs have established and implemented policies and procedures to increase their capabilities to share information among providers involved in members' care, including adopting and integrating interoperable certified EHR technologies and increasing the use of real time notification of events in care.
	Future State: MassHealth and the Mass HIway are developing a plan to encourage the expanded use of HIway Direct Messaging and other methods of health information exchange. For behavioral health providers, the exchange of e-care plans is a key use case.

Prompts	Summary
	Summary of Actions Needed: MassHealth and the Mass HIway will develop communication and training materials focused on technology solutions for behavioral health providers and what resources are available to support the agencies.
.2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* E-care plans are part of the member's health record, and providers are expanding their use of EHR systems. E-care plans can be shared via HIway Direct Messaging and other point-to-point forms of exchange, such as Secure File Transfer Protocols (SFTP).
	Future State: MassHealth and the Mass HIway are developing a plan to encourage the expanded use of HIway Direct Messaging and other methods of health information exchange. For behavioral health providers, the exchange of e-care plans is a key use case.
	Summary of Actions Needed: MassHealth and the Mass HIway communications will explore including items focused on behavioral health providers and how to arrange support.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The Commonwealth is working with providers as they are expanding their use of EHR systems. The MA HIway Direct Messaging and other point-to-point forms of exchange, such as SFTP are options for providers to exchange digital medical records during transition. The typical approach is for providers to attach PDF versions of medical records to messages for point-to-point communication.
	Future State: MassHealth and the Mass HIway are developing a plan to encourage the expanded use of HIway Direct Messaging and other methods of health information exchange.
	Summary of Actions Needed: HIway communications to providers will include items focused on youth-oriented providers and how to arrange support. This effort focuses on ensuring that the providers' EHR workflow produces meaningful transfer of digital clinical information.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* See response to 2.3, above.
	Future State: See above.
	Summary of Actions Needed: See above.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* The Mass HIway's Direct Messaging system includes webmail capability allowing easy provider adoption for secured electronic transactions of transitions of care documents. The Mass HIway has developed a Statewide ENS Framework through a certification of existing ENS vendors to increase access to ENS through universal access to ADTs

Prompts	Summary
	Future State: The Mass HIway is enhancing the Statewide ENS Framework towards improving provider experience, and improving notification timing. The Mass HIway will review policy and technical capabilities to determine the feasibility of extending access to community supports.
	Summary of Actions Needed: In early 2023, the Mass HIway and MeHI will begin conducting an environmental scan for SDOH technology to assess existing technology and determine gaps. The environmental scan will build off prior work identifying other states' initiatives around SDOH. Upon completion of the scan, the Mass HIway will determine whether there is an opportunity to either create a centralized service or a framework of vendors to provide that service statewide.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* The Mass HIway does not maintain a central data repository; in its federated model, the provider organizations retain ownership of the data and exchange electronic health information point-to-point. As described in the Mass HIway Regulations, 101 CMR 20.07(1), for HIway Direct Messaging: "Mass HIway users may transmit information via HIway Direct Messaging provided that all such transmissions shall be in compliance with applicable federal and state privacy laws and implementing regulations. [Provider organizations] may implement local opt-in and/or opt-out process that applies to the use of HIway Direct Messaging by their organization, but are not required to do so."
	Future State: No changes are expected.
	Summary of Actions Needed: None.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* MassHealth has a number of assessment platforms accessible to providers including Child and Adolescent Needs and Strengths Assessment (CANS). While MassHealth does not host a Clinical Data Repository on the MA HIway, MassHealth has an IT infrastructure that supports both centralized and federated collection of assessment data.
	Future State: MassHealth will explore opportunities to develop the capabilities to create interoperable assessment data services. By leveraging the ONC standards work and ongoing industry development the Commonwealth seeks to build a flexible HIT ecosystem.
	Summary of Actions Needed: MassHealth will continue to explore opportunities to foster interoperable data sharing between platforms and providers.
Electronic Office Visits – Telehealth (Section 5)	

Prompts	Summary
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* Telehealth has been allowed as a modality of service for behavioral health providers since January 2019. In March 2020, in response to the COVID pandemic, MassHealth broadly expanded its telehealth policy to allow delivery of both medical and behavioral health services through telehealth modalities. In addition to a modality of service, telehealth technologies are utilized for consultative services, including for connecting primary care to child psychiatry (MCPAP), connecting clinicians to support for treating chronic pain and substance use disorders (MCSTAP), and for connecting crisis teams to expert consultation for treating individuals with Autism Spectrum Disorder or other intellectual or developmental disabilities (MCPAP for ASD/IDD) through state-funded programs.
	Future State: MassHealth intends to promote the permitted uses of telehealth technologies to improve statewide mental health and primary care access, as well as access to specialty services.
	Summary of Actions Needed: Massachusetts is actively developing a post-pandemic telehealth policy, aiming to incentivize high quality service delivery in an equitable manner that enhances patient and provider experience. Clinical and program teams are evaluating both the Commonwealth's experience as well as national experience with telehealth before and during the pandemic to inform development of future state policy.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State:* MassHealth recognizes that patients with high-risk behavioral health conditions, particularly for those with SUD diagnoses, are at risk for disengaging from treatment. The Behavioral Health Community Partners (BHCPs), supporting members enrolled in MCOs and ACOs, are responsible for tracking and engaging with members with high BH needs to ensure initiation and continued engagement with care, providing personal contacts and helping to overcome barriers to attending appointments. Additionally, MassHealth has recently implemented enhanced reporting requirements on ACOs and MCOs to ensure that members with high BH needs, whether they are enrolled with a BHCP or not, are engaged in appropriate treatment. Separately, the ACO and MCO measure slate collects and analyzes data related to initiation and engagement in SUD treatment, incentivizing ACOs and MCOs to ensure that members remain engaged in care.
	Future State: The ACOs and MCOs will identify members who have challenges in attending appointments and look to adjust their processes to improve engagement of care teams with members and ensure treatment continues.
	Summary of Actions Needed: ACOs and MCOs will collect and analyze their high-risk member data, to be shared with MassHealth. Results of that analysis will inform future processes.

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* Many of Massachusetts' acute hospital EDs participate in an electronic notification system that can be utilized to share data on individuals presenting at an ED for BH treatment, however these are not specific to first episode psychosis.
	Future State: Massachusetts will require CBHCs to have referral and collaboration protocols with first episode psychosis programs, though these are not required to have HIT connectivity. Massachusetts intends to further examine baseline expectations for providers and populations requiring extra support, as well as accountability, financing and future modifications to existing care coordination programs, including how the use of Health IT can advance such efforts.
	Summary of Actions Needed: Further define policies in consultation with stakeholders.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* Ability to link parent-child relations is a feature of some certified EHRs, however, this is not a feature of the MA HIway or broadly implemented in the Massachusetts health system.
	Future State: MassHealth understands there is interest in linking parent and child medical records, including the proposed rules developed under the Office of Civil Rights Request for Information, and will ensure compliance with any federal requirements that may be issued on this topic.
	Summary of Actions Needed: Future actions to be determined pursuant to finalized federal requirements, if any, and in conjunction with provider partners and stakeholders.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* The Mass HIway does not maintain a central data repository; in its federated model, the provider organizations retain ownership of the data and exchange electronic health information point-to-point. Each provider organization with an EHR system has the ability to capture all episodes of care, and it is a primary function of the EHR system to perform appropriate patient matching so that all episodes of care are linked to the correct patient. The patient matching function is expected to be performed at each provider organization involved in electronic health information exchange, whether using the Mass HIway or another method of point-to-point exchange.
	Future State: No changes are expected.
	Summary of Actions Needed: None.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

1. Roadmap for Behavioral Health Reform: https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform
2. Mass HIWay Services, Resources and Regulations: https://www.masshiway.net/

Attachment G: SUD and SMI/SED Monitoring Protocol

What follows are the Planned Metrics, SMI-SED definitions, Planned Subpopulations, and Reporting Schedule tabs from the SUD and SMI/SED monitoring protocol workbook (part A). The full workbook is also available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SUD and SMI/SED Demonstration Components Monitoring Protocol (Part A) - SUD Planned Metrics (Version 1.0)[a]

State: Massachussets

Demonstration Name: MassHealth

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic[b]	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data source, definition, codes, target population, etc.)[c,d]	State plans to phase in reporting (Y/N)	SUD monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 1 ***(Do not delete or edit this row)***	*EXAMPLE: Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE: Assessment of need and qualification for SUD treatment services*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other monthly and quarterly metrics*	*EXAMPLE: Medical record review or claims*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 07/01/2018-06/30/2019*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY2Q1*	*EXAMPLE: This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Recommended	N								
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims or EHR	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Medical record review or claims	Year	Annually	Recommended	N								
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence: Age 18 and Older (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure][e]	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
17(2)	Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) [NCQA; NQF #3489; Medicaid Adult Core Set; Adjusted HEDIS measure][f]	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (OMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2021- 12/31/2022	Increase	Increase	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metrics that are established quality	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[g]	Administrative records	Quarter	Quarterly	Recommended	N								
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[g]	Administrative records	Quarter	Quarterly	Recommended	N								
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[g]	Administrative records	Quarter	Quarterly	Recommended	N								
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metrics	Claims; State-specific IMD database	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
Q1	*PDMP Checking by prescribers and dispensers*	Number of PDMP checks by PDMP users	Health IT	State-specific	Other annual metrics	Administrative	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase			N		
Q2	*Tracking MAT*	Number of patients who received both medication and counseling/behavioral therapy for SUD through telehealth appointments and other virtual or electronic services	Health IT	State-specific	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase			N		
Q3	*Individuals connected to alternative therapies from other community-based resources for pain management or general therapy/treatment*	Number of queries to the E-directory for community resources by providers	Health IT	State-specific	Other annual metrics	Administrative records	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase			N		
State-specific metrics																		

[Insert row(s) for any additional state-specific metrics by right-clicking on row 51 and selecting "Insert"]

[a] The Medicaid Section 1115 integrated SUD and SMI/SED Monitoring Protocol Workbook (Part A) combines the Medicaid Section 1115 SMI/SED Monitoring Protocol Workbook Version 3.0 with the Medicaid Section 1115 SUD Monitoring Protocol Workbook Version 7.0.

[b] There are no CMS-provided metrics related to milestone 3

[c] If the state is not reporting a required metric (i.e., column K = "N"), enter explanation in corresponding row in column P.

[d] The state should use column P to outline calculation methods for specific metrics as explained in Version 1.0 of the Medicaid Section 1115 Substance Use Disorder Demonstrations & Serious Mental Illness and Serious Emotional Disturbance Demonstration Components Monitoring Protocol Instructions.

[e] Rates 1 and 2 reported for Metric #17(1) correspond to rates 4 and 3 for Metric #17 from Version 1.1 of the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[f] Rates 1 and 2 reported for Metric #17(2) correspond to rates 2 and 1 for Metric #17 from Version 1.1 of the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[g] While grievances and appeals metrics are recommended for reporting, the state is required per 42 CFR 438.66(e) to provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, in its annual (Q4) monitoring report.

State Massachussets

Demonstration Name MassHealth

Table: Serious Mental Illness/Serious Emotional Disturbance Planned Metrics

#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline period (MM/DD/YYYY--MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data source, definition, codes, target population, etc.)[b, c]	State plans to phase in reporting (Y/N)	SMI/SED monitoring report in which metric will be phased in (Format DY#Q#; e.g. DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: *20* ***(Do not delete or edit this row)***	*EXAMPLE:* *Beneficiaries With SMI/SED Treated in an IMD for Mental Health*	*EXAMPLE:* *Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year*	*EXAMPLE:* *Milestone 3*	*EXAMPLE:* *CMS-constructed*	*EXAMPLE:* *Other annual metrics*	*EXAMPLE:* *Claims*	*EXAMPLE:* *Year*	*EXAMPLE:* *Annually*	*EXAMPLE:* *Required*	*EXAMPLE:* *Y*	*EXAMPLE:* *01/01/2020-12/31/2020*	*EXAMPLE:* *Increase*	*EXAMPLE:* *Consistent*	*EXAMPLE:* *N*	*EXAMPLE:* *The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE:* *Y*	*EXAMPLE:* *DY3Q1*	*EXAMPLE:* *The demonstration site will be updating its EHR during the start of the demonstration. We plan to phase in reporting after the system update has been completed by mid to late 2021 (DY2).*
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings	Two rates will be reported for this measure: 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay 2. SUB-2a: Patients who received the brief intervention during the hospital stay	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	N								
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Consistent	Y		N		
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2022	Increase	Increase	Y		N		
7	Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • Percentage of discharges for which the child received follow-up within 30 days after discharge • Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
10	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Consistent	Increase	Y		N		
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%)	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Decrease	Decrease	Y		N		
24	Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	N		Increase	Increase					
25	Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N		Increase	Increase					
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: •Percentage of children and adolescents on antipsychotics who received blood glucose testing •Percentage of children and adolescents on antipsychotics who received cholesterol testing •Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who meet the following criteria: •age 18 years and older, and •completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Increase	Increase	Y		N		
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2022-12/31/2022	Decrease	Decrease	Y		Y	DY1Q4	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. Due to MCO/ACO contractual obligations, SMI/SED will not be broken out. We will use the aggregate reports that are not stratified by diagnostic profiling.
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2022-12/31/2022	Decrease	Decrease	Y		Y	DY1Q4	Board of appeals reporting schedule. We request yearly reporting instead of quarterly. Due to MCO/ACO contractual obligations, SMI/SED will not be broken out. We will use the aggregate reports that are not stratified by diagnostic profiling.
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2022-12/31/2022	Decrease	Decrease	Y		Y	DY1Q4	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. Critical incidents are not available for FFS members by payer type. Due to MCO/ACO contractual obligations, SMI/SED will not be broken out. We will use the aggregate reports that are not stratified by diagnostic profiling.
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2022- 12/31/2022	Consistent	Consistent	Y		N		
Q1	*Connection to HIE by behavioral health providers*	Number of community mental health centers and community behavioral health centers connected to the health information exchange (HIE)	Health IT	State-specific	Other annual metrics	Survey	Year	Annually	Required	Y	01/01/2023- 12/31/2023	Increase	Increase			Y	DY3Q2	Survey won't be fielded until summer 2023
Q2	*Monitoring Pros in EHRs*	Percentage of community mental health centers and community behavioral health centers using EHRs to measure patient reported outcomes	Health IT	State-specific	Other annual metrics	Survey	Year	Annually	Required	Y	01/01/2023-12/31/2023	Increase	Increase			Y	DY2Q2	Survey won't be fielded until summer 2023
Q3	*Individuals connected to community resources*	Number of community mental health centers and community behavioral health centers that report using the HIE to make referrals	Health IT	State-specific	Other annual metrics	Survey	Year	Annually	Required	Y	01/01/2023-12/31/2023	Increase	Increase			Y	DY3Q2	Survey won't be fielded until summer 2023
State-specific metrics																		
[Insert row(s) for any additional state-specific metrics by right-clicking on row 50 and selecting "Insert"]																		

Medicaid Section 1115 SUD and SMI/SED Demonstration Components Monitoring Protocol (Part A) - SMI/SED Definitions (Version 1.0)[a]

State	Massachussets
Demonstration Name	MassHealth

Table: Serious Mental Illness/Serious Emotional Disturbance Definitions

Narrative description of the SMI/SED demonstration population		
EXAMPLE[b] *Adults age 18 or older with serious mental illness or children under the age of 18 with a serious emotional disturbance living within the state.*		
	Serious Mental Illness (SMI)	**Serious Emotional Disturbance (SED)**
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*For Adults (18+):* *- At least one acute psychiatric inpatient claim/encounter with any diagnosis of psychotic disorder, bipolar disorder, major depression, or PTSD OR* *- At least two visits to outpatient, IOP, PH, ED, AMCI, PACT, CSP, or ACCS (different dates of services) with a diagnosis of psychotic disorder, bipolar disorder, or PTSD, with or without a hospitalization* *- At least two visits to IOP, Psych Day Treatment PH, ED, AMCI or ACCS (different dates of services) with a diagnosis of major depression, with or without a hospitalization*	*For Youth (0-17):* *- At least one acute psychiatric inpatient or CBAT claim/encounter with any diagnosis of psychotic disorder, bipolar disorder, major depression, PTSD, Autism Spectrum Disorder, ADHD, or Conduct Disorder/Oppositional Defiance Disorder) OR* *- At least two visits (different dates of service) outpatient, IOP, PH, ED, YMCI, YCCS, or CBHI with a diagnosis of psychotic disorder, bipolar disorder, or PTSD OR* *- At least two visits (different dates of service) IOP, PH, ED, YMCI, YCCS, or CBHI with a diagnosis of major depression, Autism Spectrum Disorder, ADHD, or Conduct Disorder/Oppositional Defiance Disorder*
Codes used to identify population *States may use ICD-10 diagnosis codes or state-specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD-10 codes with state-specific codes.*	*Codes:Psychotic Disorders:F20, F200-F205, F208, F2081,F2089, F209, F21-F25, F250, F251, F258, F259, F28, F29,* *Bipolar Disorders: F30, F301, F3010-F3013, F302-F304, F308, F309, F31, F310, F311, F3110-F3113, F312, F313, F3130- F3132, F314-F316, F3160 -F3164, F317, F3170-F3178, F318, F3181, F3189, F319* *Depressive Disorders: F32, F321-F325, F328, F3281, F3289, F329, F33, F331-F334, F3340, F3341, F338-F341,* *PTSD: F43, F430, F431, F4310 – F4312b*	*Psychotic Disorders: F20, F200-F205, F208, F2081, F2089, F209, F21-F25, F250, F251, F258, F259, F28, F29,* *Bipolar Disorders: F30, F301, F3010-F3013, F302-F304, F308, F309, F31, F310, F311, F3110-F3113, F312, F313, F3130- F3132, F314-F316, F3160 -F3164, F317, F3170-F3178, F318, F3181, F3189, F319* *Depressive Disorders: F32, F321-F325, F328, F3281, F3289, F329, F33, F331-F334, F3340, F3341, F338-F341,* *PTSD: F43, F430, F431, F4310 – F4312* *Conduct Disorders: F630-F632, F638, F6381, F6389, F639, F91, F910-F913, F918, F919, Z72810, Z72811* *ADHD: F90, F900 – F902, F908, F909* *Autism Spectrum Disorder: F84, F840, F842, F843, F845, F848, F849*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state-specific codes) used to identify/define service requirements.*	*Outpatient: 95004-95199, 96900-96922, 96999, 99201-99215, 99241-99245, 99341-99350, 99354-99355, 99357-99360, 99366-99368, 99374-99397, 99432, 99450, 99455, 99460, 99499,99401-99405, 99408-99429, 99606, 99607, T1015, 99050-99058, 0500F-0503F, 90918-90925, 97802-97804, 99024, 99078, 99170-99175, 99195-99199, 99500-99599, T1502, T1023-T1026, T1028-T1030, 0001F, G0101-G0122, G0127, G0166-G0168, G0179, G0180-G0182, G0246-G0250, G0257, G0317-G0327, G0344, G0372, G0402, G0438, G0439, G0466-G0470, M0064, M0076, M1204, Q0081-Q0085, S0220, S0265, S0302, S0315-S0320, S0390, S0395, S0601-S0630, S0812, S0820, S2260, S0199, S8110, S9075, S9083-S9090, S9381-S9401, S9436-S9474, S9490-S9562, 90791, 90792, 90801-90802, 90804-90824, 90826-90829, 90832-90834, 90836-90847, 90849, 90853, 90855, 90857, 90862-90899, H0001-H0009, H0012-H0014, H0016-H0019, H0021-H0030, H0033-H0034, H0036, H0037, H0041-H0042, H0046-H2010, H2013-H2014, H2016-H2019, H2020-H2037, G0177, 96150-96155, T1007-T1010, H2104, H5300, HIVE2, HJ201, HOOO4, S9475-S9479, S9481-S9483, G0396, G0397, G0410-G0411, G0473, G8466, G8477, G8128, G8467, Q4094, T1006, T1012, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0373T, 0374T; Revenue codes 900-904,910,911,914-919,931,932,944,945,961,1003-1004;* *Outpatient Diversionary Including Intensive Outpatient, PH, Community Support Program and : Psych Day Treatment: H2015 or H2016 with modifier SE or +, S9480, H2012, H0015 H0035, Revenue codes 905, 906, 907;* *ESP/AMCI: H2011 with or without HO, HN, HB, S9484, S9485 with modifier HB, HE, U1 or plan submits claim as ESP service;* *ACCS S9485 with modifier ET* *PACT: H0039, H0040, Revenue codes 912, 913;*	*Outpatient: 95004-95199, 96900-96922, 96999, 99201-99215, 99241-99245, 99341-99350, 99354-99355, 99357-99360, 99366-99368, 99374-99397, 99432, 99450, 99455, 99460, 99499,99401-99405, 99408-99429, 99606, 99607, T1015, 99050-99058, 0500F-0503F, 90918-90925, 97802-97804, 99024, 99078, 99170-99175, 99195-99199, 99500-99599, T1502, T1023-T1026, T1028-T1030, 0001F, G0101-G0122, G0127, G0166-G0168, G0179, G0180-G0182, G0246-G0250, G0257, G0317-G0327, G0344, G0372, G0402, G0438, G0439, G0466-G0470, M0064, M0076, M1204, Q0081-Q0085, S0220, S0265, S0302, S0315-S0320, S0390, S0395, S0601-S0630, S0812, S0820, S2260, S0199, S8110, S9075, S9083-S9090, S9381-S9401, S9436-S9474, S9490-S9562, 90791, 90792, 90801-90802, 90804-90824, 90826-90829, 90832-90834, 90836-90847, 90849, 90853, 90855, 90857, 90862-90899, H0001-H0009, H0012-H0014, H0016-H0019, H0021-H0030, H0033-H0034, H0036, H0037, H0041-H0042, H0046-H2010, H2013-H2014, H2016-H2019, H2020-H2037, G0177, 96150-96155, T1007-T1010, H2104, H5300, HIVE2, HJ201, HOOO4, S9475-S9479, S9481-S9483, G0396, G0397, G0410-G0411, G0473, G8466, G8477, G8128, G8467, Q4094, T1006, T1012, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0373T, 0374T; Revenue codes 900-904,910,911,914-919,931,932,944,945,961,1003-1004;* *Outpatient Diversionary Including Intensive Outpatient, PH: S9480, H0015 H0035, Revenue codes 905, 906, 907* *CBHI: 90791 or 90801 and modifier HA as 1st or 2nd modifier, H0038, H0023 with modifier HT, T1017 with modifier HN or HO, H2014 with modifier HN or HO, H2019 with modifier HN or HO, H2011 with modifier HN or HO, 96110, H0038; H2011, H2014, H2019, T1017 with modifier HN or HO; T1027 with modifier EP, H0023 with modifier HT* *Outpatient ABA: H0031, H0032, H2012,or H2019 and modifier U2* *YMCI: S9485 with modifiers HA HE, HA U1; H2011 with modifier HA HE,*

[a]The Medicaid Section 1115 integrated SUD and SMI/SED Monitoring Protocol Workbook (Part A) combines the Medicaid Section 1115 SMI/SED Monitoring Protocol Workbook Version 3.0 with the Medicaid Section 1115 SUD Monitoring Protocol Workbook Version 7.0.

[b]The examples are based on a definition of SMI from the National Committee for Quality Assurance (NCQA). The examples provided are intended to be illustrative only. The example codes provided are not comprehensive.

Medicaid Section 1115 SUD and SMI/SED Demonstration Components Monitoring Protocol (Part A)

State: Massachussets
Demonstration Name: MassHealth

Table: Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance Demonstration Components Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c,d]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: Age group (Do not delete or edit this row)	*EXAMPLE: Children <18, adults 18–64, and older adults 65+*	*EXAMPLE: Required*	*EXAMPLE: Metrics #1-3, 6-12, 23, 24, 26, 27*	*EXAMPLE: CMS-provided*	*EXAMPLE: Y*	*EXAMPLE: N*	*EXAMPLE: Children/Young adults 12-21, Adults 21-65*	*EXAMPLE: N*	*EXAMPLE: 1, 2, 3*
SUD subpopulations									
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	SUD Metrics #1-3, 6-12	CMS-provided	Y	Y	Individuals with both Medicaid and Medicare coverage using flags IND_MEDICARE_A, IND_MEDICARE_B, IND_MEDICARE_C, IND_MEDICARE_D IND_MEDICARE_H. These flags indicate the member is enrolled in Medicare Part A, B, C, D and hospice during the enrollment month. The Medicare coverage must be present during the report month for monthly report metrics and during the report year for annual report metrics.	N	Dual-Eligibility is identified during anytime of the month for those eligible for both Medicaid and Medicare.
Age group	Children <18, adults 18–64, and older adults 65+	Required	SUD Metrics #1-3, 6-12, 23, 24, 26, 27	CMS-provided	Y	Y		Y	
Pregnancy status	Pregnant, Not pregnant	Required	SUD Metrics #1-3, 6-12	CMS-provided	Y	Y	We will be using the ICD-10 pregnancy codes in the HEDIS Value Set for the year we are measuring to identify pregnancy = Y. We are confirming that we are following the CMS-provided technical specifications.	Y	
Criminal justice status	Criminally involved, Not criminally involved	Required	SUD Metrics #1-3, 6-12	CMS-provided	Y	Y	MassHealth does not flag for criminal justice but can use AID Categories C1-C3 code to determine if the member is incarcerated in the measurement period. We will also include procedure code H2016-HH for individuals served through CSP-JI in the measurement period.	Y	
OUD population	Opioid diagnosis	Recommended	SUD Metrics #2-12, 23, 24, 26, 27, 36	CMS-provided	N				
SMI/SED subpopulations									
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	SMI/SED Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y	Individuals with both Medicaid and Medicare coverage using flags IND_MEDICARE_A, IND_MEDICARE_B, IND_MEDICARE_C, IND_MEDICARE_D IND_MEDICARE_H. These flags indicate the member is enrolled in Medicare Part A, B, C, D and hospice during the enrollment month. The Medicare coverage must be present during the report month for monthly report metrics and during the report year for annual report metrics.	N	Dual-Eligibility is identified during anytime of the month for those eligible for both Medicaid and Medicare.
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required	SMI/SED Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Standardized definition of SMI[e]	Individuals who meet the standardized definition of SMI	Required	SMI/SED Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
State-specific definition of SMI	Individuals who meet the state-specific definition of SMI	Required	SMI/SED Metrics #13, 14, 15, 16, 17, 18, 21, 22	State-specific	Y	Y		Y	
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended	SMI/SED Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Criminal justice status	Criminally involved, Not criminally involved	Recommended	SMI/SED Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring SUD	Individuals with co-occurring SUD	Recommended	SMI/SED Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended	SMI/SED Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
State-specific subpopulations									
[Insert row(s) for any state-specific subpopulation(s)][f]									

Planned subpopulation reporting

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is reporting on the Dual-eligible status, Pregnancy status, Criminal justice status, and OUD population subpopulation categories for the SUD demonstration and/or the Dual-eligible status population subpopulation category for the SMI/SED demonstration, the state should use column H to outline its subpopulation identification approach as explained in Version 1.0 of the Medicaid Section 1115 Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance Demonstrations Monitoring Protocol Instructions.

[d] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should (1) select N in column G and (2) provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Trend SMI/SED/Substance Use Components Monitoring Protocol (Part A) - Reporting Schedule (Version 1.0)[1]

State: Massachusetts
Demonstration Name: MassHealth

Instructions:

(1) In the reporting period, report 1(Yes), 0 (no this example is a mistake, or enter the requested information in the corresponding row of schedule B). All shaded rowing require a response in this cell. The workbook is structured to have a data cell entry properties for SUD and SMI/SED demonstration reporting, described in Table C. Cells refer to the respective row.

(2) Beyond the initial reporting schedules in the SUD and SMI/SED demonstration reporting schedules (B2A, B2B1, B). For each of the reporting categories listed in column A, a state may elect to report additional data elements that are not listed in the initial reporting schedules. If a state elects to report additional data elements, it is required to provide the data elements in a similar fit. The instructions for data entry for all such "Ad…" SUD and a "Ad…" SMI/SED" and are in column A. "Proposed alternative or data element" or refer to the evaluation schedules in schedule B or C. All other workbook and schedule editing shall remain as for (shaded) by the states.

Table 1: Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance Reporting Periods Input Table

Name of Title II Substance Use Disorder (SUD) and/or Title XIX Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) demonstration	[1] (Yes/1)
Name of Title XXI SUD and/or SMI/SED demonstration	[0] (No/0)
Name of State agency of the Medicaid and/or Title XXI demonstration	[1] (Yes)
	[0] (No)
	[1] (Yes)
	[0] (No)
Name of State agency of the Medicaid and/or Title XXI demonstration	[1] (Yes/1)
	[0] (No/0)
Name of State agency of the Medicaid and/or Title XXI demonstration	[1] (Yes/1)
Current MMIS or eligibility system	[0] (No/0)
Will monitoring report for this State plan/demonstration	[1] (Yes/1)
Will monitoring report for which the State plan/demonstration is required to submit to CMS?	[1] (Yes/1)
	[0] (No/0)
	[1] (Yes/1)
	[0] (No/0)
Name of State reporting agency	[1] (Yes/1)
	[0] (No/0)

Massachusetts SUD received approval for an 1115 Demonstration in 2022, and is under the first year of this waiver. Monitoring Protocol, v. 2021 August. Centers for Medicare & Medicaid Services. 2021 August. Accessed [Month Day, Year]. https://www.medicaid.gov/sites/default/files/2021-08/smd-21-001.pdf. Also, see Medicaid Section 1115 SMI/SED demonstration for the period [Month Day, Year] to [Month Day, Year]. **Yes, August 15, 2022. Massachusetts SUD received approval for an 1115 SMI/SED demonstration for the period August 15, 2022 through December 31, 2027. Monitoring Protocol, v. 2021 August. Centers for Medicare & Medicaid Services. 2021 August. Accessed August 15, 2022. https://www.medicaid.gov/sites/default/files/2021-08/smd-21-001.pdf. Also, see Medicaid Section 1115 SMI/SED demonstration for the period August 15, 2022 through December 31, 2027.

Table 2. Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance Demonstration Reporting Schedule

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format SUD DY#Q#; e.g., SUD DY1Q3)	SMI/SED reporting period (Format SMI/SED DY#Q#; e.g., SMI/SED DY1Q3)	Reporting category	For each reporting category, SUD measurement period for which information is captured in monitoring report per standard reporting schedule (Format SUD DY#Q#; e.g., SUD DY1Q3)[a]	For each reporting category, SMI/SED measurement period for which information is captured in monitoring report per standard reporting schedule (Format SMI/SED DY#Q#; e.g., SMI/SED DY1Q3)[a]	Deviation from standard reporting schedule (Y - SUD only/Y - SMI/SED only/Y - both/N)[b]	Explanation for deviations (if column J="Y - SUD only," "Y - SMI/SED only," or "Y - both")[c]	Proposed deviation in measurement period from standard reporting schedule in column H or I, where relevant (Format SUD or SMI/SED DY#Q#; e.g., SUD DY1Q3 and SMI/SED DY1Q3)[c]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY6Q1	SMI/SED DY1Q1	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY6Q2	SMI/SED DY1Q2	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY6Q1	SMI/SED DY1Q1	Y - both	State has an approved two-quarter lag to	n.a. - not reported in this reporting quarter
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY6Q3	SMI/SED DY1Q3	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY6Q2	SMI/SED DY1Q2	Y - both	State has an approved two-quarter lag to	SUD DY6Q1
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY6Q4	SMI/SED DY1Q4	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	SMI/SED DY1
						Other monthly and quarterly metrics	SUD DY6Q3	SMI/SED DY1Q3	Y - both	State has an approved two-quarter lag to	SUD DY6Q2
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY7Q1	SMI/SED DY2Q1	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY6Q4	SMI/SED DY1Q4	Y - both	State has an approved two-quarter lag to	SUD DY6Q3
						Annual metrics that are established quality			N		
						Other annual metrics	DY6	DY1	Y - both	State has an approved two-quarter lag to	n.a. - not reported in this reporting quarter
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY7Q2	SMI/SED DY2Q2	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY7Q1	SMI/SED DY2Q1	Y - both	State has an approved two-quarter lag to	SUD DY6Q4
						Annual metrics that are established quality			N		
						Other annual metrics			Y - both	State has an approved two-quarter lag to	SUD DY6
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY7Q3	SMI/SED DY2Q3	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY7Q2	SMI/SED DY2Q2	Y - both	State has an approved two-quarter lag to	SUD DY7Q1
						Annual metrics that are established quality	CY2022	CY2022	N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY7Q4	SMI/SED DY2Q4	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	SMI/SED DY2
						Other monthly and quarterly metrics	SUD DY7Q3	SMI/SED DY2Q3	Y - both	State has an approved two-quarter lag to	SUD DY7Q2
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY8Q1	SMI/SED DY3Q1	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY7Q4	SMI/SED DY2Q4	Y - both	State has an approved two-quarter lag to	SUD DY7Q3
						Annual metrics that are established quality			N		
						Other annual metrics	DY7	DY2	Y - both	State has an approved two-quarter lag to	n.a. - not reported in this reporting quarter
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY8Q2	SMI/SED DY3Q2	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY8Q1	SMI/SED DY3Q1	Y - both	State has an approved two-quarter lag to	SUD DY7Q4
						Annual metrics that are established quality			N		
						Other annual metrics			Y - both	State has an approved two-quarter lag to	SUD DY7
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY8Q3	SMI/SED DY3Q3	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY8Q2	SMI/SED DY3Q2	Y - both	State has an approved two-quarter lag to	SUD DY8Q1
						Annual metrics that are established quality	CY2023	CY2023	N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY8Q4	SMI/SED DY3Q4	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	SMI/SED DY3
						Other monthly and quarterly metrics	SUD DY8Q3	SMI/SED DY3Q3	Y - both	State has an approved two-quarter lag to	SUD DY8Q2
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY9Q1	SMI/SED DY4Q1	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY8Q4	SMI/SED DY3Q4	Y - both	State has an approved two-quarter lag to	SUD DY8Q3
						Annual metrics that are established quality			N		
						Other annual metrics	DY8	DY3	Y - both	State has an approved two-quarter lag to	n.a. - not reported in this reporting quarter
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY9Q2	SMI/SED DY4Q2	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY9Q1	SMI/SED DY4Q1	Y - both	State has an approved two-quarter lag to	SUD DY8Q4
						Annual metrics that are established quality			N		
						Other annual metrics			Y - both	State has an approved two-quarter lag to	SUD DY8
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY9Q3	SMI/SED DY4Q3	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY9Q2	SMI/SED DY4Q2	Y - both	State has an approved two-quarter lag to	SUD DY9Q1
						Annual metrics that are established quality	CY2024	CY2024	N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY9Q4	SMI/SED DY4Q4	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	SMI/SED DY4
						Other monthly and quarterly metrics	SUD DY9Q3	SMI/SED DY4Q3	Y - both	State has an approved two-quarter lag to	SUD DY9Q2
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY10Q1	SMI/SED DY5Q1	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY9Q4	SMI/SED DY4Q4	Y - both	State has an approved two-quarter lag to	SUD DY9Q3
						Annual metrics that are established quality			N		
						Other annual metrics	DY9	DY4	Y - both	State has an approved two-quarter lag to	n.a. - not reported in this reporting quarter
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY10Q2	SMI/SED DY5Q2	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY10Q1	SMI/SED DY5Q1	Y - both	State has an approved two-quarter lag to	SUD DY9Q4
						Annual metrics that are established quality			N		
						Other annual metrics			Y - both	State has an approved two-quarter lag to	SUD DY9
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY10Q3	SMI/SED DY5Q3	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY10Q2	SMI/SED DY5Q2	Y - both	State has an approved two-quarter lag to	SUD DY10Q1
						Annual metrics that are established quality	CY2025	CY2025	N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY10Q4	SMI/SED DY5Q4	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to report SUD grievances and appeals.	SMI/SED DY5
						Other monthly and quarterly metrics	SUD DY10Q3	SMI/SED DY5Q3	Y - both	State has an approved two-quarter lag to	SUD DY10Q2
						Annual metrics that are established quality			N		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY11Q1	SMI/SED DY6Q1	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY10Q4	SMI/SED DY5Q4	Y - both		SUD DY10Q3
						Annual metrics that are established quality			N		
						Other annual metrics	DY10	DY5	Y - both	State has an approved two-quarter lag to	n.a. - not reported in this reporting quarter
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY11Q2	SMI/SED DY6Q2	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to	n.a. - not reported in this reporting quarter
						Other monthly and quarterly metrics	SUD DY11Q1	SMI/SED DY6Q1	Y - both		SUD DY10Q4
						Annual metrics that are established quality			N		
						Other annual metrics			Y - both	State has an approved two-quarter lag to	SUD DY10 SMI/SED DY5
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY11Q3	SMI/SED DY6Q3	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to	
						Other monthly and quarterly metrics	SUD DY11Q2	SMI/SED DY6Q2	Y - both		SUD DY11Q1 SMI/SED DY6Q1
						Annual metrics that are established quality	CY2026	CY2026	N		CY2026
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Grievances and appeals	SUD DY11Q4	SMI/SED DY6Q4	Y - SMI/SED only	Data for Managed Care plans are submitted yearly by January 31st. We request yearly reporting instead of quarterly. The state does not plan to	SMI/SED DY6

Table 2. Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance Demonstration Reporting Schedule

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format SUD DY#Q#; e.g., SUD DY1Q3)	SMI/SED reporting period (Format SMI/SED DY#Q#; e.g., SMI/SED DY1Q3)	Reporting category	For each reporting category, SUD measurement period for which information is captured in monitoring report per standard reporting schedule (Format SUD DY#Q#; e.g., SUD DY1Q3)[c]	For each reporting category, SMI/SED measurement period for which information is captured in monitoring report per standard reporting schedule (Format SMI/SED DY#Q#; e.g., SMI/SED DY1Q3)[c]	Deviation from standard reporting schedule (Y - SUD only/Y - SMI/SED only/Y - both/N)[d]	Explanation for deviations (if column J="Y - SUD only," "Y - SMI/SED only," or "Y - both")[d]	Proposed deviation in measurement period from standard reporting schedule in column H or I, where relevant (Format SUD or SMI/SED DY#Q#; e.g., SUD DY1Q3 and SMI/SED DY1Q3)[c]
						Other monthly and quarterly metrics	SUD DY11Q3	SMI/SED DY6Q3	Y - both	The state is required to report data for the entire demonstration even if this falls after the demonstration's end date. Massachusetts will report data for SUD DY11Q2 and SMI/SED DY6Q2 on [illegible]	SUD DY11Q2 [illegible]
						[illegible]		[illegible]	[illegible]		
						Annual metrics that are established quality [illegible]			N		
						[illegible]			[illegible]		
[illegible]	[illegible]	[illegible]	n.a.	n.a.	n.a.	[illegible]			[illegible]		
						[illegible]			[illegible]		
						Other monthly and quarterly metrics	SUD DY11Q4	SMI/SED DY6Q4	Y	The state is required to report data for the entire demonstration even if this falls after the demonstration's end date. Massachusetts will report data for SUD DY11Q3 and SMI/SED DY6Q3 on [illegible]	SUD DY11Q3 [illegible]
						[illegible]			[illegible]		
						Annual metrics that are established quality [illegible]			N		
						Other annual metrics	DY11	DY6	Y - both	State has an approved two-quarter lag to [illegible]	n.a. - not reported in this reporting quarter
[illegible]	[illegible]	[illegible]	n.a.	n.a.	n.a.	[illegible]			[illegible]		
						[illegible]			[illegible]		
						Other monthly and quarterly metrics	SUD DY11Q4	SMI/SED DY6Q4	Y	The state is required to report data for the entire demonstration even if this falls after the demonstration's end date. Massachusetts will report data for SUD DY11Q4 and SMI/SED DY6Q4 on [illegible]	SUD DY11Q4 [illegible]
						[illegible]			[illegible]		
						Annual metrics that are established quality [illegible]			N		
						Other annual metrics			Y - both	State has an approved two-quarter lag to [illegible]	SUD DY11 SMI/SED DY6

[a] The Medicaid Section 1115 integrated SUD and SMI/SED Monitoring Protocol Workbook (Part A) combines the Medicaid Section 1115 SMI/SED Monitoring Protocol Workbook Version 3.0 with the Medicaid Section 1115 SUD Monitoring Protocol Workbook Version 7.0.

[b] **SUD and SMI/SED demonstration components start date**: For monitoring purposes, CMS defines the start date of the demonstration components as the effective date listed in the state's STCs at time of the SUD and SMI/SED component approval. For example, if the state's STCs at the time of approval note that the SUD and SMI/SED demonstration components are effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of these components. Note that the effective date is considered to be the first day the state may begin its demonstration component. In many cases, the effective date is distinct from the approval date of a demonstration approval; that is, in certain cases, CMS may approve a section 1115 demonstration component with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration component period. In many cases, the effective date also differs from the date a state begins implementing its demonstration component. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "SUD and SMI-SED reporting schedule" tab should align with the first day of a month. If a state's SMI/SED demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "SUD and SMI-SED reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[c] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each SUD and SMI/SED demonstration year and quarter. However, the state is not expected to begin reporting any metrics data until after the approval of the Monitoring Protocol. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

AA# refers to the Annual Assessment of the Availability of Mental Health Services ("Annual Availability Assessment") and the SMI/SED DY in which the Annual Availability Assessment will be submitted (for example, "AA1" refers to the Annual Availability Assessment that will be submitted with the state's Annual Monitoring Report for SMI/SED DY1). Data in each Annual Availability Assessment should be reported as of the month and day indicated in the state's approved Monitoring Protocol. If the state cannot submit its Annual Availability Assessments when it submits its Annual Monitoring Reports, it should propose and describe a reporting deviation in Columns G and H.

Medicaid Section 1115 Substance Use Disorder & Serious Mental Illness and Serious Emotional Disturbance Demonstration Components Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) and serious mental illness and serious emotional disturbance (SMI/SED) demonstration components

The state should complete this title page as part of its integrated SUD and SMI/SED monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are provided below the table.

Overall section 1115 demonstration	
State	*Massachusetts*
Demonstration name	*MassHealth*
Approval period for section 1115 demonstration	*10/01/2022-12/31/2027*
SUD demonstration	
SUD demonstration start date[a]	*10/01/2022*
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*10/01/2022*

SUD demonstration goals and objectives	**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. **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 **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. **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. **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.

	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. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD.** The state must ensure sufficient provider capacity in the critical levels of care throughout the state, including those that offer MAT. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.** 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. **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. **SUD Health IT Plan.** Implementation of the milestones and metrics for the SUD Health IT Plan.
SMI/SED demonstration	
SMI/SED demonstration start date[a]	*10/01/2022*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	10/01/2022

SMI/SED demonstration goals and objectives	**Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings**. 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. 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.[1] A transition period to comply with rules is permitted and described in STC 7.9. 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 requirements as well as a national accrediting entity's accreditation requirements. 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. 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). 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). **Improving Care Coordination and Transitioning to Community-Based Care.** 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). 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. 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. 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). 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. **Increasing Access to Continuum of Care Including Crisis Stabilization Services.** 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. Commitment to implementation of the financing plan described in STC 7.2(d). 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. 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. **Earlier Identification and Engagement in Treatment, Including Through Increased Integration.** 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. 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. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED. **Health IT Plan.** Implementation of the milestones and metrics for the SMI/SED Health IT Plan.

[a] **SUD and SMI/SED demonstration components start date:** For monitoring purposes, CMS defines the start date of the demonstration components as the *effective date* listed in the state's STCs at time of the SUD and SMI/SED component approval. For example, if the state's STCs at the time of approval note that the SUD and SMI/SED demonstration components are effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of these components. Note that the effective date is considered to be the first day the state may begin the demonstration component. In many cases, the effective date is distinct from the approval date of a demonstration component; that is, in certain cases, CMS may approve a section 1115 demonstration component with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration component period. In many cases, the effective date also differs from the date a state begins implementing its demonstration component. The SMI/SED demonstration component start date will be auto-populated with the information entered in the "SUD demonstration start date" row. The state should review for accuracy.

[b] **Implementation date of SUD and SMI/SED demonstration components:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental diseases.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has a monitoring protocol approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SUD and SMI/SED demonstration components that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data— provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first demonstration year (DY) of less than 12 months should include data for any baseline period Qs preceding the SUD and SMI/SED demonstration components, as described in Part A of the state's monitoring protocols. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD and SMI/SED demonstration components.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of the demonstration components through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its

retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (SUD Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its monitoring report (under SUD Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

5. SMI/SED Annual Assessment of the Availability of Mental Health Services reporting

☒ The state will use data as of the following month and day of each calendar year to conduct its Annual Assessment of the Availability of Mental Health Services: **January 31**

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

ATTACHMENT I
Uncompensated Care Payment Protocol (Reserved)

Title page for the Commonwealth's Hospital Quality and Equity Initiative Implementation Plan

State	Massachusetts
Demonstration Name	"MassHealth" Medicaid and Children's Health Insurance Program (CHIP) Section 1115 Demonstration Project Numbers 11-W-0030/1 and 21-00071/1
Approval Date	September 28, 2022
Approval Period	October 1, 2022 – December 31, 2027
Implementation Date	October 1, 2022

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Section 1. Overview of Massachusetts' Statewide Approach to Advance Healthcare Quality and Equity

A. Overview

Massachusetts shifted the delivery system at scale to value-based care under the previous MassHealth section 1115 demonstration approval period, transitioning over 80 percent of eligible Medicaid members into accountable care organizations (ACOs) that are at risk to deliver better health outcomes, lower cost, and improved member experience through integrated, coordinated care.

A key goal of the Commonwealth's in this demonstration period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs (HRSN) and health disparities demonstrated by variation in quality performance. To support achievement of this goal, Massachusetts is centering equity alongside quality as a pillar of value-based care and as a priority for the state's health care system.

To that end, MassHealth will implement aligned quality and equity initiatives across delivery system settings:

1. MassHealth's Accountable Care Organizations (ACOs) and acute hospitals will be accountable to annual performance on a comprehensive set of quality performance metrics.
    a. ACO quality performance will be incentivized through quality incentive programs proposed for implementation under managed care authority.
    b. Acute hospital quality performance will be incentivized through the "Clinical Quality Incentive Program," proposed for implementation under State Plan authority (and described for reference in Appendix B).
2. MassHealth's ACOs and acute hospitals will also be accountable to annual performance on a comprehensive set of quality performance metrics that advance health equity.
    a. ACO quality and equity performance will be incentivized through an equity incentive program proposed for implementation under managed care authority.
    b. Acute hospital quality and equity performance will be incentivized through the Hospital Quality and Equity Initiative (HQEI), authorized under MassHealth Medicaid and CHIP Section 1115 Demonstration authority as described in the Demonstration's Special Terms and Conditions (STCs).

Together, this constellation of coordinated quality and equity initiatives will support Massachusetts in achieving its demonstration goal to improve quality of care and advance health equity.

B. Scope of this Implementation Plan

In accordance with STC 14 and as set forth in this document, the Commonwealth may allocate expenditure authority for the HQEI, which includes two components of Massachusetts's statewide strategy to advance health quality and equity, specifically the health quality and equity incentive programs for private acute hospitals and the sole non-state-owned public hospital,

Cambridge Health Alliance. These two incentive programs will be implemented by the Commonwealth and referred to herein as the "Hospital Quality and Equity Incentive Program (HQEIP)" and the "Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP)," respectively.

This HQEIP Implementation Plan provides additional detail related to implementation of the Commonwealth's HQEI, beyond those set forth in the MassHealth Medicaid and CHIP Section 1115 Demonstration Special Terms and Conditions (STCs), for Demonstration Approval Period (October 1, 2022 –December 31, 2027).

This Implementation Plan is specific to quality and equity incentive programming in the acute hospital setting being implemented under 1115 Demonstration authority; importantly, this Implementation Plan does not describe ACO, MCO, or acute hospital quality and equity initiatives implemented under separate federal authorities; those are described in more detail in vehicles relevant to each authority. Further, the main body of this Implementation Plan pertains to the HQEIP for private acute hospitals; the CHA-HQEIP Implementation Plan is described separately in Appendix C.

Section 2. Hospital Quality and Equity Incentive Program (HQEIP) Domains and Goals

A. Overview of Targeted Domains for Improvement in the HQEIP

For the HQEIP, the Commonwealth and participating private acute hospitals will be incentivized to pursue performance improvements in the domains specified in STC 14.2 and summarized in Table 1.

Table 1. Overview of Targeted Domains for Improvement for the HQEIP

Domain 1: Demographic and Health-Related Social Needs Data	Massachusetts 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 HQEI Implementation Plan. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element.
Domain 2: Equitable Quality and Access	Massachusetts 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 language access needs; preventive, perinatal, and pediatric care services; care for chronic diseases and behavioral health; and care coordination.
Domain 3: Capacity and Collaboration	Massachusetts 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.

B. Goals for each Domain of the HQEIP

Goals for MassHealth and participating hospitals for each HQEIP domain are specified in STC 14.3-14.5 and summarized below:

1. Demographic and Health-Related Social Needs (HRSN) Data Collection Domain Goals

a. MassHealth will submit to CMS an assessment of beneficiary-reported demographic and HRSN data adequacy and completeness for purposes of the HQEI 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 for MassHealth members[1] by the end of Performance Year (PY) 3 (DY 30).
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 language, disability status, sexual orientation, and gender identity) for MassHealth members[1] by the end of PY 5 (DY 32).
d. MassHealth and its participating hospitals will be incentivized to meaningfully improve rates of HRSN screenings from the baseline period by the end of PY 5 (DY 32). "Meaningful improvement" is further described in this Implementation Plan for PYs 2-5. To meet this goal, hospitals must not only conduct screenings of beneficiaries, but establish the capacity to track and report on screenings and referrals.

2. 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 language access needs 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 metrics from the following priority areas (maternal health, care coordination, care for acute and/or chronic conditions, patient experience of and/or access to care), at least three relevant measures from "CMS' Health Equity Measure Slate" for hospital performance and at least seven for statewide performance;
b. Metric performance expectations 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

[1] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) with MassHealth as their primary insurance, including those with MassHealth Standard, CommonHealth, CarePlus, and Family Assistance coverage types; excludes members with Medicare or another payer as primary payer.

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 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/community-level markers or indices of social vulnerability;

iii. Improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.

c. For up to the first 3 performance years, performance will be based on expectations described in 2(b)(i) and 2(b)(ii), above. For at least the last two performance years, performance will also be based on expectations described in 2(b)(iii), above.

3. 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.

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 PY 3 (DY 30), as established by a national quality or accreditation organization.

Section 3. HQEIP Conceptual Framework and Performance Year (PY) Metrics

A. Conceptual Framework

To meet domain goals for the HQEIP, it is anticipated that a wide range of acute hospital initiatives will be necessary. Representative initiatives expected to be undertaken by hospitals using earned incentive payments under the HQEIP are described further in the Conceptual Framework for the HQEIP described in Figure 1, and in the three domain-specific logic models provided in Figures 2-7.

Figure 1. Overview of Conceptual Framework for the HQEIP

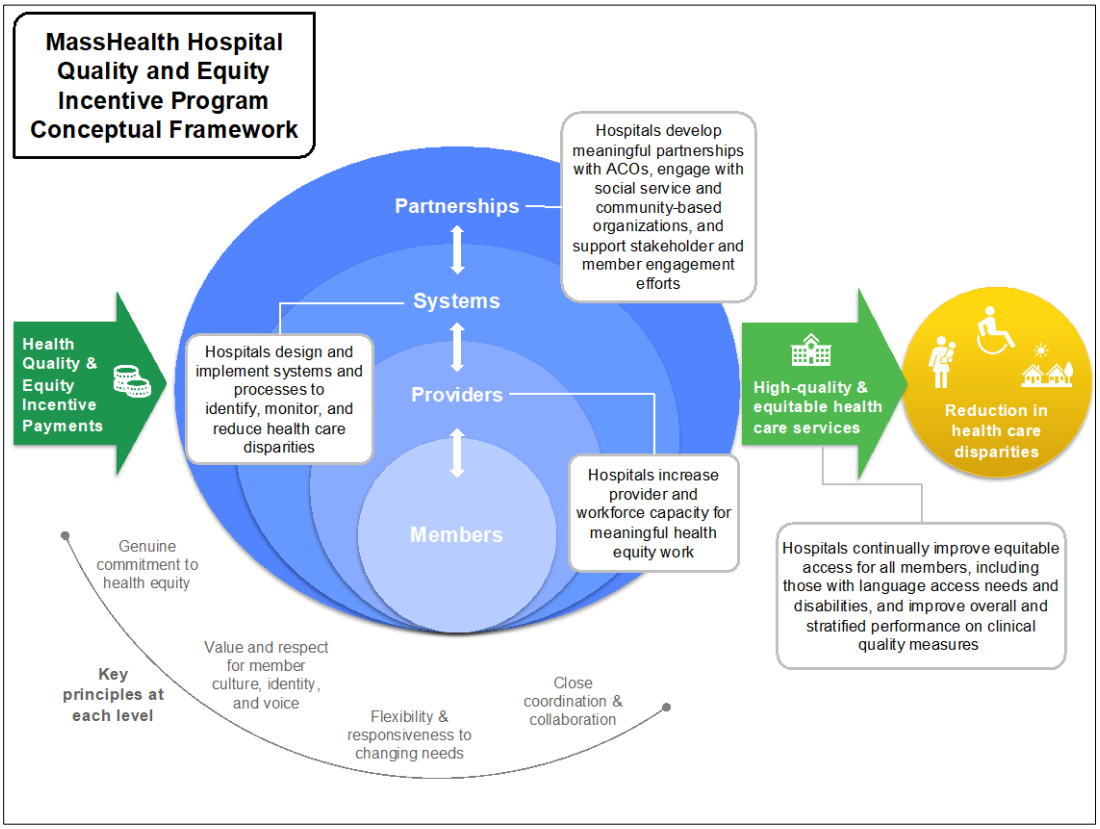


Figure 2. PY 1 Domain 1 Logic Model: Demographic & HRSN Data

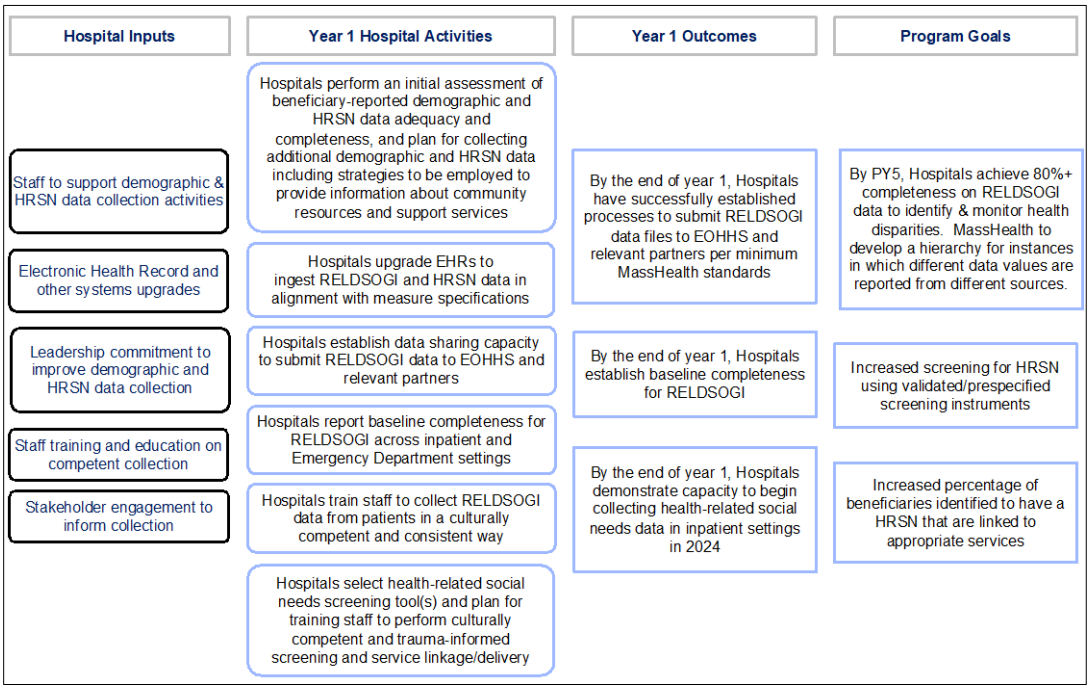


Figure 3. PY 1 Domain 2 Logic Model: Equitable Quality and Access

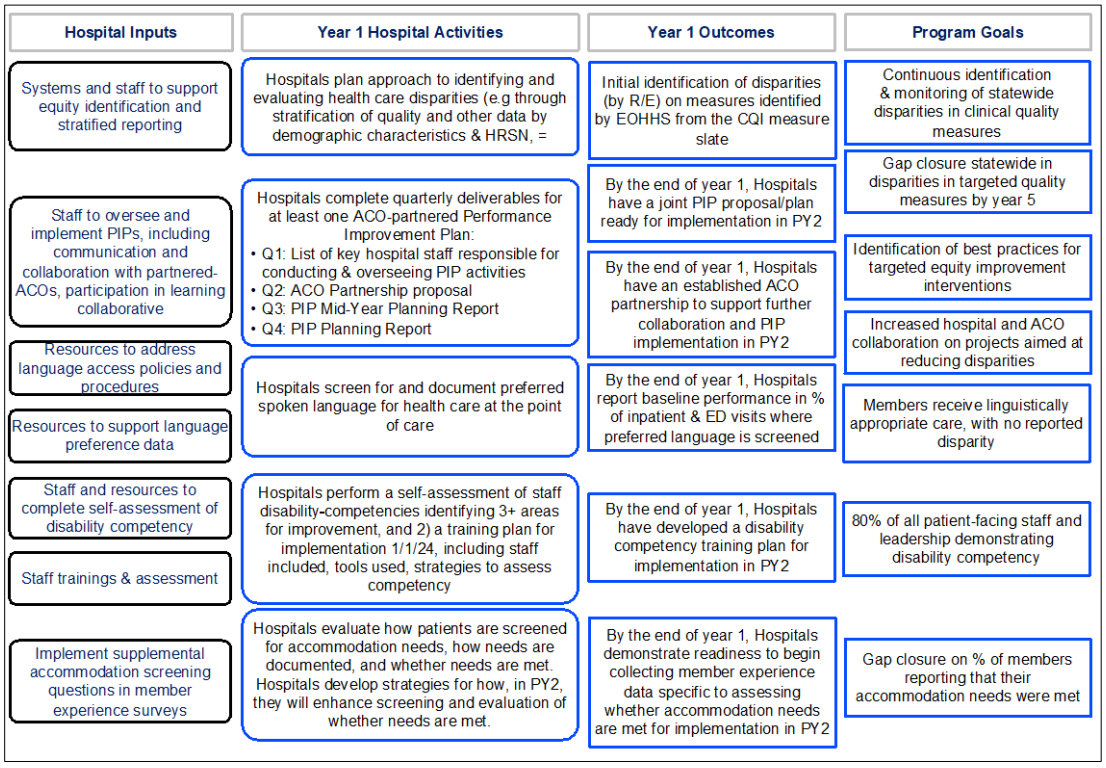


Figure 4. PY 1 Domain 3 Logic Model: Capacity & Collaboration

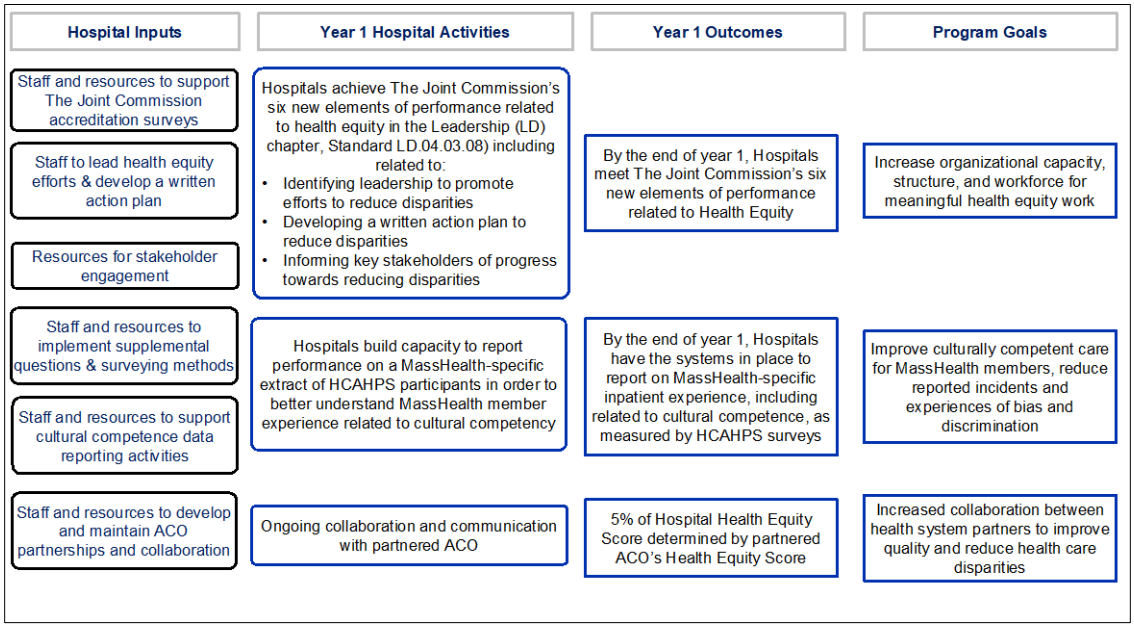


Figure 5. PY 2-5 Domain 1 Logic Model: Demographic and Health-Related Social Needs Data

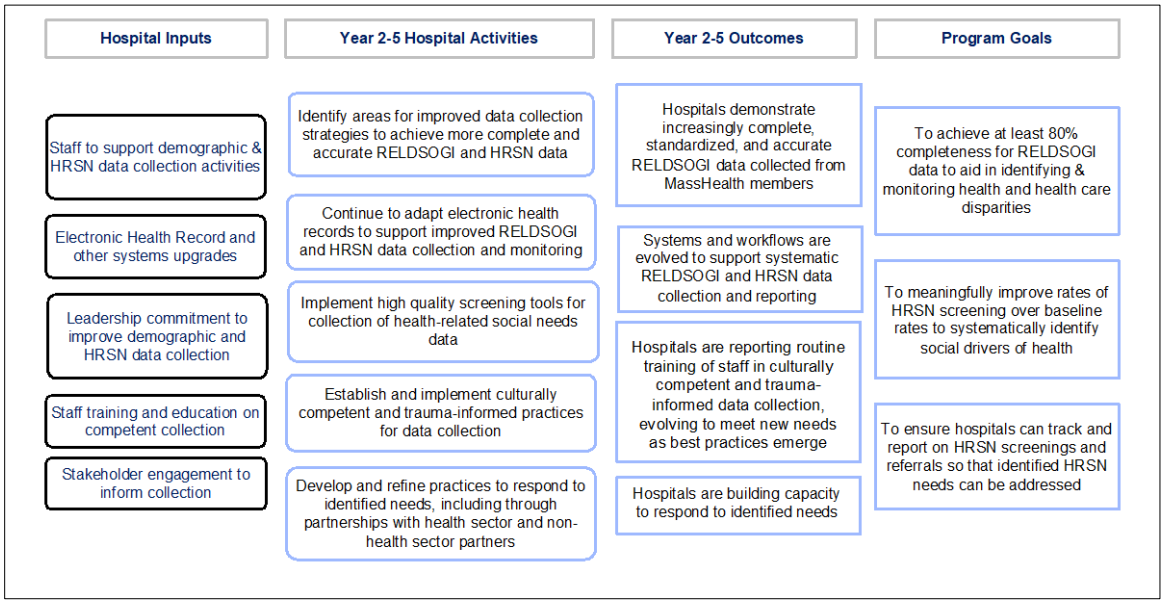


Figure 6. PY 2-5 Domain 2 Logic Model: Equitable Quality and Access

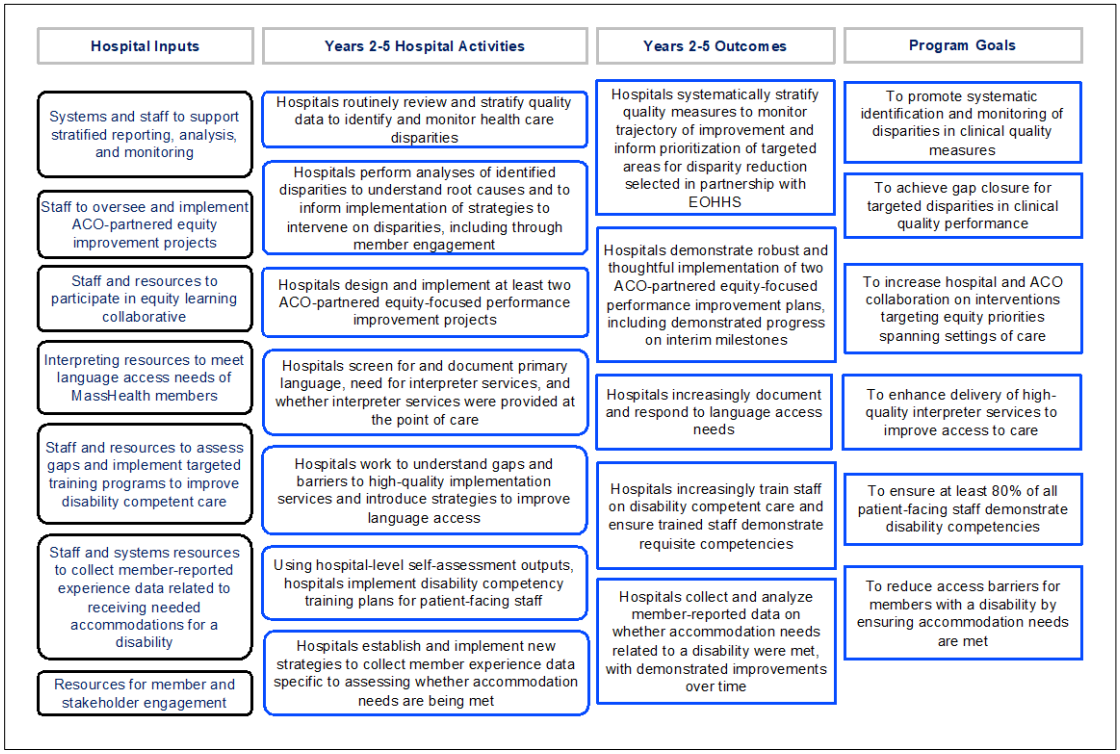
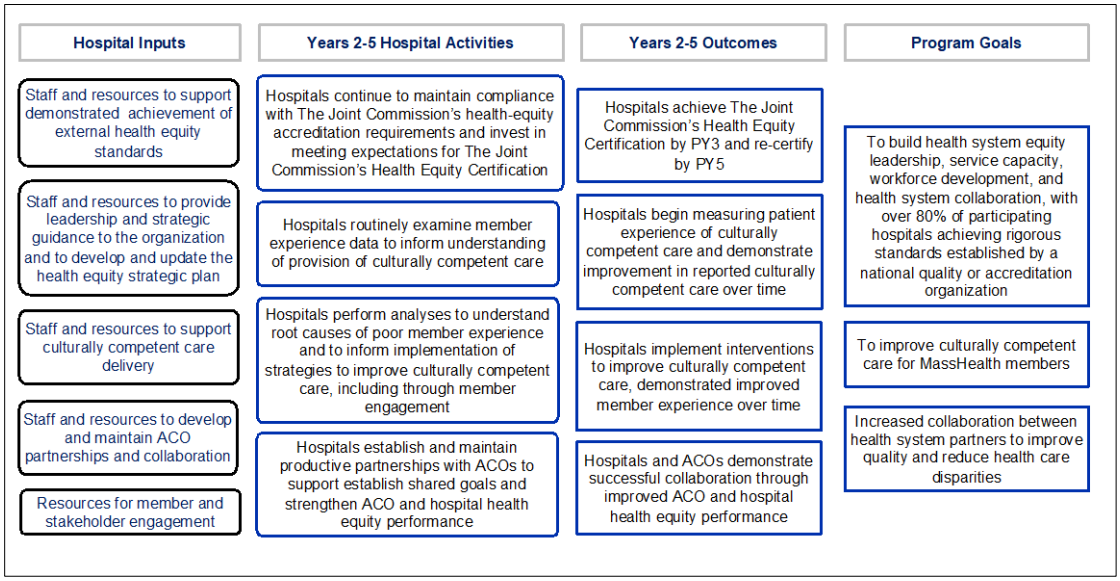


Figure 7. PY 2-5 Domain 3 Logic Model: Capacity & Collaboration



B. HQEIP Metrics and Reporting Requirements for PY 1

To establish a robust foundation for quality and equity improvement and to begin making progress towards five-year HQEI domain goals, the first performance year of the HQEIP will hold private acute hospitals accountable to metrics (listed in Table 2) evaluating contributory health system level interventions in each HQEIP domain. These metrics and associated reporting and performance expectations (described in Table 3) were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement.

Table 2. HQEIP PY 1 Metrics

	Metric (*Steward*)	**PY 1 Status***
Domain 1. Demographic and Health-Related Social Needs Data		
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Pay for Reporting (P4R)
Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*): Preparing for Reporting Beginning in PY 2	P4R
Domain 2. Equitable Quality and Access		
Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	P4R
Equity Improvement	Equity Improvement Interventions (*EOHHS*)	P4R

Access	Meaningful Access to Healthcare Services for Persons with a preferred language other than English (Oregon Health Authority)	P4R
	Disability Competencies (*EOHHS*)	P4R
	Accommodation Needs Met (*EOHHS)*	P4R
Domain 3. Capacity and Collaboration		
Capacity	Achievement of External Standards for Health Equity (*EOHHS)*	P4R
	Patient Experience: Communication, Courtesy and Respect (*AHRQ)*	P4R
Collaboration	Joint Accountability for Partnered ACO Performance (*EOHHS*)	P4P

**Reporting requirements for each measure described in relevant technical specifications.*

Recognizing that taking on accountability for equity is new for most acute hospitals serving MassHealth members, all metrics are in pay-for-reporting status in PY 1. Interim and annual reporting requirements for PY 1 are designed to promote essential foundational capacity and readiness to assume progressive risk for health quality and equity performance in PY 2 through PY 5. PY 1 measure status and summarized reporting requirements are described in Table 3.

Approved technical specifications for the HQEIP PY 1 metrics will be made available through the Commonwealth's website and describe measure requirements in more detail.

Table 3. Summary of HQEIP PY 1 Reporting/Performance Requirements

Metric	Reporting/Performance Requirements for PY 1 & Anticipated Due Dates
Domain 1. Demographic and Health-Related Social Needs Data	
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Timely (**anticipated by December 31, 2023,** or a later date as specified by Massachusetts) submission to the Massachusetts Center for Health Informatics and Analysis of the "*Enhanced Demographics Data File*," defined as the file including member-level demographic (including race, ethnicity, language, disability, sexual orientation, and gender identity) data collected by hospitals from MassHealth members during inpatient stays and/or emergency department visits during the Performance Year.
Screening for Social Drivers of Health (*CMS): Preparing for Reporting Beginning in PY 2*	Complete and timely **(December 1, 2023**) submission of a report to EOHHS describing: 1) One or more HRSN screening tool(s) selected by the hospital for intended use in screening patients beginning in PY 2; the selected tool(s) must meet requirements for screening tools for the "Screening for Social Drivers of Health" metric; and 2) A plan to begin screening for HRSN in inpatient settings in Q1 CY 2024 in order to have capacity to report on the

	"Screening for Social Drivers of Health" metric beginning in PY 2.
Domain 2. Equitable Quality and Access	
Stratified Reporting of Quality Data (*EOHHS*)	Complete and timely (**anticipated by a date following December 31, 2023**, to be determined by EOHHS) submission to EOHHS of performance data including member-level race and ethnicity for clinical measures selected by EOHHS for stratification from the Clinical Quality Incentive (CQI) measure slate.
Equity Improvement Interventions (*EOHHS*)	Complete and timely submission of quarterly deliverables for at least one ACO-partnered Performance Improvement Plan (PIP) as follows: • Q1: Complete and timely (**anticipated by March 31, 2023**) submission to EOHHS of Hospital Key Personnel/Institutional Resources Document • Q2: Complete and timely (**anticipated by July 21, 2023**) submission to EOHHS of the PIP Partnership Form • Complete and timely (**anticipated by September 30, 2023**) submission to EOHHS of the ACO Key Contact Form and the Mid-Year Planning Report • Complete and timely (**anticipated by December 31, 2023**) submission to EOHHS of the PIP Planning/Baseline Report, a comprehensive plan that incorporates information about PIP goals and objectives, baseline data, proposed interventions, and tracking measures. The PIP Planning/Baseline Report will serve as the blueprint for PIP Implementation in PY 2. Hospitals will be allowed to modify their ACO partner selection(s)at the discretion of EOHHS.
Meaningful Access to Healthcare Services for Persons with a preferred language other than English (*Oregon Health Authority*)	Complete and timely (**anticipated by December 31, 2023** or an earlier date specified by EOHHS) reporting of an organizational self-assessment of capacity related to providing access to high quality language services to patients.
Disability Competencies (*EOHHS*)	Complete and timely (**anticipated by December 1, 2023**) submission to EOHHS of the following: The Hospital's DCC Team's completed Resources for Integrated Care (RIC) ***Disability-Competent Care Self-Assessment Tool (DCCAT)***[1] Report that includes the following: 1) The members that composed your DCC Team. The members included on the Hospital's Disability Competent Care (DCC) Team can be decided by the hospital and which should represent a reasonable mix of clinical and non-clinical patient-facing staff from different clinical departments. Further, we strongly recommend including individuals with disability on the Hospital's DCC Team. 2) The summary from the Hospital DCC Team's DCCAT-Hospital tool 2 exercise. Hospitals will have freedom to further modify the 'base' DCCAT-Hospital Tool, e.g., remove, change or add new questions so long as the hospital

	submits documentation of (as part of their report) the modifications made along with the reason(s) for the modification(s). 3) Informed by the results of the DCCAT-Hospital tool exercise above, hospitals will identify at least three (of seven) Disability Competent Care (DCC) Model Pillars that the hospital plans to target for improvement beginning in PY 2, based on interpretation of the results from this exercise. 4) Lessons learned in narrative form by the hospital by creating this team and completing this DCCAT self-assessment exercise. Complete and timely (**anticipated by December 1, 2023**) submission to EOHHS of a plan for improving competency in targeted competency areas during PY 2, including: 1) selected training tools and/or educational resources, 2) which staff that will be assessed (including self-assessed) for post-educational/training competency, and 3) approaches that will be used to assess post-education/training organizational and staff competency. This plan must describe how the hospital will be prepared to begin reporting performance in PY 2 on a process measure (in development by EOHHS) beginning in PY 2 that assesses the percent of patient-facing staff demonstrating competency in targeted competency areas for improvement.
Accommodation Needs Met (*EOHHS)*	Complete and timely (**anticipated by December 1, 2023**) submission to EOHHS of a report describing the hospital's current practice and future plans for the following: 1) screening patients for accommodation needs* before or at the start of a patient encounter, and how the results of this screening is documented 2) other methods, if any, for documenting accommodation needs 3) asking patients, at or after the end of a patient encounter, if they felt that their accommodation needs were met 4) analyses that are performed at the organizational level to understand whether accommodation needs have been met. * *For this report, accommodation needs are regarded to be needs related to a disability, including disabilities as a result of a physical, intellectual or behavioral health condition. For this report, this does not include needs for language interpreters, but does include accommodation needs for vision impairments (e.g., Braille) or hearing impairments (e.g., ASL interpreters).*
Domain 3. Capacity and Collaboration	
Achievement of External Standards for Health Equity (*EOHHS)*	Complete and timely (**anticipated by December 31, 2023**) submission to EOHHS of an attestation that the hospital has completed The Joint Commission (TJC) surveys for health equity accreditation

	standards (specifically, 6 new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.)
HCAHPS: Patient Experience: Communication, Courtesy and Respect (*AHRQ*)	Complete and timely (**anticipated by a date following December 31, 2023** to be determined by EOHHS) submission to EOHHS of HCAHPS survey results for any MassHealth members participating in the hospital's HCAHPS survey sample during PY 1.
Joint Accountability for ACO Performance (*EOHHS*)	In order to promote collaboration and coordinated interventions to promote health equity across health system settings and across the spectrum of ambulatory and inpatient care, acute hospitals will be required to partner with at least one and no more than two ACO(s) (identified as "Partnered ACO(s)") serving a shared population in order to augment impact on health equity. To incentivize shared investment and goals across ACO and hospital entities, hospitals' performance in this subdomain for PY 1 will equal its Partnered ACO's Health Equity Score; if the hospital has more than one ACO Partner then its subdomain score will equal the average of each Partnered ACO's Health Equity Score. Partnered ACOs will be held accountable for health equity performance in the same domains as their Partnered Hospitals, tailored to the ACO setting: • Demographic data completion • HRSN screening and referrals • Stratified Reporting of Quality Data • Equity Improvement Interventions • Language Access • Disability Access and Accommodation • Achievement of External Standards for Health Equity • Member Experience: Cultural Competency Each of these accountability components will contribute to the ACO's Health Equity Score.

In the event that a measure is retired by a measure steward for any reason, Massachusetts will 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.

If in a given performance period a hospital does not meet the minimum denominator or other technical requirements for a measure on the HQEIP measure slate, the weight attributed to that measure will be apportioned equally across the other measure(s) in the same domain for scoring purposes for that performance period. Beginning in PY3, if a hospital is unable to meet the minimum denominator or other technical requirements for at least 50% of the measures on the HQEIP metrics slate for a performance period, the hospital's participation in the HQEIP will be

suspended for that performance period.[2] A hospital may resume participation when it is able to meet the minimum denominator or other technical requirements for at least 50% of the measures on the HQEIP metrics slate, provided that such participation shall begin at the start of the subsequent performance period and provided that the hospital will be held accountable for the performance year requirements immediately following the last performance year in which the hospital participated.

For example, if EOHHS determines that a hospital is unable to meet the minimum denominator or other technical requirements of at least 50% of the measure slate for PY3 in calendar year 2025, then the hospital will not be able to participate in PY3 in the calendar year 2025. If the hospital is able to meet the minimum requirements to participate in at least 50% of the PY3 measure slate during calendar year 2026, the hospital will resume in the HQEIP in calendar year 2026, and will be held accountable to PY3 requirements in calendar year 2026.

A new hospital that was not enrolled in MassHealth at the start of the HQEIP can participate in the HQEIP, provided that participation is permitted to start only at the beginning of a performance period regardless of when the hospital began operations and enrolled in MassHealth. Regardless of the calendar year that a hospital enters the HQEIP, a new hospital beginning participation in the HQEIP will be held accountable to PY1 requirements for the first performance period it participates, and will proceed in the HQEIP in order of performance year. For the purposes of this paragraph, a new hospital means a hospital that newly begins hospital operations after the start of the HQEIP. A new hospital does not include a hospital that, after the start of the HQEIP, purchased, acquired or otherwise took over the operations of a hospital that existed and was enrolled in MassHealth at the beginning of the HQIEP. Such hospitals shall continue on the standard HQEIP PY trajectory, subject to terms of the previous paragraph.

For example, a new hospital able to participate in HQEIP beginning in calendar year 2025 will be held accountable to PY1 requirements in calendar year 2025, accountable to PY2 requirements in calendar year 2026, and accountable to PY3 requirements in calendar year 2027.

C. HQEIP Metrics for PYs 2-5

PYs 2-5 of the HQEIP will hold private acute hospitals accountable to metrics (listed in Table 4) evaluating performance in each HQEIP domain. These metrics were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement. In the event that a measure is retired by a measure steward for any reason, Massachusetts will 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 assessments described in Section 6 of this Addendum. Approved technical specifications for the HQEIP PY 2-5 metrics, which may be updated annually or more frequently as necessary, will be made available.

[2] This approach will be used to account for any unexpected circumstances (e.g., fire or flood), that may lead to reduced services, as determined by the state.

Table 4. HQEIP PY 2-5 Metrics

Domain*	Measure Name	Measure Description	Data Source	Measure Steward^	Payment Status**			
					2024	2025	2026	2027
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	Percentage of members with acute hospital discharges within the measurement year with self-reported RELDSOGI data.	Administrative	EOHHS	R	P	P	P
	Health-Related Social Needs (HRSN) Screening	Two rates: 1) HRSN Screening Rate: Percentage of acute hospital discharges where members were screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; and 2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with acute hospital discharges in Rate 1.	Admin/ Supplemental	EOHHS (CMS~)	R	P	P	P
EQA	Quality Performance Disparities Reduction	Acute hospital progress towards reducing racial and ethnic disparities in quality performance. Quality measures identified for inclusion in this measure (drawn from the MassHealth Clinical Quality Incentive (CQI) program) are disparities-sensitive measures in the areas of coordination of care, perinatal health, and/or care for acute and chronic conditions.	Administrative/ Hybrid/ Supplemental	EOHHS	R	R	P	P
	Equity Improvement Interventions	Assessment of rigorous design and implementation of two equity-focused performance improvement projects (PIPs) focused on coordination of care, perinatal health, and/or care for acute and chronic conditions.	Supplemental	EOHHS	P	P	P	P
	Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English	Two components: 1) Language Access Self-Assessment Survey: Completion and reporting of a language access self-assessment survey; and 2) Addressing Language Access Needs in Acute Hospital Settings: Percentage of acute hospital stays serving members who report a preferred language other than English during which either interpreter servings or an in-language service provider was utilized.	Supplemental	EOHHS (OHA^)^	R	P	P	P
	Disability Competent Care	Percentage of applicable patient-facing acute hospital staff who, in the past 24 months, 1) completed disability competency training to address Disability Competent Care (DCC) pillars selected by the hospital in its DCC Training Plan Report, and 2) demonstrated competency in the relevant disability competency training area(s).	Supplemental	EOHHS	P	P	P	P
	Disability Accommodation Needs	Percentage of acute hospital discharges and/or encounters where 1) members with disability were screened for accommodation needs related to a disability, and 1) for those members screening positive for accommodation needs, a corresponding member-reported accommodation need was identified.	Supplemental	EOHHS	R	P	P	P
CC	Achievement of External Standards for Health Equity	Assessment of whether acute hospitals have achieved standards related to health equity established by The Joint Commission for its "Health Care Equity Certification"	Supplemental	EOHHS	R	P	P	P
	Patient Experience: Communication Courtesy and Respect	Assessment of MassHealth member perceptions of their hospital experience utilizing reported elements of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patients' perspectives of hospital care experience related to communication, courtesy, and respect.	Supp/Survey	EOHHS	R	P	P	P
	Collaboration	Assessment of participating acute hospital collaboration with health system partners to promote high quality and equitable care.	Supplemental	EOHHS	P	P	P	P

*DHRSN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access ; CC=Capacity and Collaboration; ** R=Pay-for-Reporting, P=Pay-for-Performance
^ EOHHS=Massachusetts Executive Office of Health and Human Services; CMS=Centers for Medicare & Medicaid Services; OHA=Oregon Health Authority
~ Adapted for HQEIP use from CMS' "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health", and OHA metrics, respectively.

D. Additional Detail on Identification of Health-Related Social Needs Screening and Referrals

1. Identification of Members with Unmet Health-Related Social Needs

MassHealth will incentivize participating acute hospitals to begin HRSN screening beginning in PY 2 through inclusion of a MassHealth-adapted version of the CMS "Social Drivers of Health" metric on the HQEIP measure slate. Accordingly, screening will be conducted in alignment with parameters specified in the measure, including related to targeted screening domains (including, at a minimum, food, housing, transportation, and utilities) and screening tools. Screening will be required to be conducted at least once annually to meet performance expectations for the metric. MassHealth, as part of its ongoing performance management of hospitals, will require hospitals to report annually to MassHealth on how the approaches they are using for HRSN screening are culturally appropriate and/or culturally informed, and will provide education and/or technical assistance to support attainment of culturally competent and/or trauma-informed screening practices.

Additional information related to screening and identification of members for HRSN services not specific to the HQEIP is described in Attachment T of the STCs, the "Health-Related Social Needs Implementation Plan."

2. HRSN Referrals

Acute hospitals will be accountable for establishing approaches to link members to HRSN services and other resources to address identified HRSN. In PY 1, hospitals will be expected to prepare for HRSN data collection by:

- Completing and reporting to MassHealth an initial assessment of beneficiary-reported HRSN 1) data adequacy and completeness across hospital settings, and 2) strategies employed to provide information about community resources and support services;
- Selecting HRSN screening tool(s);
- Adapting systems to capture and exchange HRSN data electronically;
- Training staff to competently collect HRSN data using culturally competent and trauma informed approaches; and
- Developing strategies to respond to identified HRSN that address any gaps revealed in the self-assessment, including services provided by other state agencies that address members' HRSN.

The Commonwealth intends to ensure that HRSN data collection mechanisms to support participation in the HQEI include explanatory text setting forth the anticipated uses of the collected data and that members generally have the option to decline to respond to questions (e.g., "choose not to answer"). Furthermore, hospitals are required to comply with applicable privacy and security laws as covered entities and through contractual obligations.

MassHealth intends to procure a vendor to implement an HRSN electronic referral platform that hospitals can use to electronically refer members with identified HRSNs to entities that can help to address those needs, such as social services organizations (SSOs). This platform would also facilitate a "closed feedback loop" process, where SSOs could provide back to hospitals the outcomes of those HRSN referrals (e.g., whether services were provided and impact of those services on the identified HRSNs). This platform will provide MassHealth with the ability to centrally track hospital HRSN referrals and outcomes when such referrals are made. MassHealth anticipates launching the platform in 2026. In support of the platform launch, MassHealth will provide technical assistance to hospitals and SSOs on how best to use the platform. MassHealth has received approval for an Advanced Planning Document in support of implementation of this HRSN electronic referral platform.

MassHealth will only report aggregate HRSN referral and outcomes data once the HRSN electronic referral platform is in place, in lieu of standing up an interim manual process that will then be replaced with the HRSN electronic referral platform.

3. Member Eligibility for HRSN Services

HRSN services that may be covered by the Commonwealth are described in STC 15.3, and further described in Attachment T of the STCs, the "Health-Related Social Needs Implementation Plan." Covered populations for HRSN services are described in STC 15.5 and further detailed in Attachment P of the STCs, the "Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services", and Attachment T of the STCs, the "Health-Related Social Needs Implementation Plan."

Section 4. Hospital Quality and Equity Initiative (HQEI) Payment and Corrective Action Plan

A. Hospital Quality and Equity Initiative Payment

The HQEI section 1115 expenditure authority will support the launch and maintenance of the HQEIP and the CHA-HQEIP to improve health care quality and equity within the Commonwealth. Payment for the CHA-HQEIP is described separately in Appendix C. For PY 1-5, Massachusetts will set the maximum budgeted annual incentive amount for HQEIP at $350M, below the maximum authority of $400M. Table 5 shows budgeted amounts of funding for the HQEIP, as well as the percentage of funding distributed to each HQEIP domain in accordance with STC 14.7(a).

Table 5. PY 1-5 Budget Allocation for the HQEIP (in millions)

Demonstration Year(s)	DY 27-28	DY 29	DY 30	DY 31	DY 32

Performance Year(s)	CY 2022(Q4)-23	CY 2024	CY 2025	CY 2026	CY 2027
Domain 1 (25%)	$87.5M	$87.5M	$87.5M	$87.5M	$87.5M
Domain 2 (50%)	$175M	$175M	$175M	$175M	$175M
Domain 3 (25%)	$87.5M	$87.5M	$87.5M	$87.5M	$87.5M
TOTAL (100%)	**$350M**	**$350M**	**$350M**	**$350M**	**$350M**

Funding for the HQEIP is divided into three provider-specific tiers. Provider-specific tiers are defined by hospital safety net designation, with funding distributed between tiers as described in Table 6.

For a provider to be in tier 1 or tier 2, it must be a safety net provider. As defined in the 1115 waiver STC's and Attachment N, safety net providers are acute hospitals that meet certain payer mix criteria (must have a Medicaid payer mix greater than 20% and a Commercial payer mix less than 50%) and are not identified as Massachusetts essential hospitals or Massachusetts critical access hospitals with fewer than 30 beds. To be in tier 1, a safety net provider must have historical involvement in the delivery system transformation initiative; specifically, the safety net provider must have received delivery system transformation initiative payments in 2015-2017. All other safety net providers are allocated to tier 2, and all other non-safety net providers (private acute hospitals) are allocated to tier 3.

Table 6. HQEIP PY 1 Funding by Safety Net Group Tier (in millions)

Tier	Tier Definition	Funding Amount				
		PY1	**PY2**	**PY3**	**PY4**	**PY5**
Tier 1	Safety Net Group 1 Providers	$129M	$129M	$129M	$129M	$129M
Tier 2	Safety Net Group 2 Providers	$101M	$101M	$101M	$101M	$101M
Tier 3	All Other Private Hospitals	$120M	$120M	$120M	$120M	$120M
TOTAL		**$350M**	**$350M**	**$350M**	**$350M**	**$350M**

For hospitals in Tiers 2 and 3, each hospital's maximum incentive payment will be equal to their pro-rata share of tier funding, determined by dividing each hospital's FY 2019 Medicaid Gross

Patient Service Revenues by all FY 19 Medicaid Gross Patient Service Revenues within the respective tier. For hospitals in Tier 1, each hospital's maximum incentive payment will be equal to $1M, plus their pro-rata share of remaining tier funding, determined by dividing each hospital's FY 2019 Medicaid Gross Patient Service Revenues by all FY 2019 Medicaid Gross Patient Service Revenues within the tier. If a hospital newly begins participating in the HQEIP after the beginning of the first performance period, as described in Section 3.B, Massachusetts will collect from the hospital projected Medicaid Gross Patient Service Revenues for the first 12 months that the hospital is in operation to determine an appropriate maximum incentive amount. If a hospital's participation in the HQEIP is suspended for one or more performance periods, as described in Section 3.B, Massachusetts will assign the hospital a maximum incentive amount of $0 for the performance periods the hospital is suspended from participation.

In HQEIP PY 1, Massachusetts intends to make four interim payments and one reconciliation payment to acute hospitals. In order to receive interim payments, hospitals must meet key milestones ("gates") determined by Massachusetts to be foundational to successful performance in the HQEIP; these "gates" are a form of "pay-for-reporting" where timely and complete submission of gate deliverables will be required for interim payments to be made. Across these interim payments, Massachusetts will withhold 10% of each hospital's maximum annual incentive payment. As appropriate, the remaining 10% will be paid out as a reconciliation payment in CY 2024, based on the hospitals' final PY 1 health equity performance determined by performance on the HQEIP metric slate and successfully meeting payment gate reporting deliverables; if at the conclusion of PY 1 a hospital's HQEIP performance results in earning less than 90% of its allocated incentive amount, funds will be recouped in the reconciliation payment process to ensure hospitals are paid only what they earn on the basis of their HQEIP performance for PY 1. The Health Quality and Equity Independent Assessor is not required to review relevant submissions (as described in Section 6.C) before interim payments are made. If the Independent Assessor's review finds that gating deliverables were not complete, then reconciliation payment may be withheld until they are re-submitted and complete.

Table 7. HQEIP Payment Gates for PY 1

Gated Payment	Gate Description	Anticipated Gate Deliverable Due Date
Q4 CY 2022 Payment	**Participation Attestation** – Timely and complete submission to Massachusetts of an attestation to participate in the HQEIP for PY 1, including an attestation to collaborate with a Model A or B ACO (or a request for exemption from the ACO collaboration requirement).	Dec. 19, 2022
Q1 CY 2023 Payment	**Qualified Interpreters Attestation** – Complete and timely submission to Massachusetts of an attestation that, by December 31, 2023, the hospital will implement a process for qualifying language interpreters.	March 31, 2023
Q2 CY 2023 Payment	**Race, Ethnicity, Language, Disability status (RELD) Sexual Orientation, Gender Identity (SOGI) Assessment** – Timely and complete submission to Massachusetts of an initial assessment of 1) beneficiary-reported demographic data adequacy and completeness, and 2) a proposed plan for collecting demographic data including data	June 2, 2023

	sources. MassHealth anticipates collecting additional information about data submission plans in advance of the submission of the Enhanced Demographic Data File. **Health-Related Social Needs (HRSN) Assessment** – Timely and complete submission to Massachusetts of an initial assessment of 1) beneficiary-reported HRSN data adequacy and completeness, and 2) strategies employed to provide information about referrals including to community resources and support services	
Q3 CY 2023 Payment	**Disability Competency Self-Assessment Attestation** – An attestation that the hospital is working towards timely and complete submission to Massachusetts of a report on the results of the disability competencies self-assessment, including identified disability competencies targeted for improvement in PY 2.	September 18, 2023
PY 1 Reconciliation Payment	**Health Equity Strategic Plan:** Timely and complete submission to Massachusetts of a Health Equity Strategic Plan as required by EOHHS.	Dec. 31, 2023

In each year PY 2-5 of the HQEIP, Massachusetts intends to make four interim payments to acute hospitals and complete one performance reconciliation for each acute hospital that may lead to a further payment or a recoupment. Massachusetts will withhold between 10-40% (specific percentage to be determined annually by MassHealth based on prior performance data and other factors) of each hospital's maximum annual incentive payment from their interim payments. Based on a hospital's final HQEIP health equity score for each performance year, the remaining earned incentive will be paid out as a reconciliation payment in the following calendar year or unearned funds will be recouped, as applicable. Interim payments will be made automatically, with the exception that it is anticipated that the fourth interim payment for each PY will only be paid out once hospitals have submitted a complete annual Health Quality and Equity Strategic Plan update (anticipated to be due by the end of the PY). Additional quarterly payment "gates" may be instituted at the discretion of MassHealth.

B. HQEI Corrective Action Plan

Given the importance of establishing foundational capacity for health equity accountability in the first performance year of the HQEIP and in order to set hospitals up for success in subsequent performance years, the Commonwealth will actively manage performance of participating acute hospitals to optimize performance. The Commonwealth will rigorously evaluate interim and annual deliverables to identify providers that are not on track to meet program objectives and to support concurrent corrective action for successful achievement of expectations. Underperforming participating hospitals will be notified by the Commonwealth on a periodic basis and will be supported to achieve performance year objectives.

Performance management of acute hospitals for the HQEIP in PY 1 will be multilayered:

- MassHealth program teams will be working closely with the hospitals to clearly communicate expectations of the HQEIP, maintaining an open dialogue with hospitals to respond to questions and requests for support. As part of this effort, MassHealth intends to coordinate bi-monthly educational meetings with the hospitals and providers to discuss

topics including related to HQEIP performance, with at least two educational sessions per year dedicated to the HQEIP. Additional sessions and conferences between acute hospitals and EOHHS to support performance may be convened with each hospital individually at the hospital's request or at the request of the Commonwealth. Further, MassHealth will also hold regular office hours with acute hospitals to assist in program implementation.

- The Commonwealth will use its established and contracted quality performance vendors who support current quality and equity measurement initiatives to assist in the monitoring, reporting and evaluation of acute hospital performance on HQEIP metrics.
- MassHealth will be supported in monitoring HQEIP performance by its "Health Quality and Equity Program Management Vendor." This vendor will support assessment of HQEIP documentation and deliverables and will support hospitals to meet program requirements. This vendor will also provide additional support as directed by EOHHS, such as thought leadership, help developing tools to assess deliverables, and development of materials to support public-facing reports.
- The quarterly payment strategy employed by MassHealth will provide a strong incentive to make steady progress towards PY 1 goals; missing key milestones will have immediate, tangible impacts on interim incentive payments.

Together these activities will allow the Commonwealth to recognize and intervene on deficits in acute hospital performance to optimize performance. Hospital accountability to the state is further detailed in Section 5; hospitals will not be eligible to earn back unearned funds in PY 1.

In PY 2-5, the Commonwealth will actively manage performance of the participating hospitals to optimize performance using a similar performance management approach also including a corrective action plan (CAP) process (required to be implemented by STC 14.12) consisting of the following elements:

i. MassHealth will rigorously evaluate interim and annual deliverables to identify the participating hospitals that are not on track to meet objectives. Underperforming hospitals will be notified by and expected to engage with MassHealth on a periodic basis to discuss performance and obstacles and opportunities for improvement.
ii. MassHealth will provide support and technical assistance to all hospitals on an ongoing basis throughout the Section 1115 Demonstration period through applicable interventions including engagement with individual hospitals, data reporting and analysis, hospital technical forums dedicated to health quality and equity hosted by MassHealth, and technical assistance provided by MassHealth clinical and quality experts.
iii. Beginning in PY 3 and annually thereafter through PY 5, hospitals will also be incentivized to improve through a CAP process overseen by MassHealth. The CAP process will offer participating hospitals an opportunity to identify areas of poor performance on the HQEIP slate, evaluate root causes of such poor performance, and use rapid-cycle equity improvement interventions to make progress towards improved performance on HQEIP metrics. MassHealth may require certain poor-performing hospitals to participate in the CAP process; hospitals not required by MassHealth to

participate in the CAP process may choose to voluntarily participate. The CAP process will include the following aspects:

a. Hospitals participating in a CAP intervention in a given PY will select an area of underperformance on one or more metrics on the HQEIP measure slate. HQEIP measure focus areas must be selected and justified by hospitals within the first quarter of a CAP-eligible PY using data such as prior year(s) performance data (as available), hospital-generated internal performance monitoring data, and MassHealth hospital monitoring data. HQEIP metrics that may be selected as topic areas for CAP interventions will be provided by MassHealth annually.
b. Hospitals participating in a CAP intervention must develop a CAP intervention proposal to be submitted to MassHealth within the first quarter of the performance year describing one or more proposed intervention(s) that directly address the area of underperformance, including how the proposed interventions(s) will address known root causes and/or obstacles to performance and the hospital's rationale for why addressing the root cause and/or obstacle through the proposed CAP intervention will lead to expected performance improvement. The CAP proposal must include one or more quantitative key performance indicator(s) and performance targets for such indicators. The key performance indicators should be interim markers of success anticipated to impact performance on an HQEIP metric; they must be designed to allow for frequent monitoring throughout the duration of a CAP intervention. At least one key performance indicator must relate to eliciting direct member input to inform performance improvement on the targeted HQEIP and/or CAP intervention implementation.
c. MassHealth (together with its vendor(s) as applicable) will evaluate (using criteria such as relevance of the intervention to MassHealth members, feasibility of completion within the required time period, appropriateness of key performance indicators, etc.) and approve CAP proposals, requiring proposing hospitals to make modifications prior to approval as necessary to ensure CAP interventions are rigorous and in alignment with programmatic requirements.
d. Participating hospitals will implement approved CAP interventions by the end of the given PY, submitting a final report to MassHealth at the end of the PY describing the outcomes of the intervention including performance on key performance indicators.
e. MassHealth will evaluate CAP final reports to determine performance. Hospitals that achieve targeted key performance indicators will be eligible to earn health equity score "bonus points," to be added to their health equity scores for the PY during which the CAP intervention was conducted. Bonus points (between 5 to 12 absolute percentage points, with the specific amount dependent upon factors such as PY and hospital tier, to be determined at EOHHS' discretion) may only increase a health equity score for the PY up to 100% of the eligible amount for the PY; bonus points may not result in a hospital's health equity score exceeding 100% for the PY.

Together these activities will allow MassHealth to recognize and intervene on deficits in hospital health quality and equity performance with the goal to promote quality and equity for all MassHealth members served by hospitals, regardless of the hospital's initial HQEIP

performance. This framework will support MassHealth to proactively manage performance risks through collaboration with hospitals and active performance management.

Section 5. HQEI Accountability Framework (State Accountability to CMS; Acute Hospital Accountability to the State)

A. State Accountability to CMS for the HQEI for PY 1

The State has structured an accountability framework for the HQEI under which MassHealth is accountable to CMS for statewide achievement of HQEI goals. MassHealth's failure to achieve the standards set for these goals may result in the loss of HQEI expenditure authority according to the at-risk schedule set forth in STC 14.9 and included in Table 8 below.

Table 8. Statewide funding At-Risk by Demonstration Year

Demonstration Year	**DY 27-28**	**DY 29**	**DY 30**	**DY 31**	**DY 32**
Performance Year	**Q4 2022-Q4 2023 (PY 1)**	**CY 2024 (PY 2)**	**CY 2025 (PY 3)**	**CY 2026 (PY 4)**	**CY 2027 (PY 5)**
Funding at-risk for statewide achievement	5 percent	15 percent	20 percent	25 percent	25 percent

STC 14.9(a)(i) establishes the components of statewide accountability calculations. Consistent with STC 14.9, the statewide accountability in the first performance year is described in Table 9 below. Each domain will be assigned a weight for PY 1. The State will calculate the Statewide Accountability Score by multiplying the Score for each State HQEI domain by the associated weight and then summing the totals together. For example, PY Statewide Accountability Score = Domain 1 Score * 20% + Domain 2 Score * 20% + Domain 3 Score * 20% + Statewide Reporting of CMS Health Equity Measures Score * 40%. Statewide Accountability performance will be calculated as described in Table 10.

Table 9. Statewide Accountability to CMS for HQEI Performance in PY 1

Percent of At-risk funding for PY 1	**Statewide Performance Component**
Achievement of or improvement toward performance goals on the following measures across participating hospitals (drawn from STC 14.3, 14.4, and 14.5)	
25%	1) **Domain 1**: a. 80% of participating hospitals reporting baseline RELDSOGI rates. b. 80% of participating hospitals reporting baseline HRSN rates
25%	2) **Domain 2**: Massachusetts reporting to CMS on historical hospital quality data stratified by race and ethnicity as well as by pediatric and adult populations to contribute to informing selection of targeted areas for disparities reduction in subsequent program years

Percent of At-risk funding for PY 1	Statewide Performance Component
25%	3) **Domain 3**: 80% of participating hospitals achieve new and revised requirements to reduce health care disparities, specifically, the new standards in The Joint Commission (TJC) Accreditation Leadership (LD) chapter with 6 new elements of performance (EPs). Standard LD.04.03.08 will be effective January 1, 2023.
Statewide reporting on a selection of metrics agreed upon by CMS and the Commonwealth from the draft CMS Health Equity Measure Slate for DY27 and DY28	
25%	4) Statewide Reporting for PY 1 on: • Childhood Immunization Status (CIS-CH) • Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) • Controlling High Blood Pressure (CBP-AD) • Timeliness of Prenatal Care (PPC-CH and PPC-AD) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD ad FUA-CH)* • Follow-up after Hospitalization for Mental Illness (FUH-AD) • Cesarean Birth (TJC PC-02)
N/A	5) Maternal Morbidity Measure (to be specified by CMS)

Table 10. Statewide Accountability: Performance Calculations for PY 1

Statewide Performance Component	PY 1 Performance Calculation
1) **Domain 1**: a. 80% of hospitals reporting baseline RELDSOGI rates. b. 80% of hospitals reporting baseline HRSN rates.	Domain 1 performance will be weighted equally across subcomponents a and b, calculated as described below: a. RELDSOGI baseline reporting performance calculation Massachusetts will calculate the percentage of participating hospitals reporting to EOHHS complete baseline RELDSOGI rates for PY1. • If the Commonwealth meets or surpasses the target of 80% for PY 1, the State will earn a 100% score for this component for PY1. • If at least 40% of participating hospitals reporting to EOHHS complete and timely baseline RELDSOGI rates, the State will earn a proportionate score of ((completeness % / 80 %) * 100) for this component for PY 1. • If less than 40% of participating hospitals and report to EOHHS complete and timely baseline RELDSOGI rates, the State will earn a score of 0% for this component for PY 1. b. HRSN baseline reporting calculation Massachusetts will calculate the percentage of participating hospitals reporting to EOHHS complete baseline HRSN rates for PY1.

Statewide Performance Component	PY 1 Performance Calculation
	• If the Commonwealth meets or surpasses the target of 80% for PY 1, the State will earn a 100% score for this component for PY1. • If at least 40% of participating hospitals reporting to EOHHS complete and timely baseline HRSN rates, the State will earn a proportionate score of ((completeness % / 80 %) * 100) for this component for PY 1. • If less than 40% of participating hospitals and report to EOHHS complete and timely baseline HRSN rates, the State will earn a score of 0% for this component for PY 1.
2) **Domain 2**: EOHHS reporting to CMS on historical hospital quality data stratified by race and ethnicity to contribute to informing targeted areas for disparities reduction	Massachusetts will report to CMS on historical hospital quality data stratified by race and ethnicity (self-reported and/or imputed) to inform targeted areas for disparities reduction by January 12, 2024. Specifically, the Commonwealth will report stratified performance data at the hospital level for clinical quality metrics that were used in MassHealth quality incentive programs in the three most recent performance years for which data are available for analysis (CY 2019-CY 2021). • If the Commonwealth submits a complete report to CMS by • January 12, 2024, the Commonwealth will earn a score of 100% for this component for PY 1.
3) **Domain 3**: 80% of participating hospitals achieve new and revised requirements to reduce health care disparities, specifically, the new standards in the Leadership (LD) chapter with 6 new elements of performance (EPs). Standard LD.04.03.08 will be effective January 1, 2023.	Massachusetts will calculate the percentage of participating hospitals achieving new and revised Joint Commission accreditation requirements (specifically, the new standards in the Leadership (LD) chapter with 6 new elements of performance, Standard LD.04.03.08.) • If the Commonwealth meets or surpasses the target of 80% for PY 1, the State will earn a 100% score for this component for PY 1. • If at least 40% of participating hospitals achieve the requirements, the Commonwealth will earn a score of ((completeness % / 80 %) * 100) for this component for PY 1. • If less than 40% of participating hospitals achieve the requirements, the Commonwealth will earn a score of 0% for this component for PY 1.
4) **Statewide Reporting for Performance Year 1** (metrics specified in Table 9)	Massachusetts will report statewide performance on specified metrics to CMS by December 31, 2024. • If the Commonwealth submits a complete report of performance on the specified metrics to CMS by December 31, 2024 (allowing for claims runout and processing), the State will earn a score of 100% for this component for PY 1.
5) **Maternal Morbidity Measure** (to be specified by CMS)	Not applicable

B. State Accountability to CMS for the HQEI for PY 2-5

STC 14.9(a)(i) establishes the components of statewide accountability calculations. Consistent with this framework, the state proposes statewide accountability for PY 2-5 as described in Table 11. Each component is assigned a weight for each PY as specified. The state will calculate the statewide accountability score by multiplying the score for each state accountability component by the associated weight, summing the totals together, and then adding in any bonus points (earned as described in Table 12).

The statewide accountability score will be used to calculate any reduction in at-risk statewide expenditure authority as follows:

- If the statewide accountability score for a given PY is >/= 90%, there will be no reduction in statewide expenditure authority within that performance year.
- If the statewide accountability score for a given PY is < 90%, any at-risk statewide expenditure authority reduction (as described in Table 5) will be calculated as follows:

  At-risk statewide expenditure authority for the PY (in $)(1 – (statewide accountability score for the PY/100))*

Statewide Accountability Performance Calculations are described in Table 12.

Table 11. Statewide Accountability to CMS for HQEI PY 2-5

Statewide Accountability Component	HQEIP Domain	Statewide Accountability Measure Category	Statewide Accountability Measure	Statewide Performance Targets					
				PY 2	PY 3	WEIGHT (PY 2-3)	PY 4	PY 5	WEIGHT (PY 4-5)
Achievement of or improvement toward performance goals on a selection of HQEIP metrics	**Demographic and HRSN Data**	**Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity (RELDSOGI) Data Completeness**	Completeness of self-reported data for MassHealth members	40% RE	80% RE	20	40% RELDSOGI^	80% RELDSOGI^	15
		Health-Related Social Needs (HRSN) Screening	% of MassHealth members screened for HRSN	10%	20%	7.5	30%	60%	20
			% of hospitals reporting identified HRSN needs	20%	40%	7.5	60%	80%	
	Capacity and Collaboration	**Patient Experience: Communication, Courtesy, and Respect**	% of hospitals reporting member experience data related to cultural competency	50%	60%	10	70%	80%	10
		External Standards for Health Equity	% of hospitals achieving The Joint Commission's standards for Health Equity	n/a	80%	10	n/a	80%	10
	Equitable Quality and Access	**Disability Competent Care Competencies**	% of hospitals reporting % of staff trained on disability competent care	25%	40%	7.5	55%	70%	7.5
		Language Access	% of hospitals reporting rate of receipt of interpreter services	50%	65%	7.5	80%	n/a	7.5
		Disparities Reduction: Follow Up After Hospitalization for Mental Illness (FUH) and Maternal Morbidity Measures (MMM)	% of hospitals successfully implementing Equity Improvement Projects	80%	80%	20	n/a	n/a	n/a
Maternal Morbidity Measures			Race & Ethnicity disparities reduction statewide on FUH and MMM (benchmarks to be approved by CMS pending baseline data)	n/a	n/a	n/a	TBD*	TBD*	20
Achievement of or improvement towards aggregate performance goals on a selection of CMS Health Equity Measure Slate metrics**		• **Childhood Immunization Status** • **Follow-up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence** • **Controlling High Blood Pressure** • **Timeliness of Prenatal Care**	Statewide aggregate reporting on selected CMS Health Equity Slate** measures	All measures	All measures	10	n/a	n/a	n/a
			Achieve aggregate performance of >/= National Medicaid xx%ile in the prior performance year or 2023, whichever is lower.	n/a	n/a	n/a	75%ile	90%ile	10

* Proposed approach described in Table 12 **Measures drawn from January 2023 draft version of the CMS Health Equity Slate
^CMS and MassHealth may revisit PY 4 and PY 5 targets based on additional information and findings from initial PYs.

Table 12. State Accountability: Performance Calculations for PY 2-5

Statewide Accountability Component	HQEIP Domain	PY 2-5 Statewide Performance Calculations (Calculation of performance for each PY specified below[2])

1)**Achievement of or improvement toward performance goals on a selection of HQEIP measures**	**a. Demographic and Health-Related Social Needs Data**	RELDSOGI Completeness
		• For PY 2-5, Massachusetts will calculate the percentage of MassHealth Members[1] with complete data for each relevant data element.
		  ○ In PY 2-3, completeness will be calculated for Race and Ethnicity data elements
		  ○ In PY 4-5, completeness will be calculated for Race, Ethnicity, Language, Disability, Sexual Orientation and Gender Identity data elements
		  ○ For each PY, completeness for each applicable data element for that performance year (each considered a submeasure) will contribute equally to an average completeness for the PY. (For example, for PY 2, statewide performance = (Race submeasure score + Ethnicity submeasure score)/2
		• Calculation of each submeasure that contributes to the measure score for each PY is described below[2]

		Health-Related Social Needs Screening[3]
		• For PY 2-5, Massachusetts will calculate performance for two measures:
		  ○ The percentage of MassHealth Members[1] with at least one inpatient discharge within the PY at a participating hospital that were screened for health-related social needs within the performance year
		  ○ The percentage of participating hospitals reporting identified HRSN data to EOHHS.
		• Calculation of each submeasure that contributes to the measure score for each PY is described below[2]

	b. Capacity and Collaboration	Patient Experience: Communication, Courtesy, and Respect[3] • For PY 2-5, Massachusetts will calculate the percentage of participating hospitals reporting member experience data related to cultural competency. • Calculation of the measure score for each PY is described below[2]
		Achievement of External Standards for Health Equity[3] • For PY 3 and PY 5, Massachusetts will calculate the percentage of participating hospitals that have achieved the Joint Commission's Health Care Equity Certification. • Calculation of the measure score for each PY is described below[2]
	c. Equitable Quality and Access	Disability Competent Care[3] • PY 2-5, Massachusetts will calculate the percentage of participating hospitals reporting the percent of applicable patient-facing staff that have been trained in disability competent care within the previous 24 months. • Calculation of the measure score for each PY is described below[2]
		Language Access[3] • For PY 2-5, Massachusetts will calculate the percentage of participating hospitals reporting the rate of receipt of interpreter services for members with a preferred language other than English according to applicable HQEIP specifications. • Calculation of the measure score for each PY is described below[2]

2) Maternal Morbidity Measures		Disparities Reduction: Follow up After Hospitalization for Mental Illness (FUH) and Maternal Morbidity Measures (MMM)[3] • For PY 2-3, Massachusetts will assess the percentage of participating hospitals successfully implementing ACO-hospital partnered equity-focused equity improvement projects focused on FUH, MMM, and/or another measure as approved by EOHHS (for example, for acute hospitals with neither birthing nor inpatient psychiatric services, EOHHS may allow pursuit of disparities reduction for other quality topics to meet HQEIP performance requirements). Successful implementation will be determined by submission of required quarterly performance deliverables specified in the Equity Improvement Project measure specification resulting in an average score for the measure for the PY across hospitals of at least 60%. • At least 12 months prior to the start of PY 4, Massachusetts will report available aggregate and race and ethnicity-stratified performance for all included hospitals accountable to disparities reduction on FUH and MMM, propose specific disparity reduction priorities for these metrics (e.g. to reduce the performance disparity between the highest performing racial/ethnic group and one or more other racial/ethnic groups) as well as disparities reduction targets, subject to CMS approval. In addition to the FUH measure, one or more of the MMM will be prioritized for specific disparity reduction priorities and disparities reduction targets. • For PY 4-5, Massachusetts will calculate statewide performance on the prioritized measures stratified by race and ethnicity in order to measure progress on reducing the specific disparity reduction priorities proposed by MassHealth and approved by CMS prior to PY 4. • For the purpose of this statewide accountability measure category:[3] o FUH is the "Follow-Up After Hospitalization for Mental Illness" measure (CMIT #268) o MMM are three measures impacting maternal morbidity and mortality relevant to the acute hospital setting: ▪ Prenatal and Postpartum care – Postpartum Care (CMIT #581) ▪ Cesarean Birth (CMIT #508 or the Joint Commission measure PC-02) ▪ Severe Obstetric Complications (CMIT #1633)
3) Achievement of or improvement towards aggregate performance goals on a selection of CMS Health Equity Measure Slate metrics		CMS Health Equity Measure Slate Metrics Statewide Performance Calculation • For PY 2-3, Massachusetts will calculate statewide aggregate performance on the CMS Health Equity Slate Measures specified in Table 9. o If the Commonwealth submits a complete aggregate performance report to CMS within 12 months following the end of the relevant PY, the Commonwealth will earn a score of 100% for this component. • For PY 4-5, Massachusetts will calculate statewide aggregate national Medicaid performance percentiles for each of the four specified measures. For each PY, the national Medicaid performance percentile for each measure will contribute equally to an average national Medicaid performance percentile for the PY.

[1] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) with MassHealth as their primary insurance, including those with MassHealth Standard, CommonHealth, CarePlus, and Family Assistance coverage types; excludes members with Medicare or another payer as primary payer.

[2] For each measure (and/or submeasure) in each PY:

- If the Commonwealth meets the performance target for the PY, the State will earn a 100% score for the measure/submeasure.
- If the Commonwealth meets or surpasses a threshold benchmark of (performance target * 0.25), the State will earn a proportionate score of ((actual% / target%) * 100) for the measure/submeasure for the PY.
- If the Commonwealth exceeds the performance target for the PY, the State will earn bonus percentage points up to half of the total percentage points designated for the measure/submeasure, awarded on a linear basis for performance exceeding the goal benchmark by up to 10% (i.e. if measure performance exceeds the goal benchmark by 10%, the state will earn bonus points equaling half of the total percentage points awarded for the measure/submeasure; if measure performance exceeds the goal benchmark by 5%, the state will earn bonus points equaling one quarter of the total percentage points awarded for the measure/submeasure)
- If the Commonwealth does not meet or surpass the threshold benchmark of (performance target * 0.25), the State will earn a score of 0% for the measure

[3] PY2-5 Statewide Performance Calculations for these measures for each given performance year will be based on performance of only those hospitals that are active in that performance year's requirements during the corresponding demonstration year as listed in Table 8. For example, for PY3, only those hospitals that are actively pursuing PY3 requirements would contribute to Statewide Performance Calculations. If an acute hospital is active in the HQEIP, but within Performance Year 3 in a staggered performance year pattern due to its status as a new entrant into the program or because its participation was suspended for a performance period, as such scenarios described in Section 3.B, that hospital would be excluded for the purpose of Statewide Performance Calculations.

C. Acute Hospital Accountability to the State for the HQEIP for PY 1

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will separately hold each participating acute hospital individually accountable for its performance on the HQEIP performance measures.

Total incentive amounts for each hospital for PY 1 will be distributed according to the weighting described in Table 13. Performance expectations for each metric are summarized in Table 4 above and detailed further in relevant technical specifications.

Table 13. PY 1 HQEIP Metric Weights

Subdomain	**HQEIP Metric (*Steward)***	**PY 1 Weight (%)**
Domain 1. Demographic and Health-Related Social Needs Data		**25**
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	15
Health-Related Social Needs Screening	Health-Related Social Needs Screening (*EOHHS*/*CMS*)	10
Domain 2. Equitable Quality and Access		**50**
Equity Reporting	Quality Performance Disparities Reduction (*EOHHS*)	10
Equity Improvement	Equity Improvement Interventions (*EOHHS*)	10
Access	Meaningful Access to Healthcare Services for Individuals with a Preferred Language other than English (EOHHS/*OHA*)	10
	Disability Competent Care (*EOHHS*)	10
	Disability Accommodation Needs (*EOHHS)*	10
Domain 3. Capacity and Collaboration		**25**
Capacity	Achievement of External Standards for Health Equity (*EOHHS)*	10
	Patient Experience: Communication, Courtesy, and Respect (*EOHHS/AHRQ)*	10
Collaboration	Collaboration (*EOHHS*)	5

D. Acute Hospital Accountability to the State for the HQEIP for PY 2-5

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will separately hold each participating hospital individually accountable for its performance on the HQEIP performance measures as described in STC 14.6. MassHealth's framework for the HQEIP Performance Assessment Methodology (PAM), which may be adjusted annually as needed (for example, to transition measures from pay-for-reporting to pay-for-performance, accommodate new contextual inputs, address extenuating circumstances impacting performance, etc.), is described below. Measure-specific PAM, including benchmarks, improvement targets and measure score calculation approach, will be described in each measure specification, to be made available on MassHealth's website.[3]

i. **Benchmarking:** MassHealth will establish performance targets or benchmarks no later than the start of the first pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
   a. Benchmarks for quantitative measures will include an attainment threshold and goal benchmark and will be set to apply to the full applicable performance period.
   b. Establishment of benchmarks will be informed by inputs such as initial HQEIP performance data, historical hospital data/performance, external data/trends, and/or predetermined performance targets determined by MassHealth.

ii. **Improvement Targets:** MassHealth will establish annual performance improvement targets for performance metrics, as applicable, no later than the start of each pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
   a. Specific approaches for each measure, defined no later than July 1, 2025, will be intended to apply to the full applicable performance period.
      i. Before July 1, 2025, annual "meaningful improvement" targets for HRSN screening specifically (as referenced in STC 14.3.d) will be defined each year in annual updates to the technical specifications; after July 1, 2025, annual "meaningful improvement" targets for the remaining years of the demonstration period (including PY 4-5) will be reported to CMS.
   b. The approaches and actual improvement targets may differ by measure based on factors such as performance trends or type of measure; approaches may include year-over-year self-improvement, gap-to-goal percentage point increase, absolute percentage point increases, set milestones and/or goals for improvement.

iii. **Performance Measure Score Calculation**: The performance measure scoring approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices. MassHealth will establish a methodology for performance measure scoring for each measure, to be specified in technical specifications, no later than the first day of the performance period to which the methodology applies.

[3] https://www.mass.gov/masshealth-quality-and-equity-incentive-programs

a. **Pay-for-reporting (P4R) measures.** P4R measures will be assessed on a pass/fail basis for which the hospitals who successfully report complete and timely data based on each measure's technical specifications will receive full points or credit for the metric.
b. **Pay-for-performance (P4P) measures.** The performance measure scoring and approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices, described below.
    i. Measure scoring will include the following components for each measure:
        1. Attainment points ranging from 0-10 points.
        2. Improvement points ranging from 0-10 points.
        3. Potential bonus points (with a cap) to ensure all participating hospital have incentive to improve, including high-performing hospitals (required by STC 14.6).
    ii. Performance measure scores for each measure will be defined as a ratio between 0-1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum number of points allowable for the measure is the sum of the attainment, improvement and potential bonus points with a determined cap. The score will be calculated as follows: *Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.*
    iii. Some performance measures may have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then typically equally weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows: *Performance Measure Score = Sum of each (Sub-measure Score X Sub-measure Weighting).*

iv. **Domain Score Calculation**: The domain scoring and approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. Domain scoring includes the following components:
    a. Using the predetermined weights specified in Table 14, a domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective performance measure weight: *Domain Score = Sum of each (Performance Measure Score* Performance Measure Weight).*
    b. If a hospital is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the eligible performance measures in the domain.

v. **Health Equity Score Calculation**: The overall Health Equity Scoring approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. The overall Health Equity Score includes the following components. Using the predetermined weights specified in Table 14 and STC 14.7, a health equity score will be calculated by taking each domain score and calculating the

sum of each domain score multiplied by its respective domain weight: *Health Equity Score = Sum of each (Domain Score * Domain Weight)*. Any bonus points earned through Corrective Action Plans (described in Section 4.B of this Addendum) will then be added to determine the final HQEIP Health Equity Score for the PY, not to exceed 100%. The final Health Equity Score will be used to calculate the participating hospital's earned incentive payment.

Table 14. PY 2-5 HQEIP Metric Weights

Domain*	Measure Name	Measure Weight (%) by Performance Year				Domain Weight (%)
		2024	2025	2026	2027	
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	10	10	15	15	25
	Health-Related Social Needs (HRSN) Screening	15	15	10	10	
EQA	Quality Performance Disparities Reduction	10	10	20	20	50
	Equity Improvement Interventions	10	10	5	5	
	Meaningful Access to Healthcare Services for Persons with a preferred language other than English	10	10	10	10	
	Disability Competencies	10	10	5	5	
	Accommodation Needs Met	10	10	10	10	
CC	Achievement of External Standards for Health Equity	10	10	10	10	25
	Patient Experience: Communication, Courtesy and Respect	10	10	10	10	
	Collaboration	5	5	5	5	
TOTAL						**100**

*DHRSN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access; CC=Capacity and Collaboration

Section 6. Analysis & Needs Assessment and Advisory Functions

A. Analysis & Needs Assessment for PY 1

To inform development of the HQEI, including areas for prioritization and improvement, Massachusetts engaged in a robust assessment of needs. Initial program design took into account: 1) an understanding of the population served by the acute hospital program; 2) member

and community and other stakeholder quality and equity priorities for the acute hospital program; 3) an assessment of significant health needs amongst the served acute hospital population; 4) an investigation of the acute hospital resources potentially available to address the significant health needs; 5) an evaluation of the impact of historical and current MassHealth programs on quality and equity; and 6) a review of relevant guidance and literature related to promoting quality and health equity in Medicaid programs and within health systems.

Avenues for input included:

1. Strategic planning process to identify MassHealth health equity priorities and member needs.
2. Robust review of data, including:
    a. Historical acute hospital quality performance data, including stratified by available social risk factors
    b. Acute hospital utilization data (inpatient and emergency department)
    c. Equity data from the Massachusetts Department of Public Health
3. Literature review
4. A public request for information related to introducing health equity as a component of value-based care.
5. A public request for information related to strengthening member engagement including to inform health equity programming.
6. Data from surveyed hospitals and health plans related to health equity data collection and use.
7. Recommendations from the EOHHS Quality Measure Alignment Task Force related to health equity data and principles for health equity accountability.
8. Numerous public meetings
9. Regular engagement with acute hospital stakeholders, directly and through professional society and other advocacy groups.

Massachusetts anticipates updating its statewide assessment of needs on an annual basis to inform ongoing program priorities and target areas for performance improvement. In addition to inputs used to inform initial program development, the Commonwealth will also consider, at a minimum:

10. HQEIP interim and annual performance data
11. Findings from HQEIP Needs Assessments conducted by participating hospitals. This Needs Assessment may build on requirements for Community Health Needs Assessments (CHNAs) required to be conducted by non-profit acute hospitals by the Massachusetts Office of the Attorney General. CHNAs include numerous elements, including importantly, identification of health disparities and particular types of health differences that are closely linked with economic, social, or environmental disadvantage as part of their assessment of significant health needs of the community.
12. Ongoing stakeholder engagement, including provider, health system, member, and community engagement.

The hospital-level and statewide needs assessments will inform all aspects of the program, but in particular will inform selection of quality and access metrics for improvement and/or disparities reduction entering into performance in later years of the program.

B. Analysis & Needs Assessment for PY 2-5

Participating hospitals and MassHealth will leverage needs assessments throughout the PY2-5 performance period to inform and shape HQEIP implementation. Needs assessments conducted by participating hospitals will prioritize target areas of access or quality inequities for interventions. These needs assessments will also serve as a data input for MassHealth's statewide needs assessment to identify priority quality and equity areas and to ensure program implementation is targeted towards addressing those priority areas.

In PY 1, hospitals drew from their recent Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs) to inform HQEIP implementation. CHNAs are required to be conducted by non-profit acute hospitals by the Massachusetts Office of the Attorney General and include numerous elements including, importantly, identification of health disparities and particular types of health differences that are closely linked with economic, social, or environmental disadvantage that contribute to significant health needs of their communities. Participating hospitals must interpret their most recent CHNAs and CHIPs to identify health quality and equity needs relevant to the MassHealth population, and must incorporate their assessment into the hospitals' annual Health Quality and Equity Strategic Plan update.

In PY 2-5, hospitals will be required to report annually to MassHealth on ongoing needs assessment of health quality and equity priorities, including through conduction of triennial CHNA's and annual CHIPs in the context of their required annual Health Quality and Equity Strategic Plan updates. This reporting will be required to be included in participating acute hospitals' required annual Health Quality and Equity Strategic Plan updates. Hospitals will be required to report on identified quality and equity needs of the MassHealth population, how they are using data on identified needs to inform HQEIP implementation, complementary equity-oriented activities conducted external to the HQEIP that may impact MassHealth populations, and progress towards addressing identified needs. Hospitals will also be required to report on how HQEIP data will inform future CHNAs and CHIPs.

In PY 2-5, MassHealth will continue to assess needs of the MassHealth population in order to inform HQEIP implementation. Needs assessment activities may include review and analysis of inputs such as:

1. MassHealth interim and annual equity performance data from the HQEIP;
2. MassHealth aggregate and stratified quality performance data, including from the MassHealth acute hospital program;
3. MassHealth utilization data, including inpatient, emergency department, and outpatient utilization related to the MassHealth acute hospital program;
4. Public health data on disparities from the Massachusetts Department of Public Health;
5. Data collected from hospitals and other MassHealth providers related to health equity data collection and equity programming, including hospital-level needs assessments;
6. Input provided through public meetings;
7. Input provided by members, providers, advocates, or other interested members of the public, including collected through public forums, specific member engagement forums, or other venues;

8. Input provided by hospital stakeholders, directly and through professional society and other advocacy groups; and
9. Environmental scans.

Collected data will be used to better understand the evolution of quality and equity needs of MassHealth members throughout the duration of the Section 1115 Demonstration period and further to inform implementation of the HQEIP to optimize addressing identified needs.

C. HQEI Advisory Committee

MassHealth will convene and oversee a Hospital Quality and Equity Initiative Advisory Committee (the "HQEIA Committee") that will serve as an advisory group offering expertise in health care quality and equity measurement, quality and equity improvement, and clinical, demographic, and HRSN data used in performance improvement initiatives, and best practices, as set forth in STC 14.23. Final decision-making authority over the demonstration will be retained by MassHealth (with CMS approval, as applicable), although MassHealth will consider all HQEIA Committee recommendations.

As part MassHealth's larger stakeholder engagement strategy, the HQEIA Committee will be part of a group scoped to discuss broader topics including, but not limited to, behavioral health integration, primary care sub-capitation, and care coordination. As such, this HQEIA Committee will bring a variety of stakeholders with broad perspective together, which will support the mission of improving clinical performance of HQEI activities. The HQEIA Committee may be comprised of stakeholders including, but not limited to:

- Advocacy groups
- Providers and provider associations
- Hospitals
- ACOs and Health Plans
- Social Service and Community Partner organizations
- MassHealth members
- Community representatives and/or advocates

At least 30% of HQEIA Committee members will be required to have significant expertise or experience in health quality and equity, including but not limited to employment in health quality and equity in hospitals, in government service, at managed care plans, at health systems, from companies providing health quality and equity services to above listed provider types and managed care plans, and/or lived experience. The state will work to minimize possible conflicts of interest.

D. Independent Assessor

MassHealth will identify an Independent Assessor with expertise in delivery system improvement to assist with HQEI administration, oversight, and monitoring. Broadly over the course of this Section 1115 demonstration, the Independent Assessor, in collaboration with other entities identified by MassHealth as needed (e.g., health quality and equity program management vendor), will review selected proposals, progress reports and other related documents identified

for review by MassHealth, to ensure compliance with the approved STCs, the HQEI Implementation Plan, and any applicable Protocols. In PY1 specifically, the Independent Assessor will review the following three planning deliverables: the health quality and equity strategic plans, the RELD SOGI and HRSN Assessments, and self-assessments of staff disability competencies. In PY 2-5, specifically, each year the Independent Assessor will review the Health Quality and Equity Strategic Plan updates, along with one representative deliverable from each of the three HQEI domains, and make recommendations to MassHealth for document approvals. Additionally, once annually, the Independent Assessor will make recommendations to MassHealth for program improvement based on its document review. Final decision-making authority regarding program improvement recommendations rests with MassHealth. However, MassHealth will carefully consider the Independent Assessor's recommendations. MassHealth has the authority to change Independent Assessors at MassHealth's discretion.

Appendix A. List of MassHealth Acute Hospitals by Safety Net Group Tier

Hospital	Tier
Boston Medical Center	Tier 1
Holyoke Medical Center	Tier 1
Lawrence General Hospital	Tier 1
Mercy Medical Center	Tier 1
Signature Healthcare Brockton Hospital	Tier 1
Baystate Franklin Medical Center	Tier 2
Baystate Medical Center	Tier 2
Baystate Wing Hospital	Tier 2
Berkshire Medical Center	Tier 2
Heywood Hospital	Tier 2
Lowell General Hospital	Tier 2
Martha's Vineyard Hospital	Tier 2
MetroWest Medical Center	Tier 2
Morton Hospital	Tier 2
Noble Hospital	Tier 2
North Shore Medical Center	Tier 2
Shriners Hospitals for Children Boston	Tier 2
Southcoast Hospitals Group	Tier 2
Good Samaritan Medical Center	Tier 2
Holy Family Hospital Inc.	Tier 2
Tufts Medical Center	Tier 2
Anna Jaques Hospital	Tier 3
Athol Memorial Hospital	Tier 3
Beth Israel Deaconess Hospital – Milton	Tier 3
Beth Israel Deaconess Hospital – Needham	Tier 3
Beth Israel Deaconess Hospital – Plymouth	Tier 3
Beth Israel Deaconess Medical Center	Tier 3
Boston Children's Hospital	Tier 3
Brigham and Women's Faulkner Hospital	Tier 3
Brigham and Women's Hospital	Tier 3
Cape Cod Hospital	Tier 3
Cooley Dickinson Hospital	Tier 3
Dana-Farber Cancer Institute	Tier 3
Emerson Hospital	Tier 3
Fairview Hospital	Tier 3
Falmouth Hospital	Tier 3
Harrington Memorial Hospital	Tier 3

Hospital	Tier
HealthAlliance Hospital	Tier 3
Lahey Health - Winchester Hospital	Tier 3
Lahey Hospital and Medical Center	Tier 3
Marlborough Hospital - A member of the UMASS Memorial Health Center	Tier 3
Massachusetts Eye and Ear Infirmary	Tier 3
Massachusetts General Hospital	Tier 3
Melrose Wakefield Hospital (formerly Hallmark Health)	Tier 3
Milford Regional Medical Center	Tier 3
Mount Auburn Hospital	Tier 3
Nantucket Cottage Hospital	Tier 3
New England Baptist Hospital	Tier 3
Newton-Wellesley Hospital	Tier 3
Northeast Hospital (Beverly Hospital)	Tier 3
Saint Vincent Hospital	Tier 3
South Shore Hospital	Tier 3
Saint Anne's Hospital Inc.	Tier 3
St. Elizabeth's Medical Center	Tier 3
Sturdy Memorial Hospital	Tier 3
UMass Memorial Medical Center	Tier 3
Cambridge Health Alliance	N/A

Appendix B. Overview of the MassHealth Acute Hospital Clinical Quality Incentive Program

MassHealth has had a longstanding commitment to promoting high quality care for its members spanning medical, behavioral health, and long-term services and supports. Specifically, for over a decade, MassHealth has incentivized quality performance for its private acute hospitals (including the single non-state-owned public acute hospital).

For the 1115 waiver renewal period from Calendar Year (CY) 2022 – CY 2027, MassHealth intends to continue and enhance its quality measurement program for acute hospitals, referred to as the Clinical Quality Incentive (CQI) program. The CQI will be implemented under State Plan Authority to provide opportunities for acute hospitals to earn incentives for quality reporting and performance on quality measures pertinent to MassHealth quality priorities. The incentive is designed to reward hospitals for excelling in and improving quality of care delivered to MassHealth members, and is aligned with articulated goals in MassHealth's 2022 Comprehensive Quality Strategy[4]:

1) **Promote better care**: Promote safe and high-quality care for MassHealth members.
2) **Promote equitable care**: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience.
3) **Make care more value-based**: Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care.
4) **Promote person- and family- centered care**: Strengthen member and family-centered approaches to care and focus on engaging members in their health.
5) **Improve care through better integration, communication, and coordination** across the care continuum and across care teams for our members.

Measures included in the CQI are selected to be disparities-sensitive standard quality metrics aligned with MassHealth quality priorities, including related to preventive, perinatal, and pediatric care; care coordination; care for acute and chronic conditions; and member experience (see Table 1 for example measures for the Acute Hospital Clinical Quality Incentive program for CY 2023; measures to be specified through state plan amendment). Acute Hospitals will earn incentive payments based on improvement towards and achievement of performance targets specified by MassHealth.

[4] Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. MassHealth 2022 Comprehensive Quality Strategy. https://www.mass.gov/doc/masshealth-2022-comprehensive-quality-strategy-2/download

Table 1. Example Measures for the Acute Hospital Quality Clinical Quality Incentive program for CY 2023

Quality Domain	Quality Measure (Steward)
Preventive, Perinatal, and Pediatric Care	• Cesarean Birth, Nulliparous, Singleton, Vertex (*TJC*) • Unexpected Newborn Complications in Term Infants (*TJC*) • Perinatal Morbidity Structural Measure (Includes a survey question that aligns with the CMS 0418 Maternal Morbidity Structural Measure) (*EOHHS*) • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis *(NCQA)* • Pediatric All-Condition Readmissions Measure *(COEPQM)*
Care Coordination/ Integration	• Reconciled Medication List Received by Discharged Patient *(CMS)* • Transition Record with Specified Data Elements Received by Discharged Patient *(CMS)* • Timely Transmission of Transition Record within 48 hours at Discharge *(CMS)* • Plan All-Cause Readmissions Adult (7 day and 30 day) *(NCQA)* • Follow-up After ED Visit for Mental Illness (7 day and 30 day) (*NCQA*) • Follow-Up After ED Visit for Alcohol or Drug Abuse or Dependence (7 day and 30 day) (*NCQA*) • Follow-up After Hospitalization for Mental Illness (7 day and 30 day) (*NCQA*)
Care for Acute and Chronic Conditions	• Alcohol Use – Brief Intervention Provided or Offered (*TJC Sub-2*) • Alcohol & Other Drug Use Disorder – Treatment Provided/Offered at Discharge (*TJC Sub-3*) • Safe Use of Opioids – Concurrent Prescribing (*CMS*) • Medication Continuation Following Inpatient Psychiatric Discharge (*CMS*) • Screening for Metabolic Disorders *(CMS)*
Patient Safety	• PSI-90: Patient Safety and Adverse Events Composite (*AHRQ*) • HAI: CLABSI, CAUTI, MRSA, CDI, SSI (*CDC*)
Patient Experience	• HCAHPS: Hospital Consumer Assessment of Healthcare Provider Systems Survey (*AHRQ*). Includes 7 survey dimensions: 1) nurse communication, 2) doctor communication, 3) responsiveness of hospital staff, 4) communication about medicines, 5) discharge information, 6) overall rating and 7) three item care transition.

Appendix C. Cambridge Health Alliance Hospital Quality and Equity Incentive Program

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Section 1. Overview of Massachusetts' Statewide Approach to Advance Healthcare Quality and Equity

A. Overview

An overview of Massachusetts' statewide approach to advance healthcare quality and equity that pertains to the Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP) is included in the Hospital Quality and Equity Initiative (HQEI) Performance Year (PY) 1-5 Implementation Plan (referred to in this Appendix C as "Attachment J"), Section 1.A.

B. Scope of Appendix C

Attachment J provides additional detail related to implementation of the Commonwealth's HQEI, beyond those requirements set forth in the MassHealth Medicaid and CHIP Section 1115 Demonstration Special Terms and Conditions (STCs). Attachment J applies during the performance years of the demonstration Approval Period (October 1, 2022 – December 31, 2027).

This Appendix C provides additional detail related to implementation of the Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP), a component of the HQEI.

Section 2. Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP) Design and Goals

A. Overview of Targeted Domains for Improvement in the CHA-HQEIP

For the CHA-HQEIP, Cambridge Health Alliance (CHA) will implement a program to improve health care quality and equity and develop interventions for both its Medicaid population and the uninsured individuals it serves (described in STC 14.16 and 14.17). Further, it will address both hospital and ambulatory performance (described in STC 14.17).

1. Hospital Performance Component of the CHA-HQEIP

As specified in STC 14.17(a), seventy percent of the incentive payment for CHA will be allocated to CHA's reporting and/or performance on the HQEIP domains, described in Attachment J, Section 2.A. CHA will be 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 patient population within its service area, which will be measured separately. Recognizing adaptation necessary for an uninsured population, the specific applicable domain elements, weighting, measurement, performance assessment methodology, and attribution methodology for the uninsured population for PY 1-5 are described in this Appendix C.

2. Ambulatory Performance Component of the CHA-HQEIP

As specified in STC 14.17(b), thirty percent of the incentive payment for CHA will be allocated to CHA's reporting and/or performance on ambulatory quality measures for the served uninsured population and payment may be based on both overall improvement and disparities reduction on those measures. The details for the methodology and measures for PY 1-5 are described in this Appendix C.

Section 3. CHA-HQEIP Conceptual Framework and Performance Year (PY) Metrics

A. Conceptual Framework

An overview of the conceptual framework that pertains to CHA-HQEIP is included in Attachment J, Section 3.A.

B. Hospital Performance Component of the CHA-HQEIP: Metrics and Reporting Requirements for PY 1

To establish a robust foundation for quality and equity improvement and to begin making progress towards five-year HQEI domain goals, the first performance year of the CHA-HQEIP hospital performance component will hold CHA accountable to metrics (listed in Table 1) evaluating contributory health system level interventions in each CHA-HQEIP domain. These metrics and associated reporting and performance expectations (described in Table 2) were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement.

Table 1. PY 1 Metrics for the Hospital Performance Component of the CHA-HQEIP

	Metric (*Steward)*	**PY 1 Status***
Domain 1. Demographic and Health-Related Social Needs Data		
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Pay for Reporting (P4R)

Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*): Preparing for Reporting Beginning in PY 2	P4R
Domain 2. Equitable Quality and Access		
Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	P4R
Equity Improvement	Equity Improvement Interventions (*EOHHS*)	P4R
Access	Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English (Oregon Health Authority)	P4R
	Disability Competencies (*EOHHS*)	P4R
	Accommodation Needs Met (*EOHHS)*	P4R
Domain 3. Capacity and Collaboration		
Capacity	Achievement of External Standards for Health Equity (*EOHHS)*	P4R
	(HCAHPS): Patient Experience: Communication, Courtesy and Respect (*AHRQ)*	P4R
Collaboration	Joint Accountability for Partnered ACO Performance (*EOHHS*)	P4P

* Reporting requirements for each measure described in relevant technical specifications.

Recognizing that taking on accountability for equity is new for most acute hospitals serving MassHealth members, all metrics are in pay-for-reporting status in PY 1. Interim and annual reporting requirements for PY 1 are designed to promote essential foundational capacity and readiness to assume progressive risk for health quality and equity performance in PY 2 through PY 5. Table 2 summarizes PY 1 reporting/performance expectations for the hospital performance component of the CHA-HQEIP.

In general, measures included in the CHA-HQEIP will closely align with specifications for the HQEIP for the majority of measures, adapted minimally to additionally encompass both the Medicaid population and CHA's served uninsured population. For two measures, the **Stratified Reporting of Quality Data** and the **Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English** metrics, EOHHS will make additional adaptations specific to the CHA-HQEIP, as follows:

1) For both metrics, EOHHS will allow CHA to annually report population-based electronic measures (drawn from the electronic health record) in lieu of chart-abstraction/sampling. This is aligned with EOHHS' goals toward population-based data collection. Measures will be submitted following the PY utilizing an EOHHS-approved template consistent with the CMS and Joint Commission portal fields used for e-measures.

2) For the **Stratified Reporting of Quality Data** metric, EOHHS will allow CHA to report on the HQEIP measure set with adaptations (described below and detailed in the technical specifications). EOHHS is allowing these adaptations because CHA does not participate in the Clinical Quality Incentive (CQI) program from which initial hospital-based health equity measures are drawn for PY 1. Specifically:

    a. EOHHS will allow CHA to substitute Tobacco Use Screening and Treatment Measures (TOB 1-3, listed below) in lieu of CCM Measures (CCM 1-3). These replacement measures will be reported separately for the Medicaid and served uninsured patient populations:
        - Tobacco Use Screening (TOB-1) *(NQF 1651, Joint Commission)* (for CHA medical, surgical, and maternity inpatient units)
        - Tobacco Use Treatment Provided or Offered (TOB-2) *(NQF 1654, Joint Commission)* (for CHA medical, surgical, and maternity inpatient units)
        - Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) *(NQF 1656, Joint Commission)* (for CHA medical, surgical, and maternity inpatient units).

    The tobacco measures are an area of particular interest to EOHHS relative to the Medicaid population. The Joint Commission sets forth compelling rationale for a focus on these interventions. Tobacco use is the single greatest cause of disease in the United States, according to the Centers for Disease Control and Prevention.[5] Smoking is a known cause of cancer, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases.[6] Evidence-based tobacco dependence interventions – brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved medications – are both clinically and cost effective in reducing the risk of tobacco-related disease and improving outcomes for those already experiencing a tobacco-related disease.[7] Hospitalization is an opportunity to provide cessation assistance.

[5] Centers for Disease Control and Prevention. (2014). *Current cigarette smoking among adults—United States, 2005–2013*. Morbidity and Mortality Weekly Report (MMWR), 63(47), 1108–1112. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6347a4.htm?s_cid=mm6347a4_w.

[6] U.S. Department of Health and Human Services. (2014). *The health consequences of smoking—50 years of progress: A report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf .

[7] Rigotti, N. A., Clair, C., Munafo, M. R., & Stead, L. F. (2012). *Interventions for smoking cessation in hospitalised patients*. Cochrane Database of Systematic Reviews. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/22592676.U.S. Department of Health and Human Services. (2008). *Tobacco use and dependence guideline panel. Treating tobacco use and dependence: 2008 update*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK63952/.U.S. Department of Health and Human Services. (2000). *Reducing tobacco use: A report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

b. EOHHS will allow CHA to report the same hospital-based quality measures for the Medicaid and served uninsured patient populations with the exception of the perinatal measures, which will be reported for the Medicaid population only (since served uninsured patients are likely to become eligible for Medicaid if they are pregnant and are anticipated to be captured in the Medicaid population). For the served uninsured population, in lieu of perinatal measures, CHA will report Follow-up After Hospitalization (for medical and surgical discharges), which is an important indicator for served uninsured patients.

c. Measures will be reported separately for the served uninsured and Medicaid patient populations, unless the measure specification calls for reporting on an all-payer population.

Approved technical specifications for the CHA-HQEIP PY1 metrics will be made available through the Commonwealth's website and describe measure requirements in more detail.[8]

Table 2. CHA-HQEIP Hospital Component adaptations to HQEIP reporting/performance requirements for PY 1

Metric	**Reporting/Performance Requirements for PY 1 & Anticipated Due Dates**	
	HQEIP Requirements	**Adapted Requirements for the CHA-HQEIP, if any**
Domain 1. Demographic and Health-Related Social Needs Data		
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Timely (**anticipated by December 31, 2023, or a later date as specified by Massachusetts**) submission to the Massachusetts Center for Health Informatics and Analysis of the "*Enhanced Demographics Data File*," defined as the file including member-level demographic (including race, ethnicity, language, disability, sexual orientation, and gender identity) data collected by hospitals from MassHealth members during inpatient stays and/or emergency department visits during the Performance Year.	CHA will submit a single file for Medicaid and served uninsured patients for this metric
Screening for Social Drivers of Health (*CMS): Preparing for Reporting Beginning in PY2*	Complete and timely (**December 1, 2023**) submission of a report to EOHHS describing: 3) One or more HRSN screening tool(s) selected by the hospital for intended use in screening patients beginning in PY 2; the selected tool(s) must meet	CHA will submit one report covering the Medicaid and served uninsured patient population for this metric, which will

[8] https://www.mass.gov/masshealth-quality-and-equity-incentive-programs

	requirements for screening tools for the "Screening for Social Drivers of Health" metric; and 4) A plan to begin screening for HRSN in inpatient settings in Q1 CY 2024 in order to have capacity to report on the "Screening for Social Drivers of Health" metric beginning in PY 2.	include a section discussing aspects specific to the served uninsured population.
Domain 2. Equitable Quality and Access		
Stratified Reporting of Quality Data (*EOHHS*)	Complete and timely (**anticipated by a date following December 31, 2023**, to be determined by EOHHS) submission to EOHHS of performance data including member-level race and ethnicity for clinical measures selected by EOHHS for stratification from the Clinical Quality Incentive (CQI) measure slate and as described in Section 3.B of this Appendix C.	CHA will separately report stratified quality measures for the Medicaid and served uninsured patient population. See technical specifications related to the filing of population-based electronic measures and adaptations with aligned measures.
Equity Improvement Interventions (*EOHHS*)	Complete and timely submission of quarterly deliverables for at least one ACO-partnered Performance Improvement Plan (PIP) as follows: 1) Q1: Complete and timely (**anticipated by March 31, 2023**) submission to EOHHS of Hospital Key Personnel/Institutional Resources Document 2) Q2: Complete and timely (**anticipated by July 21, 2023**) submission to EOHHS of the PIP Partnership Form 3) Complete and timely (**anticipated by September 30, 2023**) submission to EOHHS of the ACO Key Contact Form and the Mid-Year Planning Report 4) Complete and timely (**anticipated by December 31, 2023**) submission to EOHHS of the PIP Planning/Baseline Report, a comprehensive plan that incorporates information about PIP goals and objectives,	CHA will develop the PIP related to the Medicaid ACO population. It is not applicable for the served uninsured patient population.

	baseline data, proposed interventions, and tracking measures. The PIP Planning/Baseline Report will serve as the blueprint for PIP Implementation in PY 2.	
Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English (*Oregon Health Authority*)	Complete and timely (**anticipated by December 31, 2023,** or an earlier date specified by EOHHS) reporting of an organizational self-assessment of capacity related to providing access to high quality language services to patients.	None for PY 1 Note: EOHHS expects to require CHA to separately report percent of member visits with interpreter needs in which interpreter services were provided for the Medicaid and served uninsured patient populations, beginning in PY 2.
Disability Competencies (*EOHHS*)	Complete and timely (**anticipated by December 1, 2023**) submission to EOHHS of the following: The Hospital's DCC Team's completed Resources for Integrated Care (RIC) Disability-Competent Care Self-Assessment Tool (DCCAT)[1] Report that includes the following: 5) The members that composed the Hospital's Disability Competent Care (DCC) Team. The members included on the Hospital's DCC Team can be decided by the hospital and which should represent a reasonable mix of clinical and non-clinical patient-facing staff from different clinical departments. Further, we strongly recommend including individuals with disability on the Hospital's DCC Team. 6) The summary results from the Hospital DCC Team's DCCAT-Hospital tool exercise. Hospitals will have freedom to further modify the 'base' DCCAT-Hospital Tool, e.g., remove, change, or add new questions so long as the hospital submits documentation of (as part of their report) the modifications made along with the reason(s) for the modification(s).	CHA will submit one file the Medicaid and served uninsured patient population for this metric.

	7) Informed by the results of the DCCAT-Hospital tool exercise above, hospitals will identify at least three (of seven) Disability Competent Care (DCC) Model Pillars that the hospital plans to target for improvement beginning in PY 2, based on interpretation of the results from this exercise. 8) Lessons learned in narrative form by the hospital by creating this team and completing this DCCAT self-assessment exercise. Complete and timely (**anticipated by December 1, 2023**) submission to EOHHS of a plan for improving competency in targeted competency areas during PY 2, including: 4) selected training tools and/or educational resources, 5) which staff that will be assessed for post-educational/training competency, and 6) approaches that will be used to assess post-education/training organizational and staff competency. This plan must describe how the hospital will be prepared to begin reporting performance in PY 2 on a process measure (in development by EOHHS) beginning in PY 2 that assesses the percent of patient-facing staff demonstrating competency in targeted competency areas for improvement.	
Accommodation Needs Met (*EOHHS)*	Complete and timely (**anticipated by December 1, 2023**) submission to EOHHS of a report describing the hospital's current practice and future plans for the following: 1) screening patients for accommodation needs** before or at the start of a patient encounter, and how the results of this screening is documented. 2) other methods, if any, for documenting accommodation needs. 3) asking patients, at or after the end of a patient encounter, if they felt that their accommodation needs were met. 4) analyses that are performed at the organizational level to understand whether accommodation needs have been met.	CHA will submit one report covering the Medicaid and served uninsured patient population for this metric.

	*** For this report, accommodation needs are needs related to a disability, including disabilities as a result of a physical, intellectual, or behavioral health condition. For this report, this does not include needs for language interpreters, but does include accommodation needs for vision impairments (e.g., Braille) or hearing impairments (e.g., ASL interpreters).*	
Domain 3. Capacity and Collaboration		
Achievement of External Standards for Health Equity (*EOHHS)*	Complete and timely (**anticipated by December 31, 2023**) submission to EOHHS of an attestation that the hospital has completed The Joint Commission (TJC) surveys for health equity accreditation standards (specifically, 6 new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.)	CHA will submit one attestation for this metric.
HCAHPS: Patient Experience: Communication, Courtesy and Respect (*AHRQ)*	Complete and timely (**anticipated by a date following December 31,2023 to be determined by EOHHS**) submission to EOHHS of HCAHPS survey results for any MassHealth members participating in the hospital's HCAHPS survey sample during PY 1.	CHA will submit HCAHPS survey results related to MassHealth members for this metric.
Joint Accountability for ACO Performance (*EOHHS*)	In order to promote collaboration and coordinated interventions to promote health equity across health system settings and across the spectrum of ambulatory and inpatient care, acute hospitals will be required to partner with at least one and no more than two ACO(s) (identified as "Partnered ACO(s)") serving a shared population in order to augment impact on health equity. To incentivize shared investment and goals across ACO and hospital entities, hospitals' performance in this subdomain for PY 1 will equal its Partnered ACO's Health Equity Score; if the hospital has more than one ACO Partner then its subdomain score will equal the average of each Partnered ACO's Health Equity Score. Partnered ACOs will be held accountable for health equity performance in the same domains as their Partnered Hospitals, tailored to the ACO setting:	CHA will participate in this metric for its MassHealth ACO members. It is not applicable for the served uninsured patient population.

	• Demographic data completion • HRSN screening and referrals • Stratified Reporting of Quality Data • Equity Improvement Interventions • Language Access • Disability Access and Accommodation • Achievement of External Standards for Health Equity • Member Experience: Cultural Competency Each of these accountability components will contribute to the ACO's Health Equity Score.	

In the event that a measure is retired by a measure steward for any reason, Massachusetts will 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.

MassHealth will score CHA on each measure unless it does not meet eligibility requirements for a specific measure (e.g., it does not meet the minimum denominator requirement or other technical requirements). If this occurs, the weight attributed to such a measure will be redistributed equally to other measures in the same domain. Beginning in PY3, if CHA is unable to meet the minimum denominator or other technical requirements for at least 50% of the measures on the CHA-HQEIP metrics slate and 50% of the Ambulatory performance metrics slate for a performance period, CHA's participation in the CHA-HQEIP will be suspended for that performance period.[9] CHA may resume participation when it is able to meet the minimum denominator or other technical requirements for at least 50% of the measures on the CHA-HQEIP metrics slate and 50% of the Ambulatory performance metrics slate, provided that such participation shall begin at the start of the subsequent performance period and provided that the CHA will be held accountable for the performance year requirements immediately following the last performance year in which CHA participated.

C. Ambulatory Performance Component of the CHA-HQEIP: Metrics and Reporting Requirements for PY 1

For the ambulatory performance component of the CHA-HQEIP, the targeted population includes MassHealth members and the "served uninsured population" defined as patients who received at least one primary care visit from CHA during the performance year who have:

[9] This approach will be used to account for any unexpected circumstances (e.g., fire or flood), that may lead to reduced services, as determined by the state.

1. MassHealth Limited (emergency Medicaid), including those with Health Safety Net (HSN) as a secondary safety net program;
2. Health Safety Net including primary, secondary, partial, confidential, or bad debt; or
3. Children's Medical Security Plan, with HSN and/MassHealth Limited as secondary programs.

Ambulatory performance will be demonstrated in three domains, aligned with HQEIP and CHA-HQEIP hospital component domains, during PY 1. Performance metrics expectations for the ambulatory performance component of the CHA-HQEIP are described below and in Table 3; additional detail related to performance metrics is provided in ambulatory metric technical specifications for the CHA-HQEIP.

1. Ambulatory Domain 1: Health-Related Social Needs

CHA will be assessed on improvements to address the health-related social needs of the served uninsured patient population in the public hospital's primary care system.

2. Ambulatory Domain 2: Equitable Quality and Access

CHA will be assessed on improvements in three areas of equitable access and quality:

- **Ambulatory Quality Reporting and Performance:** CHA will be assessed on performance reporting of ambulatory quality and access metrics for the served uninsured population in the public hospital's primary care system. Measure categories include: 1) Wellness, Prevention, and Screening 2) Chronic Health Conditions; 3) Access; and 4) Outreach & Care Coordination. Initial measures for stratification in PY 1 are identified in Table 3. Based on the initial development of measures in PY 1 and ongoing findings, adjustments and/or replacement measures may be proposed in future years based on the findings, denominator size, assessment of opportunities, etc., for incorporation in PY 2 - 5.

- **Ambulatory Quality Improvement Initiative(s):** CHA will develop performance improvement milestone(s) that address inequities in the served uninsured patient population. Projects may include healthcare delivery system intervention(s) on defined ambulatory measure(s) or underserved geographic-based or patient population intervention(s). Milestones to be completed include pre-approved initiative elements, a submitted mid-point assessment report, and a final achievement report. The final achievement report will be adjudicated and scored by EOHHS following the end of the performance year.

- Additionally, CHA will identify and measure progress towards disparities reduction on a subset of identified ambulatory measures during the progression of the demonstration period, with pay-for-performance on disparities reduction achievement on a subset of measures no earlier than PY 4.

3. Ambulatory Domain 3: Capacity and Collaboration

CHA will be assessed on improvement in metrics such as collaboration between health system partners and the community to address opportunities for health care for the served uninsured and underserved patient populations.

Table 3. CHA-HQEIP Ambulatory Performance Component: PY 1 Metrics and Summary of Performance Expectations

CHA-HQEIP Ambulatory Performance Domain	**Metric**	**Performance Expectations for PY 1 (*Status*)**
Ambulatory Domain 1. Health-Related Social Needs		
Health-Related Social Needs	**Resource Listing to Respond to Health-Related Social Needs for the Underserved:** Submission to EOHHS of an updated resource listing and description of workflows for referral to resources to address health-related social needs, including for underserved populations.	Complete and timely **(anticipated by December 1, 2023)** submission of a health-related social needs resource listing and overview. (*P4R)*
Ambulatory Domain 2. Equity Quality and Access		
Ambulatory Quality Reporting and Performance	**Reporting of Ambulatory Quality Data for Served Uninsured Patients in public hospital's primary care system:** ● Well-Child Visits in the First 30 Months of Life ● Child and Adolescent Well Care Visit ● Childhood Immunization (CIS-CH) ● Immunization for Adolescents ● Cancer Screening Measure(s) TBD ● Hypertension: Controlling high blood pressure (CBP-AD) ● Comprehensive Diabetes Care: Poor Control (>9%) (HPC-AD) ● Achieve Outreach to Defined % of New or Past Due Served Uninsured Patients in Primary Care Panel Population ● Diabetes & Hypertension Education ● Depression Screening and Follow-up	Complete and timely (**by March 30, 2024)** submission to EOHHS of ambulatory quality measure performance data for served uninsured patients in the public hospital's primary care system for the ambulatory measures in Table 6. (*P4R)*
	Needs Assessment and Analysis of Served Uninsured Patient Population: Gather	Complete and timely **(anticipated by December 1,**

Ambulatory Quality Improvement Initiatives	information and assess opportunities for improving care delivery for the served uninsured, such as through data, patient and provider focus groups/interviews, incorporating information from the public hospital system's recent community regional well-being assessment to inform future year efforts.	**2023)** submission to EOHHS of a needs assessment report and analysis of the served uninsured patient population which may include: Information gathered and assessment of opportunities for improving care delivery for the served uninsured, such as through data, patient and provider focus groups/interviews and incorporating information from the public hospital system's recent community regional wellbeing assessment to inform future year efforts. (*P4R)*
	Equity Improvement Intervention	Complete and timely submission of deliverables for one Performance Improvement Project Plan milestone for implementation beginning in PY 2 as follows: ● Complete and timely (**by December 31, 2023**) submission to EOHHS of the Performance Improvement Project Plan Milestone Planning Report
Ambulatory Domain 3. Capacity and Collaboration		
	Completion of Supplement to the Health Equity Strategic Plan	Complete and timely **(by December 31, 2023)** submission to EOHHS of a supplement to the required Health Equity Strategic Plan (EOHHS) specifically addressing the health equity strategy for the served uninsured population. (*P4R*)

D. Hospital Performance Component of the CHA-HQEIP: Metrics for PYs 2-5

Performance years 2-5 of the CHA-HQEIP will hold CHA accountable to metrics (listed in Table 4) evaluating performance in each CHA-HQEIP domain. These metrics were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement. In the event that a measure is retired by a measure steward for any reason, Massachusetts will 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 assessments. Approved technical specifications for the CHA-HQEIP PY2-5 metrics may be updated annually or more frequently as necessary and will be made available through the Commonwealth's website.

Table 4. PY 2-5 Metrics for the Hospital Performance Component of the CHA-HQEIP

Domain*	Measure Name	Measure Description	Data Source	Measure Steward^	Payment Status**			
					2024	2025	2026	2027
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	Percentage of members with acute hospital discharge within the measurement year with self-reported RELDSOGI data.	Administrative/ Supplemental	EOHHS	R	P	P	P
	Health-Related Social Needs (HRSN) Screening	Two rates: 1) HRSN Screening Rate: Percentage of acute hospital discharges where members were screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; 2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with acute hospital discharges in Rate 1.	Supplemental	EOHHS (CMS~)	R	P	P	P
EQA	Quality Performance Disparities Reduction	Acute hospital progress towards reducing racial and ethnic disparities in quality performance. Quality measure identified for inclusion in this measure are disparities-sensitive measures in the areas of coordination of care, perinatal health, and/or care for acute and chronic conditions.	Administrative/ Supplemental	EOHHS	R	R	P	P
	Equity Improvement Interventions	Assessment of rigorous design and implementation of two equity-focused performance improvement projects (PIPs) focused on coordination of care, perinatal health, and/or care for acute and chronic conditions.	Supplemental	EOHHS	P	P	P	P
	Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English	Two components: 1) Language Access Self-Assessment Survey: Completion and reporting of a language access self-assessment survey; and 2) Addressing Language Access Needs in Acute Hospital Settings: Percentage of acute hospital stays serving members who report a preferred language other than English during which either interpreter services or an in-language service provider were utilized.	Administrative/ Supplemental	EOHHS (OHA^)	R	P	P	P
	Disability Competent Care	Percent of applicable patient-facing acute hospital staff who, in the past 24 months, 1) completed disability competency training to address Disability Competent Care (DCC) pillars selected by the hospital in its DCC Training Plan Report and 2) demonstrated competency in the relevant disability competency training area(s).	Supplemental	EOHHS	P	P	P	P
	Disability Accommodation Needs	Percentage of acute hospital discharges and/or encounters where 1) members with disability were screened for accommodation needs related to a disability, and, 2) for those members screening positive for accommodation needs, a corresponding member-reported accommodation need was identified.	Supplemental	EOHHS	R	P	P	P
CC	Achievement of External Standards for Health Equity	Assessment of whether acute hospitals have achieved standards related to health equity established- by The Joint Commission for its "Health Care Equity Certification."	Supplemental	EOHHS	R	P	P	P
	Patient Experience: Communication, Courtesy and Respect	Assessment of MassHealth member perceptions of their hospital experience utilizing reported elements of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patients' perspectives of hospital care experience related to communication, courtesy, and respect. .	Supp/Survey	EOHHS	R	P	P	P
	Collaboration	Assessment of participating acute hospital collaboration with health system partners to promote high quality and equitable care.	Supplemental	EOHHS	P	P	P	P

*DHRSN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access; CC=Capacity and Collaboration; ** R=Pay-for-Reporting, P=Pay-for-Performance
^ EOHHS=Massachusetts Executive Office of Health and Human Services; CMS=Centers for Medicare & Medicaid Services; OHA=Oregon Health Authority
~ Adapted for HQEIP use from CMS "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" metrics

In general, measures included in the CHA-HQEIP closely align with specifications for the HQEIP for the majority of measures, adapted minimally to additionally encompass both the Medicaid population and CHA's served uninsured population.[10] For two measures, the **Quality Performance Disparities Reduction** and the **Meaningful Access to Healthcare Services for Persons a Preferred Language Other than English** metrics, EOHHS will make additional adaptations specific to the CHA-HQEIP, as follows:

3) For both metrics, EOHHS will allow CHA to annually report population-based electronic measures (drawn from the electronic health record) in lieu of chart-abstraction/sampling. This is aligned with EOHHS' goals toward population-based data collection. Measures will be submitted following the year-end utilizing an EOHHS-approved template consistent with the CMS and Joint Commission portal fields used for e-measures.

4) For the **Quality Performance Disparities Reduction** metric, EOHHS will allow CHA to report on the HQEIP measure set with adaptations (described in Table 5 and detailed in the technical specifications). EOHHS is allowing these adaptations because CHA does not participate in the Clinical Quality Incentive (CQI) program from which initial hospital-based health equity measures are drawn for PY 2-5. Specifically:

    d. EOHHS will allow CHA to substitute Tobacco Use Screening and Treatment Measures (TOB 1-3, listed below) in lieu of CCM Measures (CCM 1-3). These replacement measures will be reported separately for the Medicaid and served uninsured patient populations:
        - Tobacco Use Screening (TOB-1) *(NQF 1651, Joint Commission)* (for CHA medical, surgical, and maternity inpatient units)
        - Tobacco Use Treatment Provided or Offered (TOB-2) *(NQF 1654, Joint Commission)* (for CHA medical, surgical, and maternity inpatient units)
        - Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) *(NQF 1656, Joint Commission)* (for CHA medical, surgical, and maternity inpatient units).

    e. EOHHS will allow CHA to report the same hospital-based quality measures for the Medicaid and served uninsured patient populations with the exception of the perinatal measures, which will be reported only for the Medicaid population (since served uninsured patients are likely to become eligible for Medicaid if they are pregnant and are anticipated to be captured in the Medicaid population). For the served uninsured population, in lieu of perinatal measures, CHA will report Follow-up After Hospitalization (for medical and surgical discharges), an important indicator for served uninsured patients.

[10] The served uninsured population are patients who have the following:
- MassHealth Limited (emergency Medicaid), including those with Health Safety Net (HSN) as a secondary safety net program;
- Health Safety Net including primary, secondary, partial, confidential, or bad debt; or
- Children's Medical Security Plan, with HSN and/MassHealth Limited as secondary programs.

f. Measures will be reported separately for the served uninsured and Medicaid patient populations unless the measure specification calls for reporting on an all-payer population.

Table 5. CHA-HQEIP Hospital Component Adaptations to HQEIP Reporting/Performance Requirements for PY 2-5

Metric	HQEIP Measure Description	Adapted Requirements for the CHA-HQEIP, if any
Domain 1. Demographic and Health-Related Social Needs Data		
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Percentage of members with acute hospital discharges within the measurement year with self-reported RELDSOGI data.	Single file submission separately reporting Medicaid and served uninsured patients. EOHHS may consider separate targets for the served uninsured patients and Medicaid patients, including based on initial performance.
Health-Related Social Needs Screening (*EOHHS)*	Two rates: 1) HRSN Screening Rate: Percentage of acute hospital discharges where members were screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; and 2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with acute hospital discharges in Rate 1.	CHA will separately report rate for Medicaid and served uninsured patients. EOHHS may consider separate targets for the served uninsured patients and Medicaid patients, including based on initial performance.
Domain 2. Equitable Access and Quality		
Quality Performance Disparities Reduction (*EOHHS*)	Assessment of improvement towards and/or achievement of reduced disparities in quality performance between racial and/or ethnic or other subgroups on measures prioritized for disparities by EOHHS, including focused on coordination of care, perinatal health, and/or care for acute and chronic conditions.	CHA will separately report stratified quality measures for the Medicaid and served uninsured patient population. Please see the adaptations on the quality performance measures noted above (and in the technical specifications). Recognizing that the served uninsured patient population is unique, the measures for improvement, specific measurement and performance assessment methodology, inclusive of approach for improvement targets and/or methodology will be developed for the served uninsured.

Equity Improvement Interventions (*EOHHS*)	Assessment of rigorous design and implementation of two equity-focused performance improvement projects (PIPs) focused on coordination of care, perinatal health, and/or care for acute and chronic conditions.	CHA will develop the second PIP related to the Medicaid population inclusive of the Medicaid ACO population.
Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English (*EOHHS*)	Two components: 1) Language Access Self-Assessment Survey: Completion and reporting of a language access self-assessment survey; and 2) Addressing Language Access Needs in Acute Hospital Settings: Percentage of acute hospital stays serving members who report a preferred language other than English during which either interpreter servings or an in-language service provider was utilized.	CHA will separately report percent of member visits with interpreter needs in which interpreter services were provided for the Medicaid and served uninsured patient populations.
Disability Competent Care (*EOHHS*)	Percentage of patient-facing acute hospital staff who, in the past 24 months, 1) completed disability competency training to address Disability Competent Care (DCC) pillars selected by the hospital in its DCC Training Plan Report, and 2) demonstrated competency in the relevant disability competency training area(s). .	None
Disability Accommodation Needs (*EOHHS)*	Percentage of acute hospital discharges and/or encounters where 1) members with disability were screened for accommodation needs related to a disability, and 2) for those members screening positive for accommodation needs, a corresponding member-reported accommodation need was identified.	CHA will separately report rates for Medicaid and served uninsured patients.
Domain 3. Capacity and Collaboration		
Achievement of External Standards for Health Equity (*EOHHS)*	Assessment of whether acute hospitals have achieve standards related to health equity established by The Joint Commission for its "Health Care Equity Certification."	None
Patient Experience: Communication Courtesy and Respect	Assessment of MassHealth member perceptions of their hospital experience utilizing reported elements of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patients' perspectives of hospital care experience related to communication, courtesy, and respect. .	None
Collaboration	Assessment of participating acute hospital collaboration with health system partners to promote high quality and equitable care.	None

E. Ambulatory Performance Component of the CHA-HQEIP: Metrics for Performance Years 2-5

For the ambulatory performance component of the CHA-HQEIP, the targeted population includes the "served uninsured patient population" defined as patients active in CHA's public hospital primary care system (according to the metric descriptions in the technical specifications) who have:

1. MassHealth Limited (emergency Medicaid), including those with Health Safety Net (HSN) as a secondary safety net program;
2. Health Safety Net including primary, secondary, partial, confidential, or bad debt; or
3. Children's Medical Security Plan, with HSN and/MassHealth Limited as secondary programs.

Ambulatory performance will be demonstrated in three domains, aligned with HQEIP and CHA-HQEIP hospital performance component domains, during PY2-5. Performance metrics expectations for the ambulatory performance component of the CHA-HQEIP are described below and in Table 6; additional detail related to performance metrics is provided in ambulatory metric technical specifications for the CHA-HQEIP.

Ambulatory Domain 1: Health-Related Social Needs
CHA will be assessed on improvements to address the health-related social needs of the served uninsured patient population in the public hospital's primary care system.

Ambulatory Domain 2: Equitable Quality and Access
CHA will be assessed on improvements in three areas of equitable access and quality:

- **Ambulatory Quality Reporting and Performance:** CHA will be assessed on performance reporting of ambulatory quality and access metrics for the served uninsured patient population in the public hospital's primary care system. Measure categories include: 1) Wellness, Prevention, and Screening 2) Chronic Health Conditions; 3) Access; and 4) Outreach & Care Coordination. Adjustments and/or replacement measures may be proposed in future years based on the initial development of measures in PY1, ongoing findings, denominator size, assessment of opportunities, etc.

- **Ambulatory Quality Improvement Initiative:** CHA will develop and implement no more than one performance improvement milestone at a time during each performance period that addresses inequities in the served uninsured patient population. The project may include a healthcare delivery system intervention on a defined ambulatory measure or underserved geographic-based or patient population intervention. Milestones to be completed include pre-approved initiative elements, submitted mid-point assessment report, and a final achievement report. The final achievement report will be adjudicated and scored by EOHHS following the performance year-end.

- Additionally, CHA will identify and measure progress towards disparities reduction for the served underinsured patient population on a subset of identified ambulatory measures during the progression of the demonstration period, with pay-for-performance on disparities reduction achievement on a subset of measures no earlier than PY4. Disparities are aimed to be identified for the served uninsured patient population as a whole (as compared to other patient populations in their system).

Ambulatory Domain 3: Capacity and Collaboration

CHA will be assessed on improvement in metrics such as collaboration between health system partners and the community to address opportunities for health care for the served uninsured and underserved patient populations.

Table 6. CHA HQEIP Ambulatory Performance Component: Performance Year 2-5 Metrics and Summary of Performance Expectations

Domain	Measure Name	Measure Description	Data Source	Measure Steward^	Payment Status R=reporting P=performance			
					2024	2025	2026	2027
HRSN	**Health-Related Social Needs (HRSN) Screening**	Two rates: (1) HRSN Screening Rate: Percentage of served uninsured patients with an encounter in CHA's primary care system screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; and (2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with an encounter in CHA's primary care system in Rate 1..	Supplemental	EOHHS (CMS~)	R	R	P	P
EQA	**Quality Performance Disparities Reduction**	Submission to EOHHS of ambulatory quality measure performance data for served uninsured patients in the public hospital's primary care system. This measure assesses quality performance for the served uninsured subgroup for the purpose of identifying, monitoring, and improving upon disparities. Quality measures identified for inclusion in this measure are prioritized for disparities by EOHHS.	Supplemental	EOHHS	R	R	P	P
	Needs Assessment and Analysis of Served Uninsured Patient Population	Submission to EOHHS of a needs assessment report and analysis of the served uninsured patient population.	Supplemental	EOHHS	R	R	R	R
	Equity Improvement Intervention	Assessment of development and implementation of one performance improvement milestone that addresses inequities in the served uninsured patient population. Milestones to be completed include pre-approved initiative elements, submitted mid-point assessment report, and a final achievement report.	Supplemental	EOHHS	P	P	P	P
CC	**Community Collaboration Equity Improvement Intervention**	Assessment of development and implementation of one performance improvement milestone that addresses inequities in the served uninsured patient population through collaboration with a CHA community health function and/or community partnerships. Milestones to be completed include pre-approved initiative elements, submitted mid-point assessment report, and a final achievement report.	Supplemental	EOHHS	P	P	P	P
	Completion of Supplement to the Health Equity Strategic Plan	Submission to EOHHS of a supplement to the required Health Equity Strategic Plan (EOHHS) specifically addressing the health equity strategy for the served uninsured population.	Supplemental	EOHHS	R	R	R	R

~ Adapted for HQEIP use from CMS "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" metrics

F. Additional Detail on Identification of Health-Related Social Needs Screening and Referrals

Additional detail on identification of health-related social needs and health-related social needs referrals that pertain to the hospital-based component of the CHA-HQEIP is described in Attachment J, Section 3.D.

Section 4: CHA-HQEIP Payment and Corrective Action Plan

A. CHA-HQEIP Payment

Payment for the HQEI that pertains to the HQEIP is described in Attachment J, Section 4.A. Payment pertaining to the CHA-HQEIP is described here in this Appendix C.

Section 1115 expenditure authority will support the launch and maintenance of the CHA-HQEIP to improve health care quality and equity. Table 7 shows the annual expenditure authority for the CHA-HQEIP by demonstration and performance years, as well as the allotments for hospital and ambulatory performance in accordance with STC 14.17.

Table 7. Annual Expenditure Authority Allotments for the CHA HQEIP (in millions)

	PY 1		PY 2	PY 3	PY 4	PY 5
	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
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

In PY 1, MassHealth intends to make four interim payments and one reconciliation payment to CHA accounting for performance on both hospital and ambulatory components. In order to receive interim payments, CHA must meet key hospital and ambulatory milestones ("gates") determined by Massachusetts to be foundational to successful performance in the CHA-HQEIP; these "gates" are a form of "pay-for-reporting" where timely and complete submission of gate deliverables will be required for interim payments to be made. Interim payments include both hospital and ambulatory performance dollar amounts. Across these interim payments, Massachusetts will withhold 10% of CHA's maximum annual incentive payment. As appropriate, the remaining 10% will be paid out as a reconciliation payment in CY 2024, based on CHA's final PY 1 health equity performance determined by performance on the CHA-HQEIP metric slate and successfully meeting payment gate reporting deliverables; if at the conclusion of PY 1 CHA's performance results in earning less than 90% of its allocated incentive amount, funds will be recouped in the reconciliation payment

process to ensure CHA is paid only what it earns on the basis of its CHA-HQEIP performance for PY1. The Health Quality and Equity Independent Assessor is not required to review relevant submissions (as described in Attachment J, Section 10.B. before interim payments are made. If the Independent Assessor's review finds that gating deliverables were not complete, then reconciliation payment may be withheld until they are re-submitted and complete.

While they are aligned with gates for the HQEIP for private hospitals, CHA payment gates (Table 8) are specific to the CHA-HQEIP program and incorporate additional expectations relevant to the ambulatory performance component of the program. DY 27 amounts will be payable as part of the Q4 2022 payment and gate.

Table 8. CHA-HQEIP Payment Gates

Gated Payment	Gate Description	Anticipated Gate Deliverable Due Date
Q4 2022 Payment	**Participation Attestation** – Timely and complete submission to MassHealth of an attestation to participate in the HQEIP for PY 1, including an attestation to collaborate with an ACO (or a request for exemption from the ACO collaboration requirement.)	Dec 19, 2022 or date specified by EOHHS
Q1 2023 Payment	**Qualified Interpreters Attestation** – Complete and timely submission to MassHealth of an attestation that, by December 31, 2023, the hospital will implement a process for qualifying language interpreters.	Mar 31, 2023
Q2 2023 Payment	**RELD SOGI Assessment** – Timely and complete submission to MassHealth of an initial assessment of 1) beneficiary-reported demographic data adequacy and completeness, and 2) a proposed plan for collecting demographic data including data sources. MassHealth anticipates collecting additional information about data submission plans in advance of the submission of the Enhanced Demographic Data File.	June 2, 2023
	HRSN Assessment – Timely and complete submission to MassHealth of an initial assessment of 1) beneficiary-reported health related social needs data adequacy and completeness, and 2) strategies employed to provide information about community resources and support services. Aligned with HQEIP with the addition of an ambulatory assessment related to served uninsured patients served in the public hospital's primary care system.	June 2, 2023
Q3 2023 Payment	**Disability Competency Self-Assessment Attestation**– An attestation that the hospital is working towards timely and	September 18, 2023

	complete submission to Massachusetts of a report on the results of the disability competencies self-assessment, including identified disability competencies targeted for improvement in PY 2.	
Reconciliation Payment	**Health Equity Strategic Plan** – Timely and complete submission to MassHealth of a Health Equity Strategic Plan as required by EOHHS. Aligned with HQEIP with the addition of an added component of the strategic plan describing strategy related to serving CHA's served uninsured population.	Dec 31, 2023

In each year PY2-5 of the HQEIP, Massachusetts intends to make four interim payments to CHA and complete one performance reconciliation that may lead to a further payment or a recoupment. Massachusetts will withhold between 10-15% (specific percentage to be determined annually by MassHealth based on prior performance data and other factors) of the CHA's maximum annual incentive payment from their interim payments. Based on CHA's final HQEIP health equity score for each PY, the remaining earned incentive will be paid out as a reconciliation payment in the following calendar year or unearned funds will be recouped, as applicable. Interim payments will be made automatically, with the exception that it is anticipated that the fourth interim payment for each PY will only be paid once the hospital has submitted a complete annual Health Quality and Equity Strategic Plan update (anticipated to be due by the end of the PY). CHA must also submit a supplement to the required Health Quality and Equity Strategic Plan update specifically addressing the health equity strategy for the served uninsured population. Additional quarterly payment "gates" may be instituted at the discretion of MassHealth.

B. CHA-HQEIP Hospital Component Corrective Action Plan

The corrective action plan for the HQEI that pertains to the Hospital Component of the CHA-HQEIP is described in Attachment J, Section 4.B.

C. CHA-HQEIP Ambulatory Component Corrective Action Plan

i. In addition to the CAP process outlined in Section 4.B of this Appendix C for hospital-based measures, CHA will have a CAP process for the ambulatory component of their plan. Beginning in PY3 and annually thereafter through PY5, CHA will be incentivized to improve through a CAP process overseen by MassHealth for their ambulatory performance component. The CAP process will offer CHA an opportunity to identify areas of poor performance on the ambulatory HQEIP slate, evaluate root causes of such poor performance, and use rapid-cycle equity improvement interventions to make progress towards improved performance on ambulatory HQEIP metrics. MassHealth may require CHA to participate in the CAP

process or CHA may choose to voluntarily participate. If performed in a given PY, the CAP process will include the following aspects:

a. To identify a CAP intervention in a given PY, CHA will select an area of underperformance on one or more metrics on the ambulatory HQEIP measure slate. HQEIP measure focus areas must be selected and justified within the first quarter of a CAP-eligible PY using data such as prior year(s) performance data (as available), internal performance monitoring data, and MassHealth monitoring data.
b. To conduct a CAP, CHA must develop a CAP intervention proposal to be submitted to MassHealth within the first quarter of the PY describing the proposed intervention that directly addresses the area of underperformance, including how the proposed interventions will address known root causes and/or obstacles to performance and the hospital's rationale for why addressing the root cause and/or obstacle through the proposed CAP intervention will lead to expected performance improvement. The CAP proposal may include programmatic milestone(s) and must include one or more quantitative key performance indicator(s) and performance targets for such indicators. The key performance indicators should be interim markers of success anticipated to impact performance on an HQEIP metric; they must be designed to allow for frequent monitoring throughout the duration of a CAP intervention. At least one key performance indicator must relate to eliciting direct patient input to inform performance improvement on the targeted HQEIP and/or CAP intervention implementation.
c. MassHealth (together with its vendor(s) as applicable) will evaluate (using criteria such as relevance of the intervention to MassHealth members, feasibility of completion within the required time period, appropriateness of key performance indicators, etc.) and approve CAP proposals, requiring CHA to make modifications prior to approval as necessary to ensure CAP interventions are rigorous and in alignment with programmatic requirements.

   If participating, CHA will implement approved CAP interventions by the end of the given PY, submitting a final report to MassHealth after the end of the PY describing the results of the intervention including performance on key performance indicators or elements.
d. MassHealth will evaluate CAP final reports to determine performance. If CHA achieves targeted milestone(s) and/or key performance indicator(s) it will be eligible to earn health equity score "bonus points," to be added to its ambulatory health equity score for the PY during which the CAP intervention was conducted. Bonus points may increase the health equity score for the ambulatory component of the PY to up to 100% of the eligible amount for the PY; bonus points may not result in CHA's ambulatory health equity score exceeding 100% for the PY.

Section 5. HQEI Accountability Framework (State Accountability to CMS; CHA Accountability to the State) for PY 1

A. State Accountability to CMS for the HQEI

State accountability for the HQEI, which includes the CHA-HQEIP, is described in the Attachment J, Section 5.A.

B. CHA Accountability to the State for the CHA-HQEIP in PY1

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will hold CHA individually accountable for its CHA-HQEIP performance. As described in STC 14.17(c), to determine the total earned incentive payment, Massachusetts will sum the payment earned from CHA's performance described in STC 14.17 and detailed further in Section 3 of this Appendix C, above. Total incentive amounts for CHA for PY 1 of the CHA-HQEIP will be distributed according to the weighting described in Tables 9 and 10.

Table 9. PY 1 CHA Hospital Performance Component Metric Weights

Subdomain	**CHA-HQEIP Metric (*Steward)***	**PY 1 Weight (%)**
Domain 1. Demographic and Health-Related Social Needs Data		**25**
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	15
Screening for Social Drivers of Health: *Preparing for Reporting Beginning in PY 2*	Health-Related Social Needs Screening (EOHHS/*CMS*)	10
Domain 2. Equitable Quality and Access		**50**
Equity Reporting	Quality Performance Disparities Reduction (*EOHHS*) (See Table 2)	10 (5 pertaining to the MassHealth population and 5 pertaining to the served

Subdomain	CHA-HQEIP Metric (*Steward)*	PY 1 Weight (%)
		uninsured population)
Equity Improvement	Equity Improvement Interventions (*EOHHS*)	10
Access	Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English (EOHHS/OHA)	10
	Disability Competent Care (*EOHHS*)	10
	Disability Accommodation Needs (*EOHHS)*	10
Domain 3. Capacity and Collaboration		**25**
Capacity	Achievement of External Standards for Health Equity (*EOHHS)*	10
	HCAHPS: Items Related to Cultural Competency (*AHRQ)*	10
Collaboration	Collaboration (*EOHHS*)	5

Table 10. PY 1 CHA Ambulatory Performance Component Metric Weights

Subdomain	CHA Ambulatory HQEIP Metric (*Steward)*	PY 1 Weight (%)
Domain 1. Health-Related Social Needs		**15**
	HRSN Resource Listing *(EOHHS)*	15
Domain 2. Equitable Quality and Access		**55**
Ambulatory Quality Reporting and Performance	Ambulatory Quality Performance *(EOHHS)*	15
Ambulatory Quality Improvement Initiative(s)	Needs Assessment and Analysis of Served Uninsured Population *(EOHHS)*	25
	Equity Improvement Intervention *(EOHHS)*	15

Subdomain	CHA Ambulatory HQEIP Metric (*Steward)*	PY 1 Weight (%)
Domain 3. Capacity and Collaboration		**30**
	Completion of Served Uninsured Component of Health Equity Strategic Plan *(EOHHS)*	30

C. CHA Accountability to the State for the Hospital Component of the CHA-HQEIP in PY2-5

Acute hospital accountability to the State for the HQEIP, which includes CHA accountability, is described in Attachment J, Section 5.B.

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will hold CHA individually accountable for its CHA-HQEIP performance. As described in STC 14.17(c), to determine the total earned incentive payment, Massachusetts will sum the payment earned from CHA's performance described in STC 14.17 and detailed further in Section 3 of this Appendix C, above. Total incentive amounts for CHA for PY2-5 of the CHA-HQEIP will be distributed according to the weighting described in Tables 11 and 12.

The Performance Assessment Methodology (PAM) Framework outlined in Attachment J, Section 5.B.i, pertains to the hospital component of the CHA-HQEIP, with the exception of measures that include separate reporting of data for the Medicaid and served uninsured populations (outlined in Table 5). MassHealth may determine that unique improvement targets and/or methodology are needed for the served uninsured population, as informed by initial HQEIP performance data and other deliverables. As noted above in Section 3.B. of this Appendix C and Table 5, CHA will separately report stratified quality measures for the Medicaid and served uninsured patient population. Recognizing that the served uninsured patient population is unique, the measures for improvement, specific measurement and performance assessment methodology, inclusive of approach for improvement targets and/or methodology will be developed for the served uninsured.

D. CHA Accountability to the State for the Ambulatory Component of the CHA-HQEIP in PY2-5

MassHealth's framework for the ambulatory component of the CHA-HQEIP PAM, which may be adjusted annually as needed (for example to transition measures from pay-for-reporting to pay-for-performance, accommodate new contextual inputs, address extenuating circumstances impacting performance, etc.), is described below. Measure-specific PAM, including improvement targets and/or methodology and measure score calculation approach,

will be described in each measure specification, to be made available on MassHealth's website, and may be adjusted as needed to account for the unique nature of the population and approaches in the ambulatory component of the CHA-HQEIP.

i. **Benchmarking:** MassHealth will establish performance targets and/or benchmarks no later than the start of the first pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
   a. Benchmarks for quantitative measures will include an attainment threshold and goal benchmark and will be set to apply to the full applicable performance period. To the extent that external benchmarks for the served uninsured population are not available, targets may be defined by improvement over self or other relevant methodology.
   b. Establishment of benchmarks will be informed by inputs such as initial HQEIP performance data, initial ambulatory uninsured performance data, historical hospital data/performance, external data/trends, and/or predetermined performance targets determined by MassHealth.

ii. **Improvement Targets:** MassHealth will establish annual performance improvement targets for performance metrics, as applicable, no later than the start of each pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
   a. Specific approaches for each measure, defined no later than July 1, 2025, will be intended to apply to the full applicable performance period.
      i. Before July 1, 2025, annual "meaningful improvement" targets for HRSN screening specifically (as referenced in STC 14.3.d) will be defined each year in annual updates to the technical specifications; after July 1, 2025, annual "meaningful improvement" targets for the remaining years of the demonstration period (including PY4-5) will be reported to CMS.
   b. The approaches and actual improvement targets may differ by measure based on factors such as performance trends or type of measure; approaches may include year-over-year self-improvement, gap-to-goal percentage point increase, absolute percentage point increases, set milestones and/or goals for improvement.

iii. **Performance Measure Score Calculation**: The performance measure scoring approach will be consistent, as appropriate, with other MassHealth incentive programs or other incentive program practices. MassHealth will establish a methodology for performance measure scoring for each measure, to be specified in technical specifications, no later than the first day of the performance period to which the methodology applies.
   a. **Pay-for reporting (P4R) measures.** P4R measures will be assessed on a pass/fail basis for which the hospital who successfully reports complete and timely data based on each measure's technical specifications will receive full points or credit for the metric.
      b. **Pay-for-performance (P4P) measures.** The performance measure scoring and approach will, as appropriate, be consistent with other MassHealth incentive programs or other incentive program practices.

i. Measure scoring may include the following components for each measure:
    1. Attainment points ranging from 0-10 points
    2. Improvement points ranging from 0-10 points
    3. Potential bonus points (with a cap)
ii. Performance measure scores for each measure may defined as a ratio between 0-1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum number of points allowable for the measure is the sum of the attainment, improvement and potential bonus points with a determined cap. The score will be calculated as follows: *Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.*
iii. Some performance measures may have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then typically equally weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows: *Performance Measure Score = Sum of each (Sub-measure Score X Sub-measure Weighting).*

iv. **Domain Score Calculation**: The domain scoring and approach will, as appropriate, be consistent with other MassHealth incentive programs or other incentive program practices. Domain scoring may include the following components:
    a. Using the predetermined weights specified in Table 11, a domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective performance measure weight: *Domain Score = Sum of each (Performance Measure Score* Performance Measure Weight).*
    b. If CHA is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the eligible performance measures in the domain.

v. **Health Equity Score for the Ambulatory Component of the CHA-HQEIP Calculation**: The overall health equity scoring approach will be consistent with other MassHealth incentive programs or other incentive program practices. Using the predetermined weights specified in Table 11 and STC 14.7, a health equity score will be calculated by taking each domain score and calculating the sum of each domain score multiplied by its respective domain weight: *Health Equity Score for the Ambulatory Component of the CHA-HQEIP = Sum of each (Ambulatory Domain Score * Ambulatory Domain Weight).* Any bonus points earned through ambulatory component Corrective Action Plans (described in Section 4.C of this Appendix C) will then be used to determine the final Health Equity Score for the Ambulatory Component of the CHA-HQEIP, not to exceed 100%.

vi. **Overall Health Equity Score for CHA-HQEIP:** CHA's overall health equity score will equal the weighted sum of the final Health Equity Score for the Ambulatory Component of the CHA (described in Section 5.D of this Appendix C, and accounting

for 30% of the overall Health Equity Score) and the final Health Equity Score for the Hospital Component of the CHA-HQEIP (described in section 5.C of this Appendix C, and accounting for 70% of the overall Health Equity Score). The overall Health Equity Score will be used to calculate CHA's earned incentive payment.

Table 11. Performance Years 2-5 CHA Hospital Performance Component Metric Weights

Domain*	Measure Name	Measure Weight (%) by Performance Year				Domain Weight (%)
		2024	2025	2026	2027	
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness^	10	10	15	15	25
	Health-Related Social Needs (HRSN) Screening^	15	15	10	10	
EAQ	Quality Performance Disparities Reduction^	10	10	20	20	50
	Equity Improvement Interventions	10	10	5	5	
	Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English^	10	10	10	10	
	Disability Competent Care	10	10	5	5	
	Disability Accommodation Needs Met	10	10	10	10	
CC	Achievement of External Standards for Health Equity	10	10	10	10	25
	Patient Experience: Communication, Courtesy and Respect	10	10	10	10	
	Collaboration	5	5	5	5	
TOTAL						**100**

*DHRSN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access; CC=Capacity and Collaboration
^For measures that report separately on the Medicaid and served uninsured patient populations, weighting within the measure will be 75% for Medicaid patients and 25% for the served uninsured patients.

Table 12. Performance Year 2-5 CHA Ambulatory Performance Component Metric Weights

Domain	Measure Name	Measure Weight (%) by Performance Year				Domain Weight (%)
		2024	2025	2026	2027	
DHRSN	Health-Related Social Needs (HRSN) Screening	25	25	25	25	25

EQA	Quality Performance Disparities Reduction	20	20	20	20	45
	Needs Assessment and Analysis of Served Uninsured Population	10	10	10	10	
	Equity Improvement Intervention	15	15	15	15	
CC	Community Collaboration Equity Improvement Intervention	20	20	20	20	30
	Completion of Served Uninsured Component of Health Equity Strategic Plan	10	10	10	10	

Section 6. Analysis and Needs Assessment and Advisory Functions

The Analysis and Needs Assessment activities, HQEI Advisory Committee description, and Independent Assessor information that pertain to the CHA-HQEIP are described in Attachment J, Section 6. Additional descriptions pertaining to the ambulatory served uninsured population will also be included in the needs assessment as described in Table 6.

ATTACHMENT K
Monitoring Protocol for Other Policies (Reserved)

Attachment L
Pricing Methodology for Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs)

The Commonwealth may modify this Attachment with the approval of CMS without amending the STCs.

1. Unified approach to setting Total Cost of Care (TCOC) Benchmarks for Primary Care ACOs and setting prospective Capitation Rates for MCOs and Accountable Care Partnership Plans

Massachusetts will set TCOC Benchmarks for Primary Care ACOs using a uniform methodology that aligns with the methodology for setting prospective Capitation Rates for MCOs and Accountable Care Partnership Plans (Partnership Plans) (together, MCOs, Partnership Plans, and Primary Care ACOs are Managed Care Entities (MCEs)). As described in STC 8.6, Partnership Plans and MCOs will be paid prospectively rated capitation payments, which are subject to annual rate certification, and Primary Care ACOs will share savings and losses with the Commonwealth based on comparison between their TCOC Performance and TCOC Benchmark (i.e., their performance on managing the costs of their attributed or enrolled population). The Commonwealth may also pay Primary Care ACOs' Participating PCPs an enhanced fee-for-service rate for coordination of the care delivered to their attributed Primary Care ACO enrolled members, which will be set forth in the Participating PCP contracts. The TCOC benchmark (for Primary Care ACOs) or prospective Capitation Rate (for MCOs and Partnership Plans) will be developed as follows:

1. A benchmark or rate will be developed for each individual rate cell, where a rate cell is defined as a specific region and rating category (e.g., Rating Category I – Adults in Greater Boston Region).
2. All such benchmarks and rates will be based on a unified base dataset, which will be constructed as follows:
    a) Claims and encounter experience for all Managed Care-eligible lives, including members enrolled in the MCEs and the Primary Care Clinician (PCC) Plan, will be aggregated for a baseline period established annually by the Commonwealth (e.g., one to three years of the most recent available history).
3. Only MCO and Accountable Care Partnership Plan covered services and Primary Care ACO TCOC included services will be included in the base data.
    a) Actual prices paid for covered services during the baseline period will be re-priced to reflect MassHealth FFS rates for those services. The methodology used to re-price services delivered during the base period will be developed by the Commonwealth and be included in the ACPP and MCO rate certifications submitted to CMS.
4. For each rate cell, actuarial methods will be applied to the base dataset to estimate the average per-member per-month total cost of care ("market-rate TCOC"). Actuarial adjustments could account for factors such as, but not limited to, the following:
    a) Changes in member risk and enrollment.
    b) Completion for incurred but not reported encounters in the base data.
    c) Anticipated program changes between the base period and the performance

period.
   d) Cost and utilization trends from the base period to the performance period.
   e) Other adjustments as appropriate.
5. This market-rate TCOC will be consistent across all MCEs within each rate cell, and will be incorporated into the final benchmarks and rates, along with the Network Variance factor as described in the following section.

2. Development and incorporation of the Network Variance Factor in TCOC Benchmarks and prospective Capitation Rates

The Commonwealth will incorporate an MCE-specific Network Variance Factor into the TCOC Benchmarks for Primary Care ACOs and into the prospective Capitation Rates for ACPPs and MCOs.

The Commonwealth will calculate and apply the Network Variance Factor for each MCE, for each Performance Year, as follows:

1. The Network Variance Factor will equal the MCE's projected TCOC divided by the market projected TCOC, after applying adjustments for each MCE's member mix across rate cells and member acuity.
   a) For each MCE, using a similar methodology and adjustments to those used to calculate the market-rate TCOC, the Commonwealth will develop for each rate cell an MCE's historic TCOC based on the cost experience in the base period for the Managed Care eligible members attributed to primary care providers participating in the MCE.
   b) The Commonwealth then projects the MCE-specific costs and the market costs from the base period to the Performance Year. The Network Variance Factor represents the variance between an MCE's projected TCOC and the market projected TCOC that cannot be explained by variation in price or member risk.
2. The Commonwealth will multiply each MCE's market-rate TCOC (after applying adjustments for each MCE's member mix across rate cells and member acuity) by the MCE's Network Variance Factor. The Commonwealth will calculate and apply the Network Variance Factor each year, but intends to place a decreasing weight on the Network Variance Factor over time.
3. Development and incorporation of non-market adjustments in TCOC Benchmarks and prospective Capitation Rates. There will be two adjustments to the market-based standard and MCE-specific TCOC build up described above: 1) the Provider Mix Modifier (relevant to all MCEs) and 2) the Primary Care Sub-Capitation Program (relevant to ACPPs and PCACOs only). These adjustments will be reflected in the core medical capitation rates and TCOC benchmarks.
   a) The Provider Mix Modifier (PMM) is a MCE-specific adjustment that reflects the unique composition of a provider's network and the estimated impact on average payment per unit of service.
   b) Through the tiered portion of the primary care sub-capitation model, increased payment will be tied to enhanced care delivery expectations to catalyze ongoing improvements in primary care services. These tiered payments will be reflected in an ACO-specific manner when developing rates or benchmarks.

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 Periods of July 1, 2017 – December 31, 2027.

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

In accordance with STC 12.4 of the demonstration extension STCs, the previous demonstration period STCs, 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.

Updates to the DSRIP Protocol made during the extension period effective October 1, 2022, do not apply retroactively to the DSRIP Program authorized in the previous Demonstration Approval Period through September 30, 2022.

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	DY27	DY28	DY29	DY30	DY31	DY32	Total	% of Total*
ACOs	$19.1M	$60.4M	$27.1M	$6.1M	$0.0M	$0.0M	$112.6M	**44%**
Community Partners (including CSAs)	$21.7M	$52.8M	$19.5M	$27.1M	$0.0M	$0.0M	$121.1M	**48%**
Statewide Investments	$2.9M	$4.0M	$1.0M	$0.5M	$0.3M	$0.0M	$8.7M	**3%**
State Operations and Implementation	$1.9M	$7.0M	$1.0M	$0.5M	$0.3M	$0.0M	$10.7M	**4%**
Total:	$45.7M	$124.2M	$48.6M	$34.2M	$0.5M	$0.0M	**$253.2M**	

**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 DSRIP budget periods; and (2) a Budget and Budget Narrative for each DSRIP budget period. These documents will detail how ACOs, CPs and CSAs will use DSRIP funding. The Participation Plan will cover the five DSRIP budget periods. 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 DSRIP budget-period 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), with the exception of Budget Period 5, and are thus offset from the State's demonstration years by 6 months.

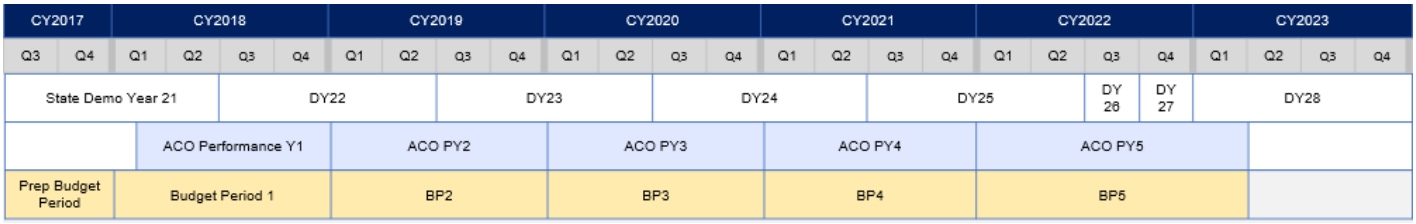
The State will disburse DSRIP funding to ACOs using six "Budget Periods" (BPs) that align with ACO performance years. The State anticipates that the first BP, the "Preparation Budget Period," will begin on July 1, 2017 or when contracts between the State and the ACOs are executed (whichever is later) 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 1-4 (BP 1-4) will each last for one full calendar year, with Budget Period 1 beginning January 1, 2018 and ending December 31, 2018, etc. Budget Period 5 will last 5 quarters, beginning January 1, 2022 and ending March 31, 2023. Please see Exhibit 2 for the schedule of the DSRIP ACO Budget Periods.

EXHIBIT 2 – Schedule of DSRIP ACO Budget Periods



3.1.2 Community Partner and CSA Budget Periods

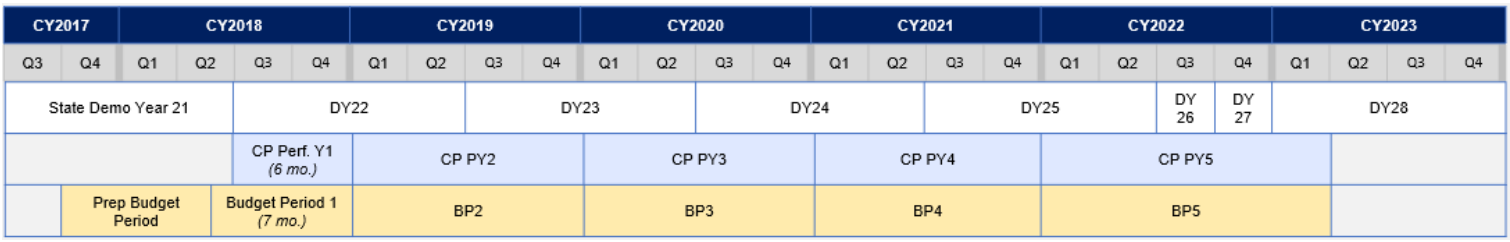
The State's 1115 demonstration years align with the State's fiscal year (July 1 to June 30). Performance years for the State's CP program (i.e., the time periods the State will use to calculate accountability for CPs) align with the calendar year (January 1 to December 31), with the exception of Performance Years 1 and 5, which are six months (from July 1, 2018 to December 31, 2018) and 5 quarters (from January 1, 2022 to March 31, 2023), respectively. 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. Budget Periods 2-4 will each last for one full calendar year, with Budget Period 2 beginning January 1, 2019 and ending December 31, 2019, etc. Budget Period 5 will last 5 quarters, beginning January 1, 2022 and ending March 31, 2023. 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



3.1.3 DSRIP Close-Out Activities and DSRIP Payments Attribution

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)

Programmatic payments, inclusive of performance-based programmatic payments, made in DY 27 and later will be accounted for in the demonstration year during which the payment is made.

For ACO flexible services funding, during the first half of BP5, the State will pay out the BP5 Quarter 1 through Quarter 4 flexible services funding prospectively, based on the ACO's approved BP5 flexible services budgets. The State will pay out BP5 Quarter 5 flexible services funding in BP 5 Quarter 4 and 5, based on updated and approved BP 5 flexible service 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 accounted for in the demonstration year during which the payment is made to CPs. For example, if payments associated with care coordination supports provided in June 2022 are made in June 2024, the payment is accounted for in DY 29.

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 a specific budget period, starting with Budget Period 3, will be accounted for in the demonstration year during which the payment is made.

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 accounted for in the demonstration year during which the payment is made.

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 accounted for in the demonstration year for which the payment is made.

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-budget period 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[1], 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
        - 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

[1] 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.

- 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 budget periods in broad based funding categories.
- Timeline: This section will include a five-budget period 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 end of the fifth budget 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 Budget Period 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-BP 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-BP 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 temple 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: *3 sub-streams*	**LTSS CPs:** *3 sub-streams*	**CSAs:** *1 sub-stream*
● Startup/Ongoing: primary care investment ● Startup/Ongoing: discretionary ● Flexible services ● DSTI Glide Path	● Care coordination ● Infrastructure and Capacity Building ● Outcomes-based		● Infrastructure and Capacity Building

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.

		Prep BP	BP1	BP2	BP3	BP4	BP5	Total
ACOs (Accountability to State)	***Total Funds***	**$138.2M**	**$284.1M**	**$238.0M**	**$192.5M**	**$132.7M**	**$64.0M**	**$1,049.5M**
	At-Risk %	**0%**	**4%**	**10%**	**19%**	**27%**	**20%**	**11%**
	At-Risk Funds	**$0.0M**	**$10.0M**	**$24.1M**	**$36.8M**	**$36.4M**	**$12.9M**	**$120.3M**
Startup/Ongoing: Primary Care Investment (Not At-Risk)	*Total Funds*	*$21.8M*	*$43.6M*	*$29.6M*	*$30.5M*	*$10.5M*	*$10.8M*	*$146.7M*
Startup/Ongoing: Discretionary	*Total Funds*	*$94.9M*	*$165.1M*	*$153.3M*	*$117.2M*	*$86.5M*	*$23.7M*	*$640.7M*
	At-Risk %	*0%*	*5%*	*15%*	*30%*	*40%*	*50%*	*18%*
	At-Risk Funds	*$0.0M*	*$8.3M*	*$23.0M*	*$35.2M*	*$34.6M*	*$11.9M*	*$112.9M*
Flexible Services (Not At-Risk)	*Total Funds*	*$0.0M*	*$40.8M*	*$32.1M*	*$27.9M*	*$23.6M*	*$24.3M*	*$148.7M*
DSTI Glide Path Funding	*Total Funds*	*$21.5M*	*$34.6M*	*$23.0M*	*$16.8M*	*$12.2M*	*$5.2M*	*$113.4M*
	At-Risk %	*0%*	*5%*	*5%*	*10%*	*15%*	*20%*	*7%*
	At-Risk Funds	*$0.0M*	*$1.7M*	*$1.1M*	*$1.7M*	*$1.8M*	*$1.0M*	*$7.4M*
Community Partners (Accountability to State)	***Total Funds***	**$15.8M**	**$59.0M**	**$105.6M**	**$125.5M**	**$122.0M**	**$118.9M**	**$546.7M**
	At-Risk %	**0%**	**0%**	**3%**	**11%**	**16%**	**20%**	**11%**
	At-Risk Funds	**$0.0M**	**$0.0M**	**$3.6M**	**$14.3M**	**$19.9M**	**$23.6M**	**$61.4M**
Behavioral Health CPs	***Total Funds***	***$11.7M***	***$46.3M***	***$80.2M***	***$91.1M***	***$86.5M***	***$83.1M***	***$398.9M***
	At-Risk %	***0%***	***0%***	***3%***	***11%***	***16%***	***20%***	***11%***
	At-Risk Funds	***$0.0M***	***$0.0M***	***$2.5M***	***$9.9M***	***$13.7M***	***$16.2M***	***$42.3M***
Care Coordination Supports	*Total Funds*	*$0.0M*	*$21.9M*	*$60.3M*	*$66.4M*	*$66.2M*	*$65.9M*	*$280.6M*
Infrastructure and Capacity Building (including CSAs)	*Total Funds*	*$11.7M*	*$24.4M*	*$19.9M*	*$23.6M*	*$19.3M*	*$16.2M*	*$115.3M*
	At-Risk %	*0%*	*0%*	*13%*	*42%*	*71%*	*100%*	*37%*
	At-Risk Funds	*$0.0M*	*$0.0M*	*$2.5M*	*$9.9M*	*$13.7M*	*$16.2M*	*$42.3M*
Outcomes-Based Stream (Incentive Pool, Not At-Risk)	*Total Funds*	*$0.0M*	*$0.0M*	*$0.0M*	*$1.0M*	*$1.0M*	*$1.0M*	*$3.0M*
LTSS CPs	***Total Funds***	***$4.0M***	***$12.7M***	***$25.3M***	***$34.4M***	***$35.5M***	***$35.8M***	***$147.8M***
	At-Risk %	***0%***	***0%***	***4%***	***13%***	***18%***	***21%***	***13%***
	At-Risk Funds	***$0.0M***	***$0.0M***	***$1.0M***	***$4.5M***	***$6.2M***	***$7.4M***	***$19.1M***
Care Coordination Supports	*Total Funds*	*$0.0M*	*$5.7M*	*$17.1M*	*$23.3M*	*$26.3M*	*$27.9M*	*$100.3M*
Infrastructure and Capacity Building	*Total Funds*	*$4.0M*	*$6.9M*	*$8.2M*	*$10.7M*	*$8.8M*	*$7.4M*	*$46.0M*
	At-Risk %	*0%*	*0%*	*13%*	*42%*	*71%*	*100%*	*41%*
	At-Risk Funds	*$0.0M*	*$0.0M*	*$1.0M*	*$4.5M*	*$6.2M*	*$7.4M*	*$19.1M*
Outcomes-Based Stream (Incentive Pool, Not At-Risk)	*Total Funds*	*$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 budget period demonstration period, 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	**$61.49M**
Cambridge Health Alliance	$12.07M	$8.45M	$6.36M	$4.09M	$3.00M	**$33.99M**
Holyoke Medical Center	$2.67M	$1.58M	$1.22M	$0.99M	$0.63M	**$7.09M**
Lawrence General Hospital	$0.58M	$0.34M	$0.26M	$0.20M	$0.43M	**$1.81M**
Mercy Medical Center	$1.18M	$0.69M	$0.53M	$0.13M	$0.00M	**$2.54M**
Signature Healthcare Brockton Hospital	$1.04M	$0.61M	$0.47M	$0.37M	$0.08M	**$2.56M**
Steward Carney Hospital	$1.80M	$1.00M	$0.81M	$0.30M	$0.05M	**$3.96M**

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	**$61.49M**
Cambridge Health Alliance	$6.04M	$10.27M	$7.41M	$5.23M	$3.55M	$1.50M	**$33.99M**
Holyoke Medical Center	$1.33M	$2.12M	$1.40M	$1.11M	$0.81M	$0.32M	**$7.09M**
Lawrence General Hospital	$0.29M	$0.46M	$0.30M	$0.23M	$0.32M	$0.21M	**$1.81M**
Mercy Medical Center	$0.59M	$0.93M	$0.61M	$0.33M	$0.07M	$0.00M	**$2.54M**
Signature Healthcare Brockton Hospital	$0.52M	$0.82M	$0.54M	$0.42M	$0.22M	$0.04M	**$2.56M**
Steward Carney Hospital	$0.90M	$1.40M	$0.91M	$0.56M	$0.18M	$0.03M	**$3.96M**

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.

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.

EXHIBIT 13 – Anticipated Schedule for LTSS CP for Infrastructure and Capacity Building (PMPM)

LTSS CP Infrastructure and Capacity Building PMPMs				
BP 1	**BP 2**	**BP 3**	**BP 4**	**BP 5**
$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:

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.

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	$2.0M	$1.5M	$1.2M	$1.0M	$7.3M
Investment in Primary Care Residency Training	$0.2M	$1.1M	$2.4M	$2.1M	$2.4M	$8.1M
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	$5.9M	$11.3M	$6.2M	$44.3M
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	$.4M	$4.8M	$2.0M	$9.9M
Total	$21.6M	$24.4M	$14.1M	$37.4M	$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.

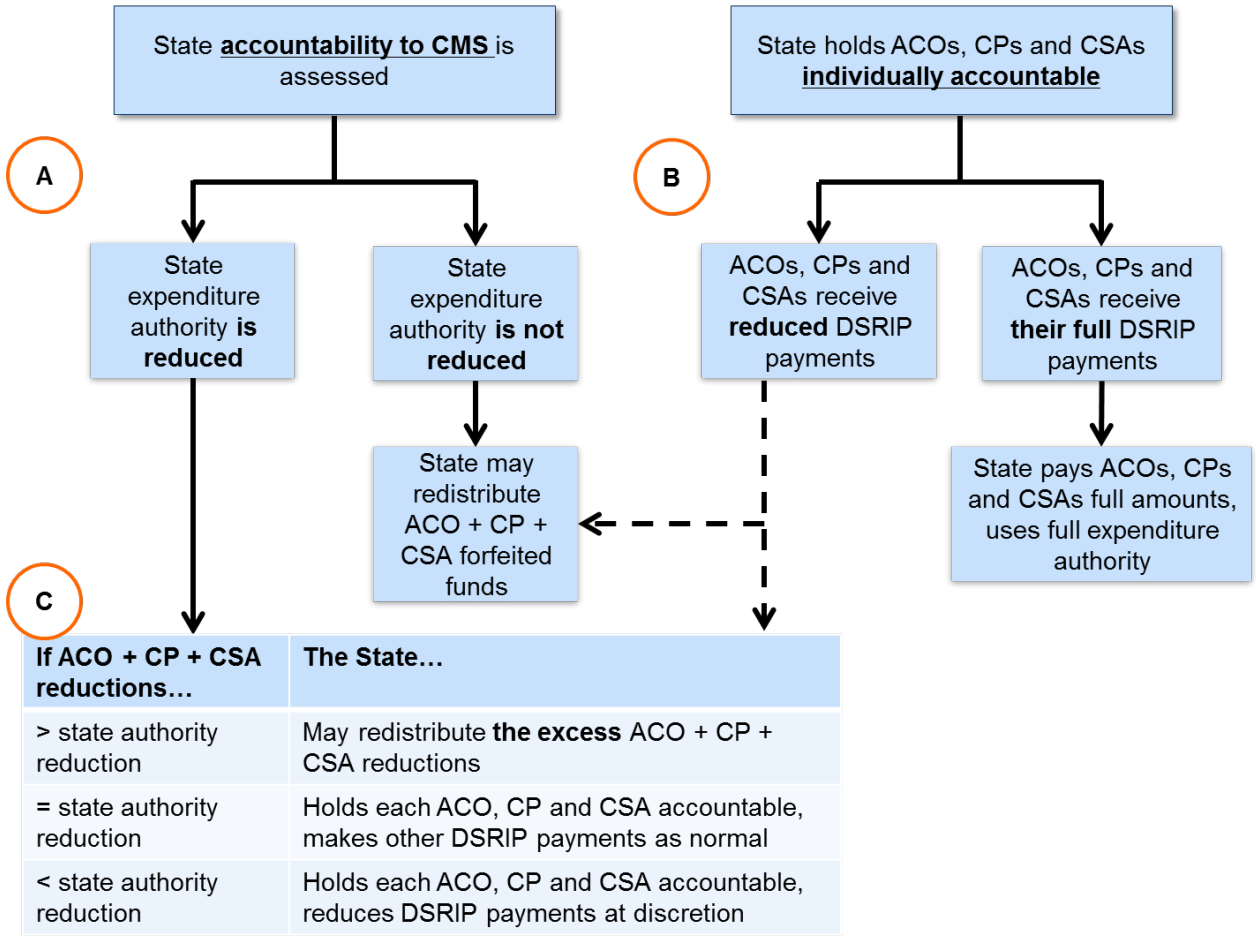
Separately, to maximize incentives for delivery system reform, ACOs, CPs and CSAs that receive DSRIP funds are each accountable to the State for their individual performance. An ACO's, CP's or CSA's failure to achieve the individual accountability standards set by the State may result in the ACO, CP 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

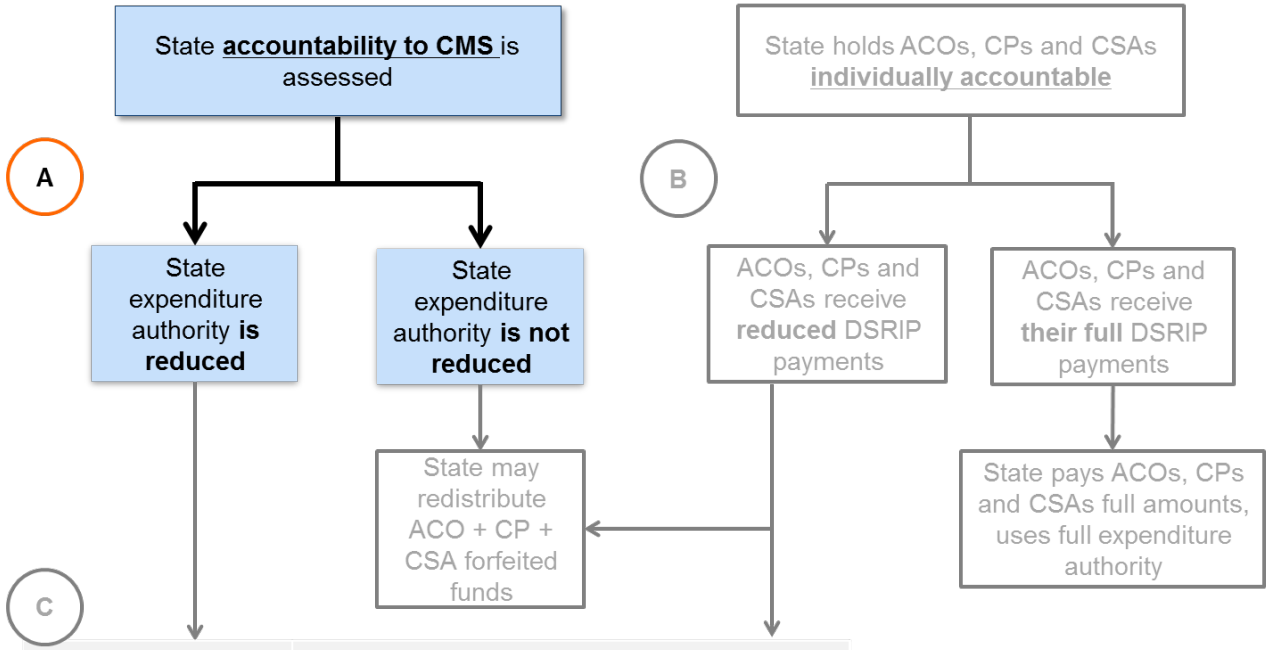
EXHIBIT 16 – Process Flow for State Accountability to CMS and Accountability of ACOs, CPs, and CSAs to the State



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

5.1.1 State Accountability to CMS

EXHIBIT 17 – Process Flow for State Accountability to CMS



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

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.

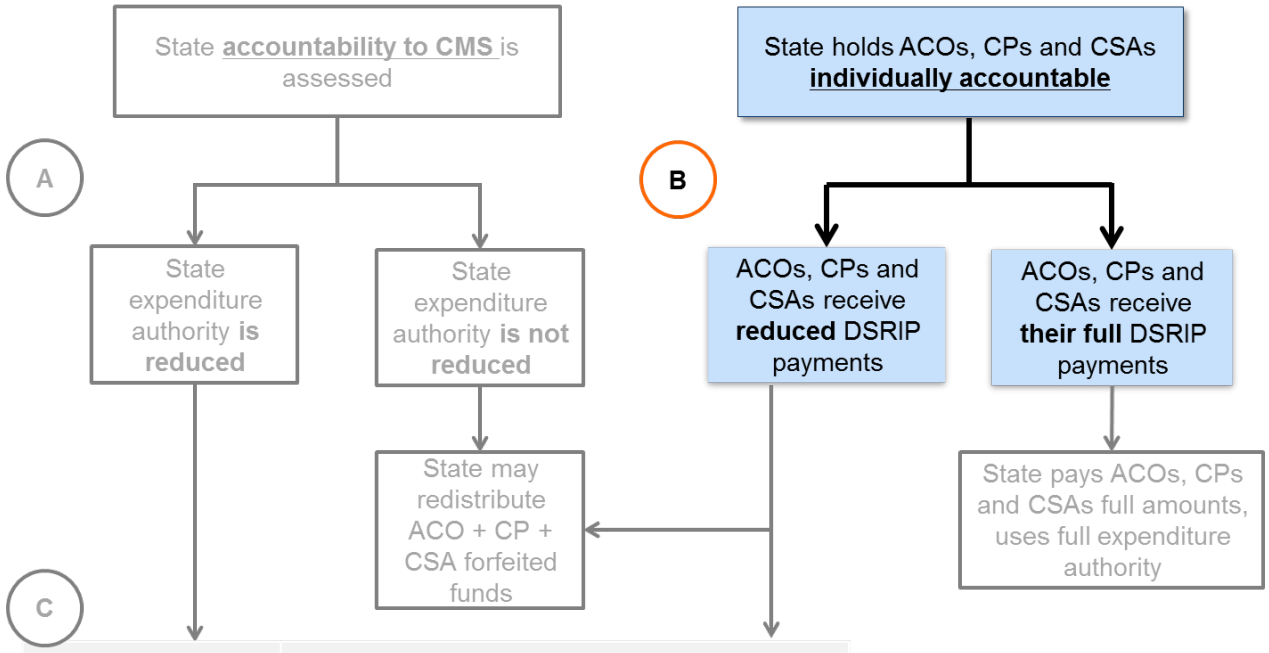
The Preparation Budget Period and BP1 will not have any at-risk expenditure authority. BP 2 has at-risk expenditure authority, and the State anticipates that its Accountability Score will not be determined until the second quarter of BP4 at the earliest. Thus, the State anticipates that any reduced expenditure authority may be reflected in the State's reduction of DSRIP payments during BP 5. As an example, if the State' 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-BP 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



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

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	**Startup/Ongoing:** *Primary Care Investment*	Fixed amount, not withheld or at-risk
	Startup/Ongoing: *Discretionary*	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	DSTI Glide Path	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	Flexible Services	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.

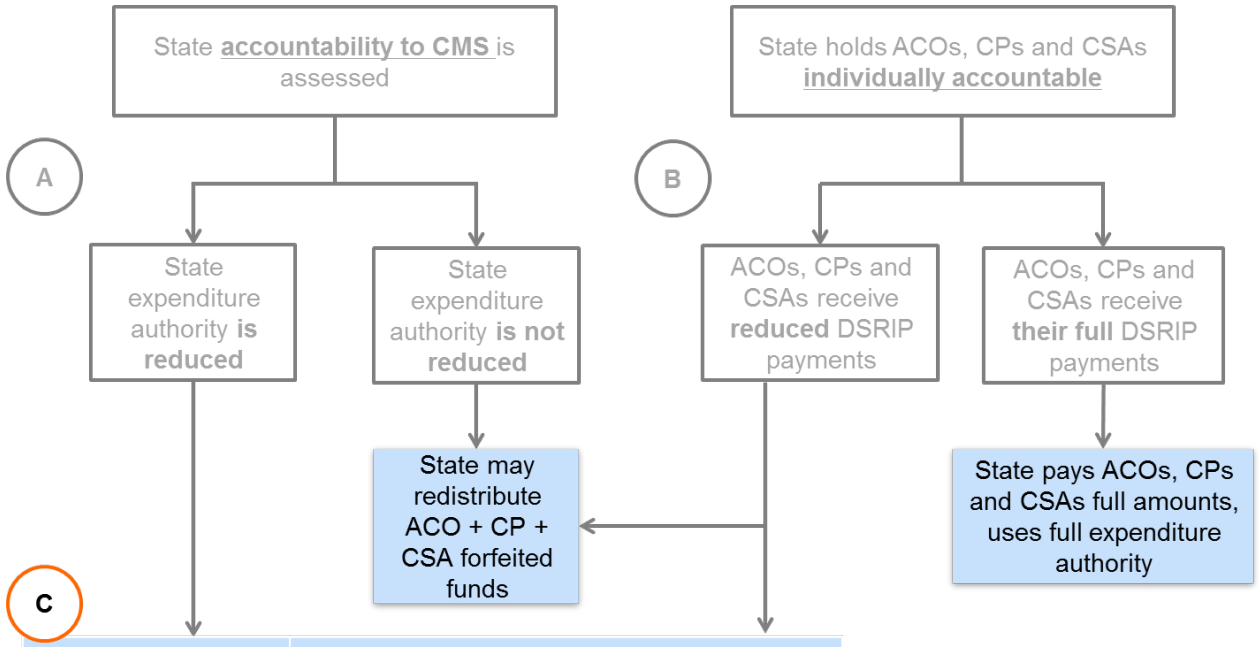
For CPs or CSAs that join after BP1, their at-risk schedule will start at the BP1 percent (i.e. 0%), and then follow the schedule above with appropriate lag. For example, if a CP joins in BP3, their at-risk schedule for the DSRIP funds would be: BP3 – 0%, BP4 – 71%, BP5 – 100%.

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



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

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 the previous demonstration period STCs and the current demonstration period STC 12.13, a portion of the State's DSRIP expenditure authority is at-risk. In accordance with STCs, 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.

EXHIBIT 24 – Percent of 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%	0%	15%	20%
Actual Expenditure Authority At-Risk	$0M	$20.625M	$0M	$41.25M	$22.5M

*BP 5 is the period from January 1, 2022 to March 31, 2023.

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		% Contribution to State DSRIP Accountability Score			
	Prep Budget	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.

The ACO/APM Adoption Rate component of the State DSRIP Accountability Score in Budget Period 5 (January 1, 2022 through March 31, 2023) will be calculated based on ACO/APM adoption rates achieved during CY 2022 (January 1 through December 31, 2022).

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 Reduction in State Spending Growth component of the State DSRIP Accountability Score in Budget Period 5 (January 1, 2022 through March 31, 2023) will be calculated based on the state spending reduction achieved during CY 2022 (January 1 through December 31, 2022).

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.

$$Baseline\ PMPM^{CY2017} = \sum_{n} Actual\ PMPM_{RC\,n}^{CY2017} \times ACOeligpopRCproportion_{RC\,n}^{CY2017}$$

- 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:

$$Avg\ Trended\ PMPM^{YEAR\ t} = \sum_{n} Trended\ PMPM_{RC\ n}^{YEAR\ t} \times ACO\ Elig\ RCproportion_{RC\ n}^{CY2017}$$

- 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:

$$Adj\ PMPM_{RC\ n}^{YEAR\ t} = \frac{Raw\ PMPM_{RC\ n}^{YEAR\ t}}{ACO\ Pop\ Risk\ Score_{RC\ n}^{YEAR\ t} \Big/ ACO\ Elig\ Risk\ Score_{RC\ n}^{CY2017}}$$

- 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:

$$Avg\ Adj\ PMPM^{Year\ t} = \sum_{n} Adj\ PMPM_{\mathrm{RC}n}^{YEAR\ t} \times ACO\ Elig\ pop\ \mathrm{RC}proportion_{\mathrm{RC}n}^{CY2017}$$

- 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:

$$Actual\ PMPM^{YEAR\ t} = Avg\ Adj\ PMPM^{YEAR\ t} - \frac{DSTI\ payments^{CY2017} - DSTI\ Glide\ Path\ payments^{YEAR\ t}}{ACO\ pop\ member\ months}$$

- 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:

$$Percent\ reduction^{YEAR\ t} = \frac{Avg\ Trended\ PMPM^{YEAR\ t} - Actual\ PMPM^{YEAR\ t}}{Avg\ Trended\ PMPM^{YEAR\ t}}$$

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
Clinical Quality Measures				
Prevention & Wellness	N/A	85%	N/A	45%
Care Integration		N/A	N/A	40%
Patient Experience Surveys				
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.

The Overall Statewide Quality Performance component of the State DSRIP Accountability Score in Budget Period 5 (January 1, 2022 through March 31, 2023) will be calculated based on the quality performance achieved during CY2022 (January 1 through December 31, 2022).

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_1, ACO_2, ACO_3), 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 ($p\geq0.05$ 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.

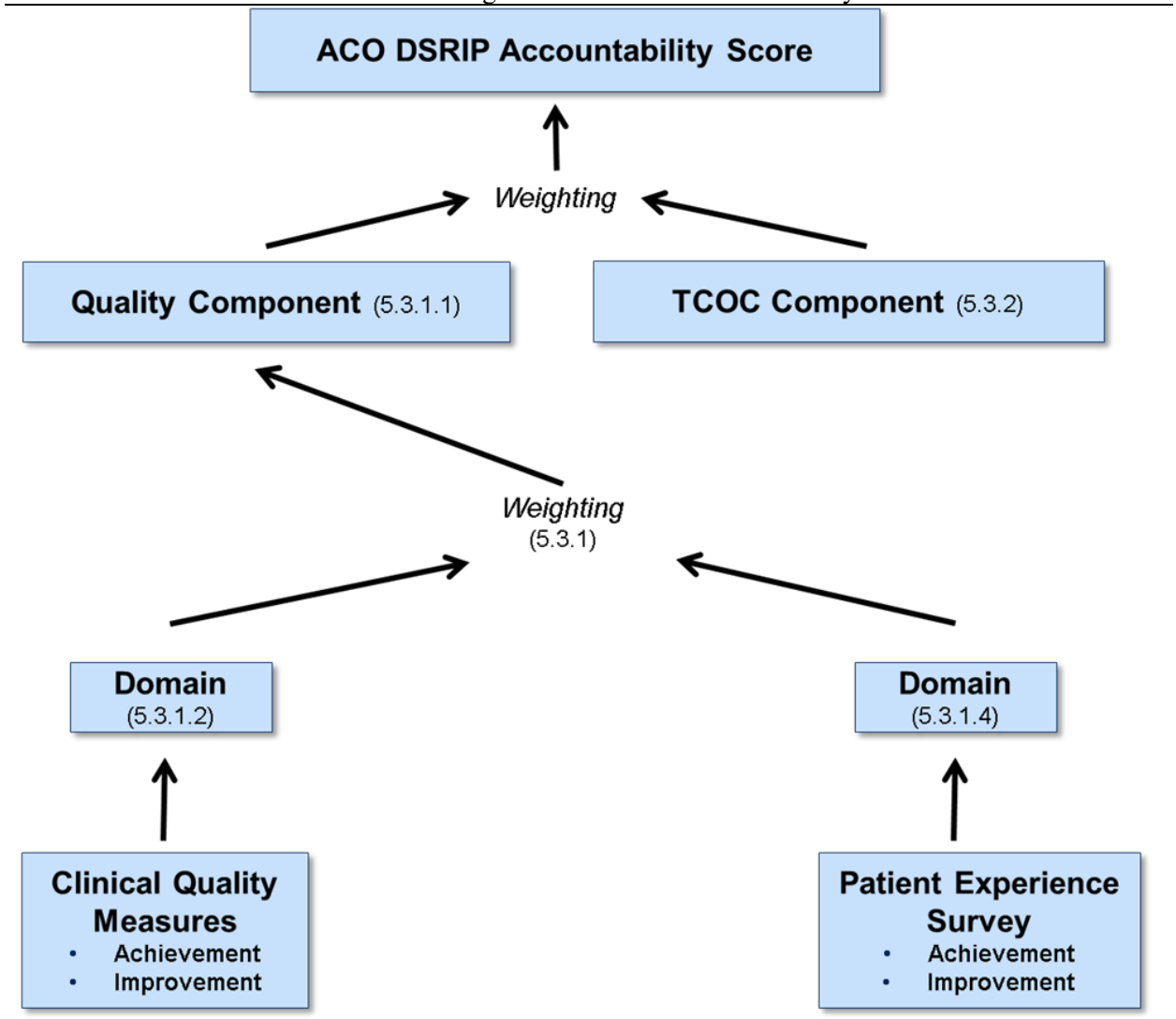
5.3 Accountability Framework & Performance Based Payments for ACOs

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**

EXHIBIT 29 – Process Flow for Calculating the ACO DSRIP Accountability Score



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. The Quality and TCOC components of ACO DSRIP Accountability Scores in Budget Period 5 (January 1, 2022 through March 31, 2023) will be calculated based on the ACO's performance during CY2022 (January 1, 2022 through December 31, 2022).

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**
Clinical Quality Measures					
1	Prevention & Wellness	100% (P4R only)	85%	65%	45%
2	Care Integration		--	20%	40%
Patient Experience Surveys					
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, CY2019 and/or CY2021 MassHealth ACO data for the purposes of benchmarking and will propose Attainment Thresholds and Goal Benchmarks to CMS by Q1 CY2023.

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 and/or CY2021 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 and/or CY2021 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 for approval by Q2 CY2022 (applicable to CY2021) and Q1 CY2023 (applicable to CY2022).

The Quality component of ACO DSRIP Accountability Scores in Budget Period 5 (January 1, 2022 through March 31, 2023) will be calculated based on the ACO's performance during CY2022 (January 1 through December 31, 2022).

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, BP4 or BP5 (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 * ((Performance Score – Attainment Threshold) / (Goal Benchmark – 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 25th percentile of HEDIS benchmarks)
Measure A Goal Benchmark = 80% (e.g., corresponding to 90th 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
• Access to care • Communications • Comprehensiveness • Self-management support • Coordination of care • Helpful, Courteous, and Respectful Office Staff • Patient Ratings of the Provider • Self-management support (composite measure) • Comprehensiveness • Integration or coordination of physical health, BH, LTSS, and health-related social services	• Access to services • Quality and appropriateness • Treatment outcomes • Person-centered planning • Social connectedness • Functioning • Self-determination • Integration or coordination of BH services by Community Partners	• Getting needed services • HCBS staff reliability • Communication with HCBS staff • Getting help from case managers • Choice of services • Personal safety • Adequacy of medical transportation • Community inclusion and empowerment • Employment (supplement) • Integration or coordination of LTSS services by Community Partners

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

Composite (Willingness to recommend - Adult)	ACO BP1 Actual Rate	ACO BP2 Actual Rate	Performance Rate Used for Scoring BP 2 and BP3
ACO A	85%	87.0 %	87.0%
ACO 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)
A – Willingness to Recommend (Adult Survey)	75.1%	75.9%	0.8 (target not met by ACO)	State Med = 1.0	YES (Step 2 applied)
B - Willingness to Recommend (Child Survey)	85.1%	87.0%	1.9 (target met by ACO)	ACO = 1.9	YES (Step 2 not needed)
C - Communications (Adult Survey)	89.5	88.7%	-0.8 (target not met by ACO)	State Med = 1.0	NO (Capped at 1: Composite A already received points)
D - Communications (Child Survey)	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, 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 ACO Community Tenure measure, 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). For the ACO Community Tenure measure, the Bipolar/Schizophrenia/Psychotic Disorder population is 80% of the composite score and the LTSS population 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)

Composite Scores: Equally Weighted Components	
Domain: Overall Rating and Care Delivery (consisting of 4 composite scores)	Point Calculation
Composite 1: Willingness to Recommend-Adult Survey	Achievement points: 5.6 Improvement points: 5
Composite 2: Willingness to Recommend-Child Survey	Achievement points: 7.5 Improvement points: 0
Composite 3: Communications-Adult Survey	Achievement points: 8.0 Improvement points: 0
Composite 4: Communications-Child Survey	Achievement points: 9.1 Improvement points: 5
Average Achievement points: (5.6 + 7.5 + 8.0 + 9.1)/4 = 7.6	
Average Improvement points: (5 + 0 + 0 + 5)/4 = 2.5	
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	
Composite Scores: Unequally Weighted Components	
Domain: Care Integration (consisting of 2 composites scores)	Point Calculation
Component1: BH CP Engagement	Achievement points: 5.6 Weighted (20%): 5.6 * (0.2) = 1.1

	Component 2: Annual Treatment Plan	Achievement points: 7.5 Weighted (80%): 7.5 * (0.8) = 6.0	
	Sum of weighted components: (1.1 + 6.0) = 7.10		

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% * Final TCOC Benchmark - TCOC Performance after risk sharing) / (5% * Final TCOC Benchmark)

        - For Partnership Plans: (105% * risk-adjusted medical capitation payments – TME Performance after risk sharing) / (5% * 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%.

7. ACO's TCOC component in Budget Period 5 (January 1, 2022 through March 31, 2023) will be calculated based on the ACO's performance during CY2022 (January 1, 2022 through December 31, 2022).

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% of the TCOC Benchmark - $20) / 5% 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

- 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)

ACO DSRIP Accountability Score = (Quality Component * Weight of Quality Component) + (TCOC Component * Weight of TCOC Component) = (75% * 75%) + (80% * 25%) * 100% = 76.2%

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 budget period 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.

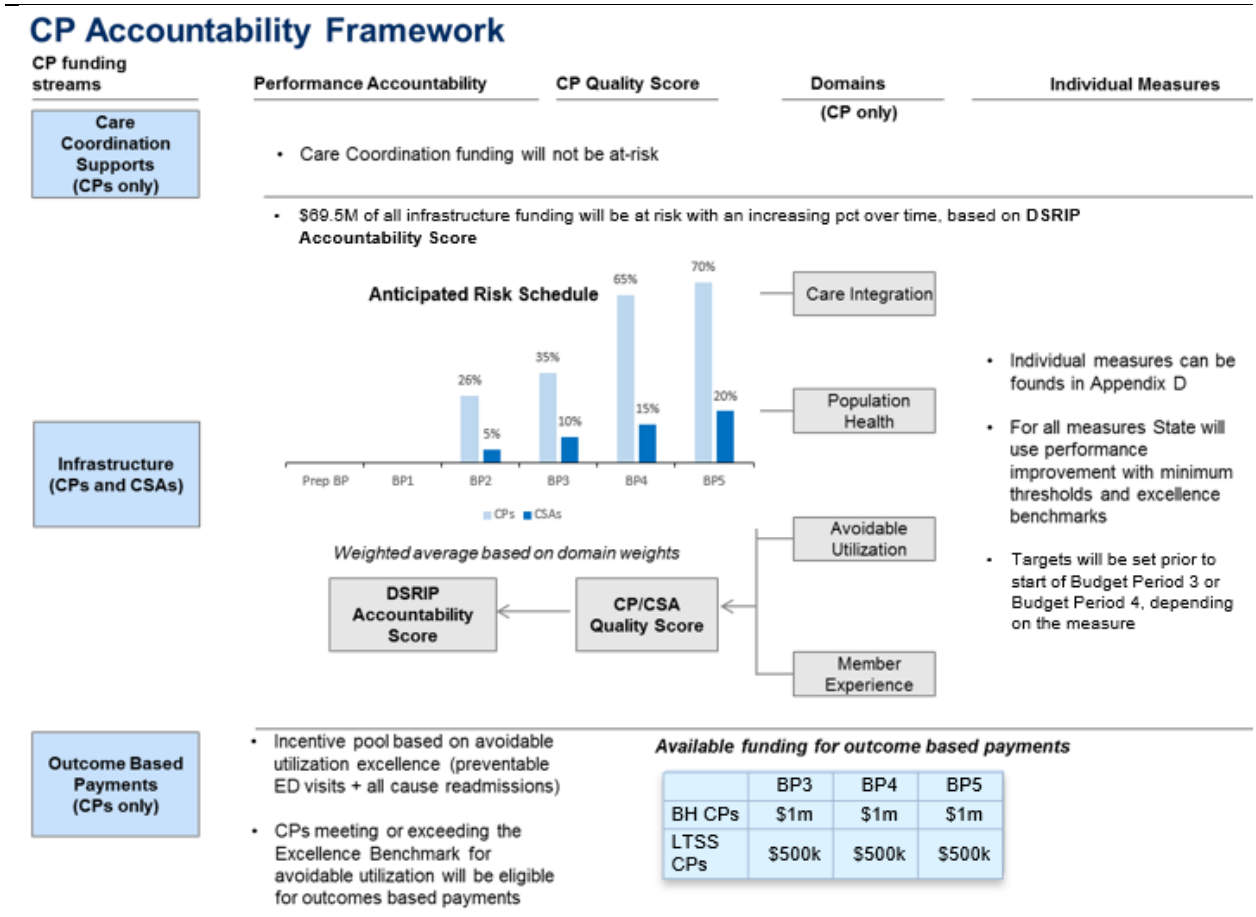
If the ACO's contract is terminated and a portion of its practice sites join another ACO, then the State may reduce the amount of DSRIP startup/ongoing and DSTI Glide Path funding that the ACO is required to return to the State. In such cases, the State may reduce the required amount to be returned by 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 and/or CY2021 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 and/or CY2021 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 for approval by Q2 CY2022 (applicable to CY2021) and Q1 CY2023 (applicable to CY2022).

CPs and CSAs DSRIP Accountability Scores in Budget Period 5 (January 1, 2022 through March 31, 2023) will be calculated based on CPs and CSAs performance during CY2022 (January 1 through December 31, 2022).

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*((Performance Score – Attainment Threshold) / (Goal Benchmark – 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
Average Achievement Points Earned				**0.60**

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%
TOTAL		**100%**	**100%**

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 is 85%

- A BH CP with a Total Quality Score ≥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 various Budget Periods. Budget Periods 2-4 will follow the same pattern as Budget Period 1, adjusted for the respective years. Budget Period 5 is extended by one quarter, making Budget Period 5 Progress Report 2 due one quarter later than in previous Budget Periods.

- **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**
- **BP5 Progress Report 1:** This report is due no later than **August 31, 2022** and shall include the information detailed above for the period of **January 1 - June 30, 2018**
- **BP5 Progress Report 2:** This report is due no later than **June 30, 2022** and shall include the information detailed above for the period of **January 1, 2022 – March 31, 2023**

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 and 4 will follow the same pattern as Budget Period 2 adjusted for the respective year. Budget Period 5 is extended by one quarter, making Budget Period 5 Progress Report 2 due one quarter later than in previous Budget Periods.

- **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**

- **BP5 Progress Report 1:** This report is due no later than **August 31, 2022** and shall include the information detailed above for the period of **January 1 - June 30, 2018**
- **BP5 Progress Report 2:** This report is due no later than **June 30, 2022** and shall include the information detailed above for the period of **January 1, 2022 – March 31, 2023**

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.[2] 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:
    - 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.

[2] 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.

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 budget period 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

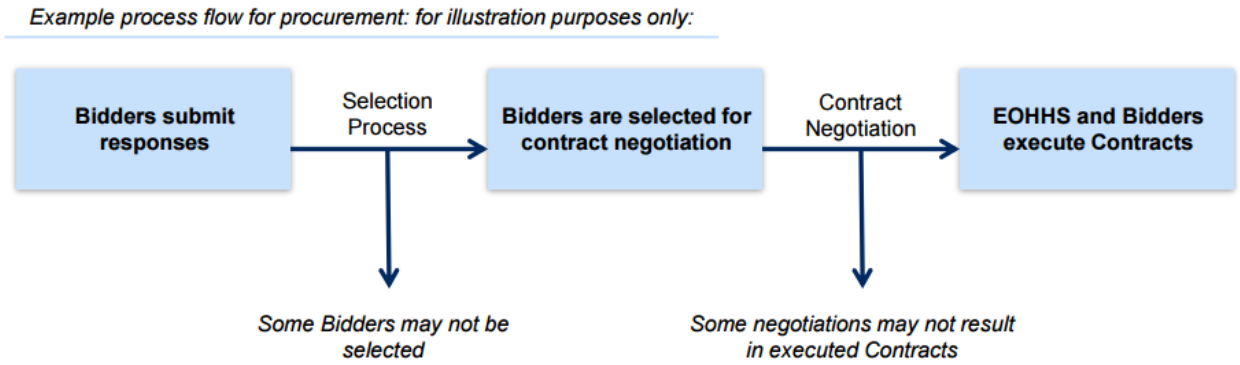
To achieve Massachusetts' DSRIP goals as described above, the State is transitioning a significant portion of the delivery system from a fragmented, fee-for-service model to one where providers come together in new partnerships to take financial accountability for the cost and quality of care for populations 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 budget periods 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:



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.

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.

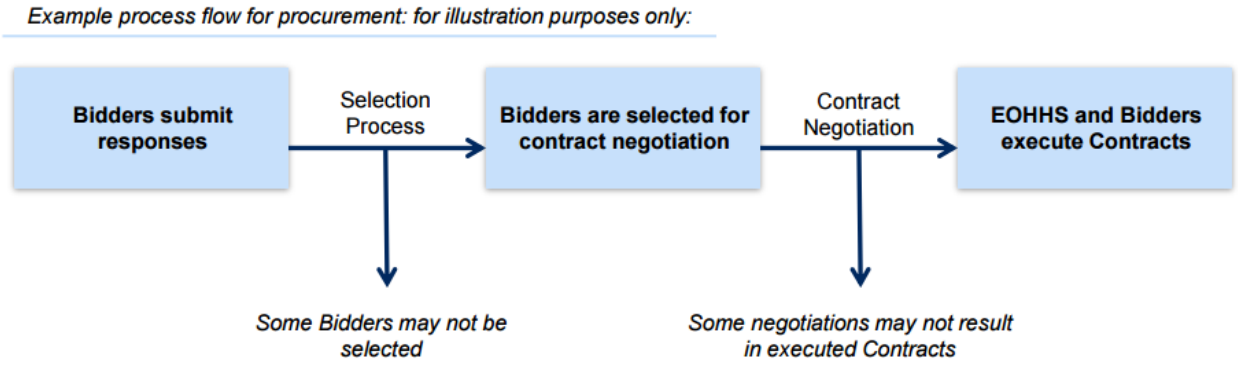
CPs will not be able to authorize services for members under either model.

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:



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.

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

Comprehensive Assessment	ACO or MCO	ACO and MCO enrollees assigned to a LTSS CP or with LTSS needs as specified by EOHHS
LTSS segment of Care Planning	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
Service Authorization	*Before LTSS becomes covered services and included in TCOC:*	
	MassHealth	ACOs and MCOs enrollees, including LTSS CP engaged enrollees
	After LTSS become covered services and are included in TCOC (~year 3):	
	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,

$$\frac{Percent\ of\ reduction\ target\ achieved - 50\%}{100\% - 50\%}$$

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	**1.1% off of trended PMPM**	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:

$$Percent\ of\ reduction\ target\ achieved = \frac{0.9\%}{1.1\%} \approx 82\%$$

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**
Clinical Quality Measures				
1	Prevention & Wellness	**N/A**	**85%**	**45%**
2	Care Integration		**N/A**	**40%**
Patient Experience Surveys				
3	Overall Rating and Care Delivery	**N/A**	**15%**	**7.5%**
4	Person-centered Integrated Care	**N/A**	**N/A**	**7.5%**

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%

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
DSRIP Quality Domains	Domain Scores			Domain Scores			Domain Scores			Aggregate Domain Score
Prevention & Wellness	30%	33%	31%	40%	41%	39%	50%	52%	49%	**40.0%**
Care Integration	60%	50%	53.3%	70%	50%	63.3%	80%	70%	73.3%	**63.3%**
PES: Overall Rating and Care Delivery	60%	60%	60%	50%	60%	56.7%	60%	70%	66.7%	**60.0%**

PES: Person-centered Integrated Care	60%	60%	60%	50%	50%	50%	70%	70%	70%	**60.0%**

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 ($p\geq0.05$, 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		
	Total (BP 1-2)	**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%	**Better and Statistically Significant**	**100%**	45%
Care Integration	63.3%	60%	66.7%	70%	66.7%	**Not Statistically Different**	**100%**	40%
PES: Overall Rating and Care Delivery	60%	50%	53.3%	60%	53.3%	**Worse and Statistically Significant**	**0%**	7.5%
PES: Person-centered Integrated Care	60%	50%	50%	50%	50.0%	**Worse and Statistically Significant**	**0%**	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%
Overall Statewide Quality Performance (sum of the products) =			**85%**

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%
			State DSRIP Accountability Score =	**82.75%**

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	**$41.25M**	$22.5M

To calculate how much at-risk funding the State has earned for BP 4:

$$BP\ 4\ amount\ at\text{-}risk\ \times BP\ 4\ State\ DSRIP\ Accountability\ Score$$
$$\$41.25M\ \times 82.75\% = \$34.13M$$

To calculate how much at-risk funding the State has lost for BP 4:

$$BP\ 4\ amount\ at\text{-}risk - BP\ 4\ at\text{-}risk\ funding\ earned$$
$$\$41.25M - \$34.13M = \$7.12M$$

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
Domain 1 – Prevention & Wellness								
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
Domain 2 – Care Integration								
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	R	P

		community setting without utilizing acute, chronic, or post-acute institutional health care services during the measurement year.						
Domain 3 – Patient Experience: Overall Rating and Care Delivery								
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
Domain 4 – Patient Experience: Person-Centered Integrated Care								
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
Domain 1: Care Integration											
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
Domain 2: Population Health											
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
Domain 3: Avoidable Utilization											
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
Domain 4: Member Experience											
	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
Domain 1: Care Integration											
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
Domain 2: Population Health											
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
Domain 3: Avoidable Utilization											
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
Domain 4: Member Experience											
	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
Domain 1: Care Integration											
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
Domain 2: Member Experience											
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 Hospital Provider Payment Eligibility and Allocation Protocol

Hospitals that meet the eligibility criteria to receive a Safety Net Provider Payment pursuant to STC 11.2 and their corresponding potential payments are listed in Table 2 below.

Safety Net Provider Payment Eligibility and Allocation Methodology

Hospitals that are eligible to receive Safety Net Provider Payments must meet the eligibility criteria below and have a demonstrated Medicaid and Uninsured shortfall as reported on the Uncompensated Care Cost and Charge Report (UCCR). The eligibility criteria use hospitals' fiscal year 2019 Center for Health Information and Analysis (CHIA) hospital cost reports.

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 reports.

Eligible hospitals are split into two groups based on these criteria:

- ***Group 1***: Any hospital that received Delivery System Transformation Initiative (DSTI) payments in the SFY 2015-2017 demonstration period.
- ***Group 2***: Any hospital that did **not** receive DSTI payments in the SFY 2015- 2017 demonstration period.

Twenty percent (20%) of each hospital's total Safety Net Provider Payments for each demonstration year will be at risk and subject to an Accountable Care Organization (ACO) accountability score, which has performance requirements aligned with the Commonwealth's ACO program. Of the twenty percent, 15% will be tied to the quality performance of the hospital's partnered ACO (ACO quality score) and 5% will be tied to the total cost of care (TCOC) performance of the hospital's partnered ACO (ACO TCOC score). Executive Office of Health and Human Services (EOHHS) will calculate the ACO quality score as set forth in Appendix Q of the Accountable Care Partnership Plan (ACPP) contract and Appendix B of the Primary Care ACO (PCACO) contract. EOHHS will determine the ACPP TCOC score based on ACO Plan Corridor performance as set forth in Section 4 of the ACPP contract. EOHHS will determine the PCACO TCOC Score based on TCOC Performance as set forth in Section 4 of the PCACO contract. Table 1 sets forth the relationship between TCOC Performance (Plan Corridor performance for ACPPs) and the ACO's TCOC Score.

Table 1. TCOC Performance and TCOC Score

TCOC Performance (Plan Corridor Performance for ACPPs)	TCOC Score
>0% gain	100%
0-5% loss	75%
5-10% loss	50%
>10% loss	0%

The at-risk payments will be withheld until performance results are available or can be estimated as described below.

Table 2. Safety Net Provider Potential Payments by Eligible Hospital Provider (in millions)

Hospital Provider	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
	Oct - Dec 22	CY 23	CY 24	CY 25	CY 26	CY 27
Group 1						
Boston Medical Center	34.865	139.458	139.458	139.458	139.458	139.458
Holyoke Medical Center	2.151	8.603	8.603	8.603	8.603	8.603
Lawrence General Hospital	3.801	15.204	15.204	15.204	15.204	15.204
Mercy Medical Center	3.990	15.959	15.959	15.959	15.959	15.959
Signature Healthcare Brockton Hospital	4.398	17.590	17.590	17.590	17.590	17.590
Steward Carney Hospital Inc.*	1.697	6.787	6.787	-	-	-
Group 2						
Baystate Franklin Medical Center	0.389	1.554	1.554	1.554	1.554	1.554
Baystate Medical Center	4.434	17.735	17.735	17.735	17.735	17.735
Baystate Wing Hospital	0.312	1.247	1.247	1.247	1.247	1.247
Berkshire Medical Center	1.492	5.969	5.969	5.969	5.969	5.969
Heywood Hospital	0.499	1.995	1.995	1.995	1.995	1.995
Lowell General Hospital	1.887	7.549	7.549	7.549	7.549	7.549
Martha's Vineyard Hospital	0.291	1.165	1.165	1.165	1.165	1.165
MetroWest Medical Center	1.606	6.422	6.422	6.422	6.422	6.422
Noble Hospital	0.211	0.845	0.845	0.845	0.845	0.845
North Shore Medical Center	2.303	9.213	9.213	9.213	9.213	9.213
Shriners Hospitals for Children Boston	0.219	0.875	0.875	0.875	0.875	0.875
Shriners Hospitals for Children Springfield*	0.135	0.539	-	-	-	-
Southcoast Hospitals Group	3.631	14.524	14.524	14.524	14.524	14.524
Good Samaritan Medical Center	0.876	3.505	3.505	3.505	3.505	3.505
Holy Family Hospital, Inc.*	0.989	3.954	3.954	-	-	-
Morton Hospital	0.394	1.570	1.570	1.570	1.570	1.570
Tufts Medical Center	4.083	16.333	16.333	16.333	16.333	16.333
Total	74.650	298.600	298.056	287.315	287.315	287.315

* Shriners Hospitals for Children Springfield closed prior to DY29 (CY2024) and will receive no further SNPP payments in or after DY29. Steward Carney Hospital, Inc. closed prior to DY30 (CY2025) and will receive no further SNPP payments in or after DY30. Steward Holy Family Hospital, Inc. was sold to a new owner prior to DY30 and no longer exists as Steward Holy Family Hospital, Inc. The entity purchasing the former Steward Holy Family Hospital, Inc. will not receive any SNPP or SNCP payments for the hospital.

Estimated Payments and Reconciliation

Generally, the Commonwealth will make payments to eligible hospitals for ACO quality and TCOC performance as described above when results become available. For performance measures that rely on claims and/or other lagged sources of data, the state will make estimated payments, which will be subject to final reconciliation. The Commonwealth will perform an annual reconciliation once final quality and TCOC performance results are available to identify the final payment amount due to the hospital. The Commonwealth will pay the hospital any amount due above the estimated payment or recoup from the hospital any amount by which the estimated payment exceeded the final amount due.

ATTACHMENT O
Retired

Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services

In accordance with STC 15.7, this protocol describes beneficiary eligibility and needs-based criteria for individuals eligible to receive HRSN services through the Flexible Services Program (FSP), Specialized Community Support Programs (CSPs), Short-term Pre-procedure and Post-hospitalization Housing (STPHH), and the Emergency Assistance (EA) Family Shelter Program, and provider qualifications for each service. This protocol also describes infrastructure investments in the form of an HRSN Integration Fund for Social Service Organizations seeking to develop and implement HRSN services.

A. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services.

1. State Flexibility in Coverage of HRSN Services and Beneficiary Qualifying Criteria

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in this Attachment P.
Certain changes to the state's service offerings and eligibility criteria, within what CMS has approved in Attachment P, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    ii. The state must provide public notice.
    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment P, the state must follow the process below to update the protocol:
    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 30 of the STC.
    ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this subpart (b).
    iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this subpart

(b). This restriction is not applicable to the process and scope of changes outlined in subpart (a).

B. Flexible Services Program (FSP) (Effective beginning April 1, 2023)

1. Assessment of Needs

An ACO 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.

2. Flexible Service Planning

A member and the member's ACO will create a plan for a member to obtain Flexible Services specific to the member's needs. This Flexible Service Plan (FS Plan) will be in writing and agreed to by the member and approved by the ACO.

a. ACOs shall complete the FS Plan with the member, or a representative for the member in the cases where a member is unable to participate in the completion of the plan.

b. The FS Plan will include the recommended Flexible Service(s), the units of service(s), the goals of the service(s), steps to obtaining the services, the follow-up plan, and the individual that will be responsible for managing the member's FS Plan. The ACO may conduct periodic reassessments, such as during the follow-up plan, to determine if the FS Plan warrants updates, including inclusion of additional services or extension of services already received. Room services (i.e., rent, utilities) may not be extended beyond the limits specified in the service definitions within this document and the STCs. Other services may be renewed as clinically necessary.

c. A parent, guardian, or caregiver of a child assessed to need Flexible Services that resides with the child may receive such services on the child's behalf when in the best interest of the child as determined through the FS Plan.

3. Flexible Services Availability in 2023 and 2024

The State may implement new Flexible Services and member eligibility groups, in accordance with an implementation plan set forth by the State and approved by CMS.

a. Due to the capped nature of the demonstration authority, neither the State nor the ACOs will be expected to make Flexible Services available to each eligible member. At the State's discretion[1], ACOs may (1) elect to provide Flexible Services only to members with certain health needs-based criteria or with certain risk factors from among those listed in Table 1; (2) restrict the number of members within those categories who will receive services; and (3) elect which Flexible Services they intend to offer. The State will require ACOs to estimate the number of members they

[1] MassHealth complies and requires its contractors to comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping). (https://www.mass.gov/service-details/nondiscrimination-statement)

expect to provide Flexible Services to each year and report to the State on the actual number of members served.

b. The State may establish requirements that the ACO must meet before ACO Flexible Service programs and funds will be approved.

4. Additional Requirements for Providing Flexible Services:

To provide Flexible Services pursuant to a member's FS Plan, 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.

5. Flexible Services Availability in 2025-2027

At the State's discretion, ACOs may elect which Flexible Services they intend to offer. The state will follow the process set forth in STC 15.8.c.vi. related to such elections. Transparency is required by the Commonwealth for beneficiaries and providers clarifying what services are provided by each ACO (see Appendix for weblink to the services that each ACO has elected to offer).

6. Eligibility Criteria

ACO-enrolled members ages 0-64 who also meet at least one of the health needs-based criteria and at least one of the risk factors associated with the need for Flexible Services as determined by the Flexible Service assessment, may be eligible for Flexible Services.

Table 1: FSP Eligibility Criteria
Needs-Based Criteria
1) The individual is clinically 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 clinically 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 clinically assessed to have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). 4) The individual has repeated incidents of emergency department use (defined as 2 or more visits within six months, or 4 or more visits within a year). 5) Pregnant individuals who are experiencing high risk pregnancy or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period;

Table 1: FSP Eligibility Criteria
6) Pregnant individuals or postpartum individuals up to twelve months postpartum, without additional clinical factors.[2]
Risk Factors
1) **Risk Factor 1:** The member is homeless as demonstrated by one of the elements below: 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) immediately prior to entering the institution; b) An individual or family who will imminently lose their primary nighttime residence, provided that: i) The primary nighttime residence will be lost within 14 days of the date of Flexible Services assessment; 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; or 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] MassHealth currently intends to implement Needs-Based Criteria #6 up to two months postpartum beginning in 2025. If MassHealth exercises its authority to implement Needs-Based Criteria #6 up to the full 12 months postpartum in the future, it will notify CMS per the process laid out in Section A.1.a.

Table 1: FSP Eligibility Criteria
2) **Risk Factor 2[3]:** The member is at risk of homelessness as demonstrated by one of the elements below: a) The member is at risk of homelessness as defined by the following: i) 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** ii) Meets one of the following conditions: (1) Has moved because of economic reasons two or more times during the 60 days immediately preceding the Flexible Service assessment; (2) Is living in the home of another because of economic hardship; (3) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days. (4) 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; (5) Lives in a single-room occupancy or efficiency apartment unit in which more than two persons reside, or lives in a larger housing unit in which more than 1.5 people per room reside; (6) Is exiting 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); 3) **Risk Factor 3[4]:** The Member is housing unstable as demonstrated by one of the elements below: a) Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs to transition to another housing option. b) Has utility payments in arrears or lacks income for utility payments, such that the lack of utilities may negatively impact their health. c) Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost-effectively, or the housing cannot be modified cost-effectively and the member needs to transition to another housing option. d) Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction; or

[3] MassHealth does not currently intend to implement Risk Factor 2 as a Flexible Services eligibility criterion beginning in 2025. If MassHealth exercises its authority to implement Risk Factor 2 in the future, it will notify CMS per the process laid out in Section A.1.a.

[4] MassHealth does not currently intend to implement Risk Factor 3.b, 3.c. or 3.e as Flexible Services eligibility criteria beginning in 2025. If MassHealth exercises its authority to implement these subparts of Risk Factor 3 in the future, it will notify CMS per the process laid out in Section A.1.a.

Table 1: FSP Eligibility Criteria
e) Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and cannot be cost-effectively remediated and the member needs to transition to another housing option. 4) **Risk Factor 4:** The member meets either the USDA definition of low or very low food security.[5]

7. Service Descriptions

Flexible Services consist of two services, Tenancy Preservation Supports (TPS) and Nutrition Sustaining Supports (NSS), which may include case management and transportation supports as noted below. These services are covered for eligible members when determined necessary through the Flexible Service assessment and subsequent FS Plan development.

In the context of Flexible Services, "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 regard to a particular service(s).

Table 2: Service Descriptions	
Benefit Categories	**Description of Services**
Tenancy Preservation Supports	
Pre-tenancy supports	Pre-tenancy supports include one or more of the following: 1. Assessing and documenting the member's preferences related to the tenancy the member seeks and the accommodations needed by the member. 2. Assisting the member with budgeting for tenancy/living expenses and assisting the member with obtaining discretionary or entitlement benefits and credit. 3. Assisting the member with obtaining, completing, and filing applications for community-based tenancy. 4. Assisting the member with understanding their rights and obligations as a tenant. 5. Assisting the member with locating and obtaining services needed to establish a safe and healthy living environment. 6. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed. 7. Assisting the member with locating, obtaining, and/or providing the member with transitional goods including

[5] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/

Table 2: Service Descriptions	
Benefit Categories	**Description of Services**
	one or more of the following: move-in expenses (security deposit; utility set-up fees/deposits and up to six months of unresolved utility arrearages [the combination of arrears payments and prospective payments for utilities cannot exceed 6 months per demonstration] if necessary to set up services in new residence; and first month's coverage of utilities, including water, garbage, sewage, recycling, gas, electric, internet, and phone (inclusive of land line phone service and cell phone service)), deposits or one-time start-up payments of miscellaneous fees outlined in the lease, housing deposits, moving costs, relocation expenses, costs for filing applications, costs related to obtaining and correcting needed documentation to access housing, one time household set up expenses needed to establish community-based tenancy (pantry stocking[6], initial supply of toiletries, initial supply of cleaning supplies, and household goods and furniture), and services necessary for member's health and safety in housing (eradication/remediation of mold/pests, or other medically necessary home modifications that are necessary for the individual's health and safety, cleaning prior to occupancy).[7]
Tenancy sustaining supports	Tenancy sustaining supports include one or more of the following: 1. 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. 2. Assisting with the review, update, and modification of the member's tenancy support needs on a regular basis (e.g., assessing the member's needs on a quarterly basis or more frequently, as needed) to reflect current needs and address existing or recurring barriers to retaining community tenancy. 3. Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit.

[6] State and its vendors will align with Supplemental Nutrition Assistance Program (SNAP) coverable goods for pantry stocking as of July 1, 2024.
[7] Until July 1, 2024, broker or rental agent fees to help locate housing will be an allowable pre-tenancy support.

Table 2: Service Descriptions	
Benefit Categories	**Description of Services**
	4. Assisting the member with obtaining appropriate sources of tenancy training. 5. 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 the member to appropriate sources of legal services. 6. Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed. 7. 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.
Home Modifications	Home Modifications consist of limited physical adaptations to the member's community-based dwelling that are for the primary benefit of the beneficiary and are not normally considered the responsibility of the landlord when clinically 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, heat pumps, hypoallergenic mattress and pillow covers, traction or non-skid strips, night lights, and training to use such supplies and modifications correctly).[8]
Nutrition Sustaining Supports	
Nutrition sustaining supports (NSS)[9]	NSS include one or more of the following: 1. The provision of healthy, well-balanced, home-delivered meals for the member up to 3 meals a day for up to 6 months at a time. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months

[8] Home Modifications are only allowed under Flexible Services when they fall outside of the state plan coverage of medical equipment or appliances under Home Health Services. Flexible Service Home Modifications will not duplicate or supplant other MassHealth benefits.

[9] MassHealth does not currently intend to implement NSS #2, #4, or #7 as Flexible Services supports beginning in 2025. If MassHealth exercises its authority to implement these NSS components in the future, it will notify CMS per the process laid out in Section A.1.a.

Table 2: Service Descriptions	
Benefit Categories	**Description of Services**
	postpartum[10], or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.[11] 2. Assisting the member with obtaining discretionary or entitlement benefits and credit. 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 cooking 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 for up to 6 months at a time. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months postpartum[12], or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For

[10] For members that are pregnant/postpartum, MassHealth currently intends to offer NSS #1 up to two months postpartum, or for up to 6 months with an option for renewal for up to 6 months, beginning in 2025. If MassHealth exercises its authority to implement NSS #1 up to the full 12 months postpartum in the future, it will notify CMS per the process laid out in Section A.1.a.

[11] The definition of a household for the purpose of this intervention must align with the Commonwealth's SNAP definition of a household.

[12] For members that are pregnant/postpartum, MassHealth currently intends to offer NSS #6 up to two months postpartum, or for up to 6 months with an option for renewal for up to 6 months, beginning in 2025. If MassHealth exercises its authority to implement NSS #6 up to the full 12 months postpartum in the future, it will notify CMS per the process laid out in Section A.1.a.

Table 2: Service Descriptions	
Benefit Categories	**Description of Services**
	the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.[13]. 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 and directing a member to appropriate sources of legal services. No legal services will be provided.

8. Additional Criteria for HRSN Housing Services

In addition to the eligibility criteria detailed in Section B.6, MassHealth may define additional criteria for the HRSN Housing services. Such criteria may specify:

a. Diagnoses (e.g., home remediations meant to improve air quality such as HEPA filters for members with uncontrolled asthma),
b. Members over a certain age (e.g., providing a subset of services to members aged 55+), and
c. Degree of risk of homelessness (e.g., tenancy sustaining supports for members facing eviction or who have a lease violation).
d. Certain services may only be available to members who are also receiving other specific services.

MassHealth also may expand the clinical criteria for two of the Specialized CSP Services (CSP-HI and CSP-TPP) to include ACO-enrolled members with any health needs-based criteria (HNBC) as described in Table 1 of Section B.6.

9. Additional Criteria for HRSN Nutrition Services

In addition to the eligibility criteria detailed in Section B.6, MassHealth may define additional criteria for the HRSN Housing services. Such criteria may specify:

a. Diagnoses (e.g., medically tailored food for members with diabetes),
b. Degree of ability to prepare meals (e.g., home delivered meals if the member is unable to prepare their own meal), and

[13] The definition of a household for the purpose of this intervention must align with the Commonwealth's SNAP definition of a household.

c. Degree of food insecurity (e.g., members with the highest level of food/nutrition needs based on a food security screening).
d. Certain services may only be available to members who are also receiving other specific services (e.g., a member can only receive NSS #3 if they are also receiving NSS #1 or #6; see Table 2 for a description of these services)

10. Flexible Service Provider Minimum Qualifications

Providers of Flexible Services must possess the following qualifications, as applicable.

Table 3: Flexible Services Provider Minimum Qualifications

Service Type	Qualifications
Tenancy Preservation Supports	Tenancy Preservation Supports providers must meet both of the following criteria: 1. Education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field, or at least 1 year of relevant professional experience or lived experience; or training in the field of service. 2. Knowledge of principles, methods, and procedures of services included under Tenancy Preservation Supports (as applicable to the position), or comparable services meant to support a member's ability to obtain and sustain residency in an independent community setting.
Nutrition Sustaining Supports	Nutrition Sustaining Supports providers must meet both of the following criteria: 1. Education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field, or at least 1 year of relevant professional experience or lived experience; or training in the field of service. 2. Knowledge of principles, methods, and procedures of services included under Nutritional Sustaining Supports (as applicable to the position), or comparable services meant to support a member's ability to obtain or maintain food security.

C. Social Service Organization (SSO) Funding

1. HRSN Integration Fund

In accordance with STC 15.17, entities may apply for and utilize funding from the HRSN Integration Fund to support infrastructure needs associated with the implementation of FSP and Specialized CSP.

a. The State will establish an application process for eligible entities to submit proposals for HRSN Integration funding. For an application to be considered, it must be:

i. from an entity that is providing or is eligible to provide Flexible Services or Specialized CSP, or an organization that provides centralized administrative functions to providers of Flexible Services and Specialized CSP (e.g., a hub); and
ii. for funding based on one of the categories outlined in Section C.1.c.

b. The State will review the applications and distribute the funding to the awardees based on factors such as the number of applicants, the level of need, and the quality of the application.

c. Awardees may spend their funding to support the following areas, as approved by the State:
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, technical systems to support the establishment and operation of hubs);
ii. Developing and implementing business and operational practices to support delivery of Flexible Services or Specialized CSP (e.g., developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation, establishing organizational workflows, meeting provider qualifications, establishing and implementing hubs and associated workflows);
iii. Workforce development (e.g., cultural competency training, trauma-informed training, Community Health Worker certification, training staff on new policies and procedures); and
iv. Outreach and education (e.g., design and production of outreach and education materials, translation, obtaining community input).

d. The State may also utilize HRSN Integration Funds to provide technical assistance to entities that provide or are eligible to provide Flexible Services and Specialized CSP, and hub organizations in the form of one-on-one support, trainings, or learning communities, including providers, entities, and hub organizations who were not awarded HRSN Integration Fund funding.

2. ACO Administrative Payments to FSP Providers

a. As part of their payments for Flexible Services, ACOs may include administrative payments to FSP providers to support the necessary capacity and infrastructure to implement the FSP and to support ongoing administration/overhead of the provision of Flexible Services. This includes but is not limited to personnel for FSP, Health Information Technology, software, assessments and reporting costs surrounding FSP.

b. The Commonwealth will report on its HRSN infrastructure investments, including its oversight of SSOs (including SSOs providing both FSP and Specialized CSP) receiving infrastructure investments, in its demonstration quarterly and annual reports.

3. Additional Payment Details

a. For providing HRSN services to members who satisfy HRSN eligibility requirements, HRSN providers may submit claims or invoices with additional required documentation to the member's ACO or any entity administering HRSN services.

b. ACOs and entities administering HRSN services will pay HRSN providers according to Section 11 of the Commonwealth's HRSN Implementation Plan.

c. ACOs and entities administering HRSN services may also pay HRSN services providers in advance for select services, with the intent of conducting a reconciliation no less than annually to ensure services were rendered.

D. Specialized Community Support Programs (Specialized CSP) (Effective beginning April 1, 2023)

1. Assessment of Needs

A Specialized CSP provider performs a needs assessment that (1) determines a member's eligibility for services; and (2) identifies ways to support the member in mitigating barriers to accessing and utilizing clinical treatment services and attaining the skills and resources to maintain community tenure. This needs assessment informs the development of a Specialized CSP Service Plan. For CSP for Individuals with Justice Involvement (CSP-JI) services, the needs assessment must also include determination of criminogenic needs.

2. Specialized CSP Service Planning

The Specialized CSP Service Plan must be person-centered and must identify the member's needs and individualized strategies and interventions (e.g., clinical interventions, services, and benefits) for meeting those needs. As appropriate, the Service Plan must be developed in consultation with the member and member's chosen support network including family, and other natural or community supports and, as appropriate and available, must incorporate records from referring and existing providers and agencies. The Service Plan must be in writing and must identify the staff responsible for implementing the Service Plan.

3. Specialized CSP Eligibility Criteria

Fee for service (FFS) and managed care enrolled MassHealth members who meet the health needs-based criteria and the risk factors as set forth below, may be eligible for Specialized CSP services. The State may limit availability of Specialized CSP services to eligible members based on the availability of full federal financial participation, and requirements for federal funding, pursuant to EOHHS' Section 1115 Demonstration waiver and any other applicable federal statue, regulation, or payment limit.

Table 4: Specialized Community Support Program (CSP) Eligibility Criteria
Needs-Based Criteria

Table 4: Specialized Community Support Program (CSP) Eligibility Criteria
Members must meet both of the following needs-based criteria: 1) The member has a behavioral health diagnosis, which requires and can reasonably be expected to respond to the intervention. 2) The member does not require a more intensive level of service, including requiring structure or supervision beyond the scope of the Specialized CSP service, or have medical conditions or impairments that would prevent utilization of Specialized CSP services, including posing an imminent risk to self or others
Risk Factors
Members must meet the first risk factor listed below to indicate need for behavioral health diversionary services and the risk factor(s) for at least one of the Specialized CSP services: 1) The member is at risk for admission to 24-hour behavioral health inpatient or diversionary services, as determined by the following: a) Within the past year for CSP-JI services, or the past 180 days for other Specialized CSP services, discharge from a 24-hour behavioral health inpatient or diversionary level of care, including discharge from a correctional institution infirmary or crisis stabilization unit for detoxification or close mental health observation within a correctional institution, or discharge from a residential treatment unit in a correctional institution; b) Within the past year for CSP-JI services, or the past 90 days for other Specialized CSP services, more than one acute behavioral health services encounter, including Adult or Youth Mobile Crisis Intervention Services (AMCI/YMCI), Adult or Youth Community Crisis Stabilization Services (Adult CCS/YCCS), Emergency Department (ED) services, behavioral health urgent care provider services, or encounters with restoration centers; or c) Documented barriers to accessing or consistently utilizing medical and behavioral health services. Risk factor(s) for Specialized CSP Services: 2) CSP for Homeless Individuals (CSP-HI) a) The member is chronically homeless, as defined by the U.S. Department of Housing and Urban Development (HUD); or b) The member is a frequent user of acute MassHealth services, as defined by the State, and is homeless, as defined by HUD in section (1)(i)-(iii) of the definition of "homeless" in 24 CFR 91.5. 3) CSP for Individuals with Justice Involvement (CSP-JI) a) The member is a member with justice involvement, defined as a member who has been released from a correctional institution within the past year; or an individual under the supervision of the Massachusetts Probation Service, Massachusetts Parole Board or both; and b) The member has barriers to accessing or consistently utilizing essential medical and behavioral health services, as evidenced by one or more of the following: i) The member demonstrates antisocial behaviors, including criminal activity that has led, or could lead, to criminal justice involvement; lack of concern

Table 4: Specialized Community Support Program (CSP) Eligibility Criteria
for others; antisocial cognition; diagnosis with antisocial personality disorder; and/or disregard for authority, as expressed through distrust, conflict, or opposition. ii) The member's behavioral health and/or substance use disorders produce cyclical relapse and justice involvement, without the opportunity for treatment; iii) The member engages repetitively in behaviors that pose a risk of relapse to substance use and/or mental disorder; iv) The member has insufficient community and social supports to reinforce recovery; or v) The member is identified as high risk, or above, of recidivism on validated risk assessments due, at least in part, to a substance use disorder, mental health disorder or co-occurring disorder. 4) CSP Tenancy Preservation program (CSP-TPP) a) The member is at risk of homelessness and is facing eviction. i) A member at risk of homelessness does not having 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.

4. Specialized CSP Service Descriptions

Specialized CSP services consist of three services: (1) CSP for Homeless Individuals (CSP-HI); (2) CSP for Individuals with Justice Involvement (CSP-JI); and (3) CSP Tenancy Preservation program (CSP-TPP).

All Specialized CSP services may include core CSP service components and additional service components that are specialized to each type of Specialized CSP. Members receiving Specialized CSP services may receive both the core services and the additional components, as appropriate to meet a member's individualized needs.

Specialized CSP services do not include room and board, or any housing-related goods or expenses (e.g., security or housing deposits, moving costs, utility deposits, household goods) or fees (e.g., application fees, legal fees).

Table 5: Specialized CSP Service Descriptions	
Category	**Description of Services**
Core Services	a) Assisting members in improving their daily living skills so they are able to perform them independently or access services to support them in doing so; b) Spending time with members and providers in the context of providing CSP services; c) Providing members and their families with education, educational materials, and training about behavioral health and

Table 5: Specialized CSP Service Descriptions	
	substance use disorders and recovery. The provider facilitates access to education and training on the effects of psychotropic medications, and ensures that the member is linked to ongoing medication monitoring services and regular health maintenance; d) Coordinating services and assisting members with obtaining benefits, housing, and healthcare; e) Communicating with members or other parties that may include appointment reminders or coordination of care; f) Collaborating with crisis intervention providers, state agencies, and outpatient providers, including working with these providers to develop, revise, and utilize member crisis prevention plans and safety plans; g) Encouraging and facilitating the utilization of natural support systems, and recovery-oriented, peer support, and self-help supports and services; h) Referring members to community resources and other providers for services; and i) Discharge planning, from the CSP service, to expedite a member-centered disposition to other levels of care, services, and supports, as appropriate.
CSP-HI	a) pre-tenancy supports, including engaging the member and assisting in the search for an appropriate and affordable housing unit, including one or more of the following: such as 1. Assessing and documenting the member's preferences related to the tenancy the member seeks and the accommodations needed by the member. 2. Assisting the member with budgeting for tenancy/living expenses and assisting the member with obtaining discretionary or entitlement benefits and credit. 3. Assisting the member with obtaining, completing, and filing applications for community-based tenancy. 4. Assisting the member with understanding their rights and obligations as a tenant. 5. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed. b) support in transition into housing, including assistance arranging for and helping the member move into housing, including one or more of the following: such as: 1. Assisting the member with locating and obtaining services needed to establish a safe and healthy living environment. 2. Assisting the member with locating and obtaining one-time household set-up costs and move-in expenses; and c) tenancy sustaining supports, including assistance focused on helping the member remain in housing and connect with other

Table 5: Specialized CSP Service Descriptions	
	community benefits and resources, including one or more of the following: such as: 1. 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. 2. Assisting with the review, update, and modification of the member's tenancy support needs to reflect current needs and address existing or recurring barriers to retaining community tenancy. 3. Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit. 4. Assisting the member with obtaining appropriate sources of tenancy training. 5. 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 the member to appropriate sources of legal services. 6. Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed. 7. 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.
CSP-JI	a) if the referral source is a correctional institution, coordinating with the provider conducting in-reach services; b) ensuring that the CSP-JI service plan does not conflict with the member's probation and parole supervision plan, as applicable; c) addressing the member's criminogenic needs in the service plan goals, including interventions and strategies for developing alternative behaviors; and d) Assisting or providing the member with transportation to any of the approved CSP-JI services when needed.
CSP-TPP	a) assessing the underlying causes of the member's eviction, and identifying services to address both the lease violation and the underlying causes; b) developing a service plan to maintain the tenancy; c) Providing clinical consultation services as well as short term, intensive case management and stabilization services to members; and

Table 5: Specialized CSP Service Descriptions	
	d) Making regular reports to all parties involved in the eviction until the member's housing situation is stabilized. e) Assistance locating alternative housing as needed.

5. Specialized CSP Service Provider Minimum Qualifications

Providers of Specialized CSP services must possess the following qualifications, as applicable.

Table 6: Service Provider Minimum Qualifications for all Specialized CSPs	
Service	**Qualification**
CSP-HI	1) CSP-HI providers must have: a) experience providing services to persons with mental health disorders or substance use disorders or both; and at least two years of history providing pre-tenancy, transition into housing, and tenancy sustaining supports to persons experiencing homelessness. This must include experience serving people experiencing chronic homelessness and with documenting their chronic homeless status in accordance with requirements set by the U.S. Department of Housing and Urban Development. b) Specialized professional staff with knowledge of housing resources and dynamics of searching for housing such as obtaining and completing housing applications, requesting reasonable accommodations, dealing with housing and/or credit histories that are poor or lacking, mitigating criminal records, negotiating lease agreements, and identifying resources for move-in costs, furniture and household goods. 2) A CSP-HI program must have a licensed, master's-level behavioral health clinician or licensed psychologist to provide supervision to staff. 3) All staff must have at least a bachelor's degree in a related behavioral health field, or two years of relevant work experience, or lived experience of homelessness, behavioral health conditions and/or justice involvement. 4) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement.
CSP-JI	1) A CSP-JI provider must be an organization that provides mental health or substance use disorder services and operates

Table 6: Service Provider Minimum Qualifications for all Specialized CSPs	
	under a valid license issued by the Massachusetts Department of Public Health (DPH). 2) A CSP-JI program must have a licensed, master's-level behavioral health clinician or licensed psychologist to provide supervision to staff. 3) All staff must have at least a bachelor's degree in a related behavioral health field, or two years of relevant work experience, or lived experience of homelessness, behavioral health conditions and/or justice involvement. 4) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement.
CSP-TPP	1) CSP-TPP providers must have an active contract with Department of Housing and Community Development or MassHousing to provide tenancy preservation program services. 2) A CSP-TPP program must have a licensed, master's-level behavioral health clinician or licensed psychologist to provide supervision to staff. 3) All staff must have at least a bachelor's degree in a related behavioral health field, or two years of relevant work experience, or lived experience of homelessness, behavioral health conditions and/or justice involvement. 4) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement.

E. Emergency Assistance Family Shelter Program (Effective beginning April 19, 2024)

In accordance with STC 15.3.a.viii. and STC 15.6.c., MassHealth is expanding HRSN housing supports and related services to include rent/temporary housing with room and board for up to six months per demonstration for MassHealth-eligible pregnant individuals and families with children who are experiencing homelessness, participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program, and demonstrate qualified clinical criteria. The EA program is operated by the Massachusetts Executive Office of Housing and Livable Communities (EOHLC or HLC).

1. EA Assessment of Needs

EA Family Shelter Program providers hold monthly individual Rehousing Meetings with each family. Starting with the first Rehousing Meeting, and every 60 days or more frequently as needed, the provider conducts a Rehousing Assessment with each family. Rehousing Assessments are used to identify a family's strengths, history, and areas that need improvement to support the family's rehousing efforts.

The state also uses information gathered during the Rehousing Meetings and as part of the Rehousing Assessments to determine whether anyone in the family meets clinical eligibility criteria. The state may also determine clinical eligibility using claims and encounter data.

2. EA Service Planning

Based on the results of the Rehousing Assessment, program staff and family will jointly create a Rehousing Plan designed to address the specific barriers that family faces to securing stable housing. This plan is updated every 30 days or more frequently as needed with the progress the family has made compared to the prior month and their goals for the month ahead.

All families must identify goals (a) related to finding their new home, (b) related to long-term success/saving 30% of net income, and (c) specific to the family's situation. Depending on a family's goals, the program staff may incorporate referrals to additional service providers in the Rehousing Plan.

As families transition into community-based housing, the program staff continues to aid families in connecting to appropriate services and navigating complex systems with the goal of ensuring that each family remains stably housed. The program staff in collaboration with the family will determine the necessary supports following transition. Together, they will develop a Stabilization Plan that will be updated every 30 days.

3. EA Eligibility Criteria

To receive rent/temporary housing under HRSN, an individual must meet the following criteria:

A. EA enrollment: For a family or pregnant individual to be enrolled in the EA family shelter program, they must meet the following eligibility requirements, as described below and in 760 CMR 67.00[14]:
   - Residency: Be a resident of Massachusetts
   - Lawful residence: At least one household member must be a citizen, or a non-citizen lawfully admitted for permanent residence or otherwise permanently residing under color of law in the United States
   - Income: Have gross income equal to or less than 115% of the Federal Poverty Level, adjusted for household size
   - Assets: Have total countable assets that do not exceed $5,000
   - Family composition: Have at least one child under the age of 21 living within the household, or be pregnant
   - Homelessness:
     - Must be in one of the following situations:
       - At risk of domestic abuse or is homeless because the head of household fled domestic violence

[14] 760 CMR 67.00 Eligibility for Emergency Assistance (EA), https://www.mass.gov/doc/760-cmr-67-1/download

        - Experiencing homelessness due to no-fault fire, flood, natural disaster,
        - Experiencing homelessness due to no-fault eviction due to foreclosure, condemnation, conduct of a guest or former household member who is no longer part of the household, or nonpayment of rent due to disability or loss of income
        - Children are in a housing situation not meant for human habitation and exposed to a substantial health and safety risk that is likely to result in significant harm
    - The household must lack feasible alternative housing including temporary housing with relatives, friends, or charitable organizations
    - The household must verify that its current or prior living situation is no longer available to the household via a thorough third-party verification process

B. MassHealth benefit: An individual must be enrolled in the full MassHealth benefit (i.e., not MassHealth Limited).
C. Clinical criteria: The individual must meet both the social risk criteria and at least one of the clinical risk factors as set forth below.

The state will determine medical appropriateness for claiming FFP using MassHealth claims data and clinical and social risk assessment data collected by program staff and recorded in members' case records.

Table 7: HRSN/Emergency Assistance Family Shelter Program (EA) Eligibility Criteria	
Social Risk Criteria	
Social Risk Factor	**Social Risk Factor Description**
Homelessness	An individual who is homeless as defined by 24 CFR 91.5.
Clinical Needs Based Criteria	
Clinical Criteria	**Clinical Criteria Description**
Complex or Chronic Behavioral Health Condition	An individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Disability	An individual with a disabling condition, including a developmental disability, intellectual disability, or disability that interferes with activities of daily living (ADLs), that requires services or supports to achieve and maintain care goals.
Complex or Chronic Physical Health Condition	An individual with a persistent, disabling, progressive or life-threatening physical health condition(s) that requires treatment or supports, or both treatment and supports, in

Table 7: HRSN/Emergency Assistance Family Shelter Program (EA) Eligibility Criteria	
	order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Experience of Interpersonal Violence	An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence.
Repeated Emergency Department Use	An individual with repeated use of emergency department care (defined as two or more visits in the past six months or four or more visits within the past 12 months).
Pregnant / Postpartum	1. Pregnant individuals who are experiencing high risk pregnancy[15] or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period; 2. Pregnant individuals or postpartum individuals up to twelve months postpartum, without additional clinical factors.

4. EA Service Descriptions

Rent/temporary housing assistance with room and board includes two services: (1) room and board or rent for up to six months, and (2) supportive services.

Table 8: HRSN/Emergency Assistance Family Shelter Program (EA) Service Descriptions	
Service	**Description**
Temporary Housing Assistance	Room and Board (up to 3 meals/day) in one of the following temporary housing arrangements for up to 6 months per demonstration period: - Congregate: multiple units with shared common areas within one building - Co-shelter: two units with shared common areas within one apartment - Scattered site: single unit in full apartment - Hotel: units within a hotel/motel site Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24

[15] Pursuant to STC 15.6.c., a pregnant or postpartum individual experiencing homelessness or nutrition insecurity would by definition constitute a high-risk pregnancy because they have defined adverse health outcomes.

Table 8: HRSN/Emergency Assistance Family Shelter Program (EA) Service Descriptions	
Service	**Description**
	hours a day, and facilities without private sleeping space are excluded. Rent and utility stipends for up to 6 months
Supportive Services	Supportive services may include one or more of the following (not time limited): - Assessment o Social risk assessment: assessment conducted by EA Homeless Coordinator upon intake to EA system that includes assessing housing instability, enrollment in social services, member self-assessment and, depending on the outcomes, may also include reasonable accommodation, health and safety, and domestic violence assessments to determine social risk. o Clinical assessment: health assessment conducted by a licensed clinician such as a Registered Nurse, Nurse Practitioner, Physician's Assistant, or Physician contracted by the Massachusetts Department of Public Health (DPH) to identify clinical and safety risks. - Case Management o Care management, outreach, and education including linkages to other state and federal benefit programs, and benefit program application assistance. - HRSN Housing Supports o Pre-tenancy & tenancy sustaining services including supports to ensure members remain stably housed, as described in Table 2 of Section B.7. o Housing transition navigation services including services to facilitate member's transition from shelter into safe, alternative, permanent housing, as described in Table 2 of Section B.7. o One-time transition & moving costs including expenses associated with rehousing, as described in Table 2 of Section B.7.

Table 8: HRSN/Emergency Assistance Family Shelter Program (EA) Service Descriptions	
Service	**Description**
	○ Medically necessary home environment modifications and remediations, as described in Table 2 of Section B.7.

5. EA Service Provider Minimum Qualifications

EOHLC will provide temporary housing assistance services through vendors that possess the following qualifications, as applicable.

Table 9: HRSN/Emergency Assistance Family Shelter Program (EA) Minimum Provider Qualification Requirements	
Service	**Description**
Room and board for up to six months	EOHLC will provide rent/temporary housing services through contracted vendors. Contracted vendors must meet both of the following criteria, as well as all other minimum criteria defined by HLC: 1. Experience serving families experiencing homelessness or substantially similar populations, and 2. Demonstrates capacity to provide safe, clean, and well-maintained shelter for homeless families.
Supportive services	EOHLC will provide Supportive services through contracted vendors. Contracted vendors must meet the following criteria, as well as all other minimum criteria defined by HLC: 1. Experience serving families experiencing homelessness or substantially similar populations. 2. Demonstrates capacity to aid families in rapidly identifying and securing housing 3. Demonstrates capacity to provide case management and system navigation services 4. Demonstrates capacity to provide stabilization services to ensure families remain stably housed

F. Short Term Pre-Procedure and Post-Hospitalization Housing (STPHH) (anticipated to be effective beginning January 3, 2025)

Short-term pre-procedure and/or post-hospitalization housing, with room and board, is for individuals experiencing homelessness, involving a lower-intensity care setting for individuals who would otherwise lack a safe option for discharge or recovery after hospitalization, or to prepare for certain procedures. STPHH is anticipated to be available to eligible members in Fee For Service (FFS) and managed care plans.

1. Assessment of Needs

Pre-Procedure Assessment of Needs: The STPHH provider screens potential eligible members to confirm eligibility for pre-procedure colonoscopy services.

Post-Hospitalization Assessment of Needs: Within 24-hours of admission to the STPHH site, the STPHH provider conducts an assessment to identify immediate medical needs of the member. Within four calendar days of admission, the STPHH provider conducts a comprehensive baseline needs assessment to determine factors that will influence care, treatment, safety in the milieu and needed services from the STPHH provider and other community-based providers. Within the first week of a member's STPHH stay, the STPHH provider conducts a comprehensive housing assessment. The STPHH provider conducts reassessments regularly.

2. STPHH Service Planning

Pre-Procedure Service Planning: The STPHH provider ensures, prior to rendering the service to a member, that the STPHH provider is able to render all necessary service components to the member, including screening, intake, admission, support, and discharge planning services.

Post-Hospitalization Service Planning: The STPHH provider completes an individualized care plan for every member receiving post-hospitalization STPHH services upon completion of the comprehensive baseline needs assessment. The STPHH provider regularly reviews the individualized care plan, including, at a minimum, after each comprehensive assessment, and updates it, as necessary. The individualized care plan identifies the member's needs, goals, and priorities, and includes planned treatments, strategies and interventions to support the member's goals. The individualized care plan is developed in consultation with the member and the member's chosen support network and incorporates available records from referring and existing providers and agencies when appropriate.

3. STPHH Eligibility Criteria

FFS and managed care enrolled MassHealth members who meet the eligibility criteria set forth below, may be eligible for STPHH services. STPHH includes two services: (1) Pre-procedure colonoscopy services, and (2) post-hospitalization medical respite services.

Table 10: STPHH Eligibility Criteria
1. 18 years of age or older

<table>
<tr><td colspan="2">2. Currently experiencing homelessness as defined in 24 CFR 91.5 as any person who[16]:
a. Who lacks a fixed, regular, and adequate nighttime residence, meaning:
i. has 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 group; or
ii. is living in a supervised publicly or privately operated emergency 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. is exiting an institution where they resided for 90 days or less and who met eligibility criteria (2)(a)(i) or (2)(a)(ii) immediately prior to entering the institution;
b. Who will imminently lose their primary nighttime residence, provided that:
i. The primary nighttime residence will be lost within 14 days of the date of STPHH referral;
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; or
c. 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.</td></tr>
<tr><td colspan="2">STPHH Service Specific Eligibility Criteria</td></tr>
<tr><td>Pre-Procedure Services</td><td>MassHealth member:
1. Has a referral for a colonoscopy procedure or a colonoscopy procedure scheduled within one day of admission to the medical respite; and
2. Cannot prepare for the colonoscopy effectively due to not having consistent access to a private bathroom.</td></tr>
<tr><td>Post-Hospitalization Services</td><td>MassHealth member:</td></tr>
</table>

[16] MassHealth does not currently intend to implement STPHH Eligibility Criteria 2.b or 2.c as STPHH eligibility criteria beginning in 2025. If MassHealth exercises its authority to implement STPHH Eligibility Criteria 2.b. or 2.c in the future, it will notify CMS per the process laid out in Section A.1.a.

	1. Has been admitted to an acute care hospital medical or surgical service or has presented to an acute care hospital emergency department with a medical or surgical issue; 2. Has a primary acute medical issue that is not yet resolved but is expected to resolve and can be safely managed in a medical respite setting with the STPHH provider's support accessing primarily home- and community-based MassHealth services; 3. Does not meet nursing facility level of care criteria; 4. Is anticipated to no longer require or does not currently require acute care hospital level of care and has been deemed stable and ready for discharge to a home-based setting in the community; 5. Does not have a stable and safe housing option identified or the resources to obtain appropriate housing where they can be safely discharged; and 6. Is independent with regards to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), except for needing short-term assistance with regaining the ability to perform ADLs and IADLs as part of the recuperative process.

4. STPHH Service Descriptions

STPHH includes two services: (1) Pre-procedure colonoscopy services, and (2) post-hospitalization medical respite services. STPHH services are delivered to members in a community-based setting and include room and board.

Table 11: STPHH Service Descriptions

Service	Description
Pre-Procedure Services	1. Coordinate the scheduling of the pre-procedure colonoscopy services with the provider conducting the colonoscopy procedure, ensure the member has all necessary prescriptions for pre-procedure preparation, and coordinate transportation to and from procedure. 2. Provide access to appropriate accommodations for pre-procedure preparation activities and post-procedure recovery, including access to a private or semi-private room and private bathroom, for up to 48 hours, and ensure the room is available post-procedure for recovery prior to discharge; 3. Provide appropriate pre- and post-procedure fluids and foods in accordance with instructions from the procedure provider, and provide counseling and supervision support, as desired by the member, for adherence to such instructions; 4. Arrange for necessary post-discharge support and clinical services and coordinate transportation.

Post Hospitalization Services	1. Participate, as appropriate, in member discharge planning with the referring acute care hospital provider, which may include sending a staff person to the acute care hospital to meet the referred member or discussing the member's health needs with the acute care hospital staff; 2. Provide case management services, which includes coordinating with and facilitating connections with other providers, as well as formal and informal supports, as appropriate; 3. Provide health and referral navigation services, which includes facilitating member access to primary care, other community and home-based health care services and equipment (e.g., Durable Medical Equipment), coordinating referrals, when appropriate, providing assistance with member self-administration of medications and setting up and scheduling appointments, transferring health information to providers, addressing external barriers to receiving and engaging in services, and partnering with MassHealth Community Support Program for Homeless Individuals (CSP-HI) providers to deliver intensive housing navigation services; 4. Provide three meals per day and snacks; and 5. Deliver discharge planning services based on the member's specific circumstances, which includes engagement with the member's MassHealth health plan, assisting with transition of care and post-discharge support, and providing options for placement after discharge.

5. STPHH Provider Minimum Qualifications

Providers of STPHH services must possess the following qualifications.

Table 12: STPHH Provider Minimum Qualifications
1. Have at least two years of experience providing services to persons experiencing homelessness. 2. Be able to ensure timely access to primary care services, as necessary, including the provision or coordination of orders, referrals and prescriptions for services to address physical, mental or functional needs, through a partnership with a licensed medical provider whose scope of practice allows for delivery of medical services in a home setting, including the medical respite service location. 3. Demonstrate comprehensive knowledge of: a. available community resources, including but not limited to health care, behavioral health, and home health services; b. how to access these resources in a timely manner; c. how to arrange for services to be delivered onsite at the medical respite, if applicable; and

d. how to arrange for transportation to receive services in the community.

4. Be able to ensure the provision of intensive housing navigation services through a partnership with a MassHealth CSP-HI provider

Appendix

A. Flexible Services – Availability of Services and Eligibility Criteria

As described in Section B.5 of Attachment P, ACOs may elect which Flexible Services to offer. The services that ACOs have elected to offer can be found at https://www.mass.gov/masshealth-health-related-social-needs-services. All ACOs are required to use the same set of Flexible Services eligibility criteria – they do not have flexibility to implement only a subset of the eligibility criteria.

Massachusetts 1115 HRSN Services Matrix

Target Populations	Housing Services									Nutrition Services			
	Rent/temporary housing for up to 6 months	Pre-procedure housing	Post-hospitalization housing	Utility costs	One-time transition and moving costs	Housing deposits to secure housing	Pre-tenancy and tenancy sustaining services	Housing transition navigation services	Medically necessary home accessibility modifications and remediation services	Nutrition counseling and education, including on healthy meal preparation	Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months	Meals or pantry stocking	Fruit and vegetable prescriptions, for up to 6 months
Managed care eligible members ages 0-64 who are enrolled in an ACO (Flexible Services)				X	X	X	X	X	X	X	X	X	X
Fee for service (FFS) and managed care enrolled MassHealth members (Specialized CSP)							X	X					
MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program Shelter Program	X			X	X	X	X	X	X				
FFS and managed care enrolled MassHealth members 18 years of age or older (Short-term Post-Hospitalization Housing, Pre-Procedure Housing)		X	X					X					

**Note that not all services will be available, given ACO-level variation. Transparency is required by the Commonwealth for clarifying to beneficiaries and providers what services are provided by each ACO.*

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the population
Short-term post-hospitalization housing	FFS and managed care enrolled MassHealth members 18 years of age or older	Social Risk Factor 1	Clinical Risk Factor 8
Pre-procedure housing	FFS and managed care enrolled MassHealth members 18 years of age or older	Social Risk Factor 1	Clinical Risk Factor 9
Rent/temporary housing for up to 6 months	MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program (Emergency Assistance Family Shelter Program)	Social Risk Factor 1	Clinical Risk Factors 1, 2, 3, 4, 5, 6, or 7
Utility costs	MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program (Emergency Assistance Family Shelter Program) OR Managed care eligible members ages 0-64 who are enrolled in an ACO (Flexible Services)	Social Risk Factor 1, 2, or 3	Clinical Risk Factors 1, 2, 3, 4, 5, 6, or 7
One-time transition and moving costs	MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program (Emergency Assistance Family Shelter Program) OR Managed care eligible members ages 0-64 who are enrolled in an ACO (Flexible Services)	Social Risk Factor 1, 2, or 3	Clinical Risk Factors 1, 2, 3, 4, 5, 6, or 7
Housing deposits to secure housing	MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program (Emergency Assistance Family Shelter Program) OR Managed care eligible members ages 0-64 who are enrolled in an ACO (Flexible Services)	Social Risk Factor 1, 2, or 3	Clinical Risk Factors 1, 2, 3, 4, 5, 6, or 7
Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention	Managed care eligible members ages 0-64 who are enrolled in an ACO (Flexible Services) OR Fee for service (FFS) and managed care enrolled MassHealth members (Specialized CSP) OR MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program (Emergency Assistance Family Shelter Program)	Social Risk Factor 1, 2, 3, or 5	Clinical Risk Factors 1, 2, 3, 4, 5, 6, or 7
Housing transition navigation services	Managed care eligible members ages 0-64 who are enrolled in an ACO (Flexible Services) OR Fee for service (FFS) and managed care enrolled MassHealth members (Specialized CSP) OR MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program (Emergency Assistance Family Shelter Program) OR FFS and managed care enrolled MassHealth members 18 years of age or older (Short-term Post-Hospitalization Housing, Pre-Procedue Housing)	Social Risk Factor 1, 2, 3, or 5	Clinical Risk Factors 1, 2, 3, 4, 5, 6, 7, 8, or 9
Medically necessary home accessibility modifications and remediation services	Managed care eligible members ages 0-64 who are enrolled in an ACO (Flexible Services) OR MassHealth-eligible pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program (Emergency Assistance Family Shelter Program)	Social Risk Factor 1, 2, or 3	Clinical Risk Factors 1, 2, 3, 4, 5, 6, or 7

Massachusetts 1115 HRSN Services Matrix: Nutrition

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the Population
Nutrition counseling and education, including on healthy meal preparation	Managed care eligible members ages 0-64 who are enrolled in an ACO who meet at least one of the clinical criteria and at least one of the social risk factors (Flexible Services)	Social Risk Factor 4	Clinical Risk Factors 1, 2, 3, 4, 5, or 6
Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months	Managed care eligible members ages 0-64 who are enrolled in an ACO who meet at least one of the clinical criteria and at least one of the social risk factors (Flexible Services)	Social Risk Factor 4	Clinical Risk Factors 1, 2, 3, 4, 5, or 6
Meals or pantry stocking	Managed care eligible members ages 0-64 who are enrolled in an ACO who meet at least one of the clinical criteria and at least one of the social risk factors (Flexible Services)	Social Risk Factor 4	Clinical Risk Factors 1, 2, 3, 4, 5, or 6
Fruit and vegetable prescriptions, limited to 6 months, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement	Managed care eligible members ages 0-64 who are enrolled in an ACO who meet at least one of the clinical criteria and at least one of the social risk factors (Flexible Services)	Social Risk Factor 4	Clinical Risk Factors 1, 2, 3, 4, 5, or 6

	Clinical Risk Factor	Clinical Criteria Detail - Flexible Services	Clinical Criteria Detail - Specialized CSP	Clinical Criteria Detail - Emergency Assistance	Clinical Criteria Detail - Pre-Procedure Housing	Clinical Criteria Detail - Post Hospitalization Housing
Risk Factor 1	**Behavioral Health Need**	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)	The member has a behavioral health diagnosis, which requires and can reasonably be expected to respond to the intervention. The member is at risk for admission to 24-hour behavioral health inpatient or diversionary services.	A persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.	N/A	N/A
Risk Factor 2	**Physical Health Need**	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)	N/A	A persistent, disabling, progressive or life-threatening physical health condition(s) that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.	N/A	N/A
Risk Factor 3	**Disability**	Have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)	N/A	Have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)	N/A	N/A
Risk Factor 4	**Emergency Department Utilization**	Has repeated incidents of emergency department use (defined as 2 or more visits within six months, or 4 or more visits within a year)	N/A	Has repeated use of emergency department care (defined as two or more visits in the past six months or four or more visits within the past 12 months).	N/A	N/A
Risk Factor 5	**High Risk Pregnancy**	Pregnant individuals who are experiencing high risk pregnancy or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period	N/A	Pregnant individuals who are experiencing high risk pregnancy or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period	N/A	N/A
Risk Factor 6	**Pregnancy (other)**	Pregnant individuals or postpartum individuals up to twelve months postpartum, without additional clinical factors	N/A	Pregnant individuals or postpartum individuals up to twelve months postpartum, without additional clinical factors	N/A	N/A
Risk Factor 7	**Experience of violence**	N/A	N/A	Is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence.	N/A	N/A
Risk Factor 8	**Pre-Procedure**	N/A	N/A	N/A	Has a referral for a colonoscopy procedure or a colonoscopy procedure scheduled within one day of admission to the medical respite and cannot prepare for the colonoscopy effectively due to not having consistent access to a private bathroom.	N/A
Risk Factor 9	**Post-Hospitalization**	**N/A**	N/A	N/A	**N/A**	Post-Procedure Housing: - Has been admitted to an acute care hospital medical or surgical service or has presented to an acute care hospital emergency department with a medical or surgical issue; - Has a primary acute medical issue that is not yet resolved but is expected to resolve and can be safely managed in a medical respite setting with the STPHH provider's support accessing primarily home- and community-based MassHealth services; - Does not meet nursing facility level of care criteria; - Is anticipated to no longer require or does not currently require acute care hospital level of care and has been deemed stable and ready for discharge to a home-based setting in the community; - Does not have a stable and safe housing option identified or the resources to obtain appropriate housing where they can be safely discharged; and - Is independent with regards to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), except for needing short-term assistance with regaining the ability to perform ADLs and IADLs as part of the recuperative process.

Note: Clinical Criteria are described in greater detail in the HRSN Protocol (Attachment P) of MassHealth's 1115 Demonstration Waiver

	Social Risk Factor	Detail of Risk Factor - Flexible Services	Detail of Risk Factor - Specialized CSP	Detail of Risk Factor - Emergency Assistance	Detail of Risk Factor - Pre-Procedure Housing	Detail of Risk Factor - Post Hospitalization Housing
Risk Factor 1	**Homeless**	As described in Table 1 of Attachment P (HRSN Services Protocol): – lacks a fixed, regular, and adequate nighttime residence; – will imminently lose their primary nighttime residence; OR – 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	As described in Table 4 of Attachment P (HRSN Protocol): - Is chronically homeless, as defined by the U.S. Department of Housing and Urban Development (HUD); OR - Is a frequent user of acute MassHealth services and is homeless, as defined by HUD in section (1)(i)-(iii) of the definition of "homeless" in 24 CFR 91.5.	As defined by 24 CFR 91.5.	As described in Table 10 of Attachment P (HRSN Protocol): - lacks a fixed, regular, and adequate nighttime residence, and who has 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; OR - is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements	As described in Table 10 of Attachment P (HRSN Protocol): - lacks a fixed, regular, and adequate nighttime residence, and who has 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; OR - is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements
Risk Factor 2	**At risk of homelessness**	As described in Table 1 of Attachment P (HRSN Protocol): Does not have sufficient resources or support networks available to prevent them from moving to an emergency shelter or another place not meant for human habitation; AND – has moved because of economic reasons two or more times during the previous 60 days; – Is living in the home of another because of economic hardship; – Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days; – Lives in a hotel or motel; – Lives in an over-crowded unit; OR – Is exiting a publicly funded institution, or system of care	As described in Table 4 of Attachment P (HRSN Protocol) is facing eviction and does not having 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	N/A	N/A	N/A
Risk Factor 3	**Housing Unstable**	As described in Table 1 of Attachment P (HRSN Protocol): – Requires a clinically appropriate home modification/remediation service; – Has utility payments in arrears or lacks income for utility payments, such that the lack of utilities may negatively impact their health; – Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition; – Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction; OR – Is living in housing that is negatively impacting their health	N/A	N/A	N/A	N/A
Risk Factor 4	**Low or Very Low Food Security**	As defined by the USDA	N/A	N/A	N/A	N/A
Risk Factor 5	**Justice-involved**	N/A	As described in Table 4 of Attachment P (HRSN Protocol) has been released from a correctional institution within the past year; or is under the supervision of the Massachusetts Probation Service, Massachusetts Parole Board; or both	N/A	N/A	N/A

Note: Social Risk Factors are described in greater detail in the HRSN Protocol (Attachment P) of MassHealth's 1115 Demonstration Waiver

Attachment Q
Medicaid Managed Care Entity/ACO Performance-Based Payment Mechanisms

1. Overview

Over the prior demonstration, the Commonwealth shifted payments to risk-based alternative payment models focused on accountability for quality, integration and total cost of care. Similarly, Massachusetts implemented Medicaid managed care directed payments aligned with the goals of the Commonwealth's delivery system reforms by holding hospitals accountable for quality and care integration.

The Commonwealth will continue these successful alternative payment models during the current demonstration by directing Medicaid Managed Care Entities/Accountable Care organizations (MMCE/ACO) to administer performance improvement initiatives and/or fee schedule requirements for hospitals as described below ("MMCE/ACO payment mechanism"). In addition to being critical to the delivery system reform goals shared by the Commonwealth and CMS, these performance improvement initiatives and fee schedule requirements are integral to the Commonwealth's overall financing of activities authorized under the demonstration, and are compliant with requirements for payments made under 42 CFR 438.6(c)

This Attachment Q is intended to describe a common understanding between the Commonwealth and CMS on a framework for implementing these state directed payments. The attachment does not prohibit the Commonwealth from modifying the payment amounts or the performance measures to best meet its needs and submitting such revisions through the CMS managed care directed payment review and approval process; such changes shall not require an amendment to the demonstration.

2. General Requirements

The MMCE/ACO payment mechanisms described below, which the Commonwealth agrees to establish, shall be implemented through MMCE/ACO contracts consistent with this Attachment in order to meet the requirements of 42 CFR 438.6(c).

3. Description of the Payment Mechanisms

The Commonwealth intends to direct MMCE/ACOs to administer the following MMCE/ACO payments:

a. **Clinical Quality Incentive for Acute Hospitals (DY 28 – DY 32):** For participating private in-state acute hospitals, the Commonwealth will direct MMCE/ACOs to make payments based on clinical quality performance.
b. **Hospital Quality Incentive (DY 28 – DY 32):** The Commonwealth will direct MMCE/ACOs to make payments to non-federal, non-state-owned public hospitals based on hospital quality performance.
c. **Hospital Performance Improvement Initiative (DY 28 – DY 32):** The Commonwealth will direct MMCE/ACOs to make payments to hospital systems affiliated with the state-owned medical school based on hospital quality performance.
d. **Integrated Care Incentive (DY 28 – DY 32):** In the event that primary care providers employed by or affiliated with Cambridge Health Alliance participate in the Commonwealth's Accountable Care Partnership Plan model, the Commonwealth will direct

that MMCE/ACO to make payments to non-federal, non-state-owned public hospitals based on the accountable care performance of such hospitals' owned or affiliated primary care providers.

e. **Behavioral Health Quality Incentive (DY 28 – DY 32):** The Commonwealth will direct the Commonwealth's single Prepaid Inpatient Health Plan (PIHP) to make payments to non-federal, non-state-owned public hospitals in its network based on behavioral health quality performance.
f. **Professional Services Performance Improvement Initiative (DY 28 – DY 32):** The Commonwealth will direct MMCE/ACO to make payments to hospital systems affiliated with the state-owned medical school based on performance tied to physician services.
g. **Rate Add-on for Acute Hospitals (DY 28 – DY 32):** The Commonwealth will direct MMCE/ACOs to make a rate add-on payment to all contracted in-state acute hospitals.

4. General Methodology Linking Payment Mechanisms to Utilization/Delivery of Services

The Commonwealth shall include in its MMCE/ACO contracts payment mechanisms consistent with the following approach:

a. The Commonwealth will specify the maximum allowable payment amount that it will direct each MMCE/ACO to pay to one or more designated classes of hospitals during the MMCE/ACO contract year.
b. The maximum payment amount earned by a specific hospital will be equal to the total amount directed to the designated class multiplied by the proportion of the class's total managed Medicaid Gross Patient Service Revenue ("Medicaid GPSR") or other measure of utilization and delivery of services through managed care, for which the specific hospital's Medicaid managed care GPSR, or other measure of managed care-delivered services, accounts during the MMCE/ACO contract year. For performance improvement initiatives under 42 CFR 438.6(c)(1)(ii), a hospital will earn its maximum payment amount only if it achieves full quality performance as set forth in the corresponding state directed payment preprint. Note that, for the Rate add-on for Acute Hospitals, payment will be based on managed care inpatient discharges and outpatient episodes, not GPSR.
c. The Commonwealth will calculate periodic lump sum payments that MMCE/ACOs will be directed to pay to specific hospitals. The periodic lump sum payments will be calculated based on:
    i. The Commonwealth's projection of each hospital's Medicaid managed care GPSR, or other measure of utilization and delivered services through managed care during the MMCE/ACO contract year;
    ii. For performance improvement initiatives, each hospital's expected performance (based on prior year or other data);
    iii. A target for the MMCE/ACO to pay a percentage greater than 50% of each hospital's expected earned payments in advance of a final reconciliation after the MMCE/ACO contract year.
d. Within seven days prior to each scheduled lump sum payment described above, the Commonwealth shall make a payment to each MMCE/ACO that is directed to make a payment to hospitals. The Commonwealth's payment to each MMCE/ACO shall be equal to the sum of all payments that the MMCE/ACO is directed to make. The Commonwealth may use any permissible source, including intergovernmental transfers, as the source of the non-federal share for MMCE/ACO payments.
e. Following the MMCE/ACO contract year, actual Medicaid managed care GPSR, or other

measure of utilization and delivered services, for each hospital and performance under each contract as applicable will be determined and the actual payment amount earned by hospitals will be calculated.

f. Final reconciliation: Based on the difference between the periodic lump sum amounts paid to hospitals during the MMCE/ACO contract year and the actual amount earned, MMCE/ACOs will be directed to make a final reconciliation payment to hospitals. In the event that the lump sum payments made by the MMCE/ACO to a hospital during the MMCE/ACO contract year exceeded the total actual amount earned, the hospital will remit the excess payment to the MMCE/ACO as part of the final reconciliation. For the Rate Add-on for Acute Hospitals, any amount remitted by a hospital to a MMCE/ACO as part of the reconciliation shall in turn be remitted by the MMCE/ACO to the Commonwealth.

5. Performance Measures and Evaluation Plan

As required under 42 CFR 438.6(c)(2)(i)(D), the Commonwealth shall have a plan to evaluate the extent to which the payment mechanisms achieve the goals and objectives identified in the managed care quality strategy. The Commonwealth may include process, improvement, outcomes, system transformation, and innovative measures and indicators that are consistent with the Commonwealth's delivery system reforms and quality strategy. For the performance improvement initiatives, as a matter of general principle, where practicable, the Commonwealth will utilize measures drawn from nationally vetted and endorsed measure sets (e.g., National Quality Forum, National Committee for Quality Assurance, the Joint Commission, etc.) or measures in wide use across Medicare and Medicaid quality initiatives (e.g., the Medicaid Child and Adult Core Set Measures, CMS Core Quality Measures Collaborative measure sets, Health Home measure sets, Behavioral Health Clinic measure sets, and Merit-based Incentive Payment System and Alternative Payment Model measures, etc.).

For performance improvement initiatives, each participating hospital's performance, under each payment mechanism, shall be measured against approved benchmarks and a score for each measure or group of measures will be calculated according to a methodology to be defined by EOHHS and approved by CMS. Benchmarks for any individual performance measure may be set either on the basis of absolute performance standards or improvement targets for individual hospitals. Scores will be summed, with or without weighting, across all measures or groups of measures in order to calculate an overall performance score between 0 and 100 percent. Under the MMCE/ACO payment mechanism, each hospital's performance score shall be multiplied by that hospital's maximum payment amount in order to calculate the actual payment earned by the hospital.

For the rate add-on, the state may use utilization-based measurement to evaluate the payment arrangement.

The Commonwealth will submit the evaluation plan and performance measures to CMS for approval through the submission of state directed payment preprints under 438.6(c).

6. MMCE/ACO vehicles and Anticipated Payment Amounts

The scheduled maximum dollar amounts directed to designated classes of providers under each of the MMCE/ACO payments mechanisms are:

#	Payment Title	MMCE/ ACO vehicle	Hospital Class	Maximum MMCE/ACO incentive payment to designated hospital class, by demonstration year ($ millions)				
				DY 28	DY 29	DY 30	DY 31	DY 32
1*	Clinical Quality Incentive for Acute Hospitals	MMCOs, ACOs and PIHP	All participating private in-state acute hospitals	118	118	118	118	118
2	Hospital Quality Incentive	MMCOs	Non-federal, non-state-owned public hospitals	134	134	134	134	134
3	Hospital Performance Improvement Initiative	MMCOs	Hospital systems affiliated with the state-owned medical school	125	125	125	125	125
4	Integrated care Incentive	Accountable care partnership plans affiliated with Cambridge Health Alliance	Non-federal, non-state-owned public hospitals in network	124	124	124	124	124
5	Behavioral health Quality Incentive	PIHP	Non-federal, non-state-owned public hospitals in network	60	60	60	60	60
6	Performance Improvement Initiative for Professional Services	ACO plan partnered with hospital system affiliated with the state-owned medical school	Hospital systems affiliated with the state-owned medical school	75	75	75	75	75
7**	Rate Add-on for Acute Hospitals	MMCOs, ACOs and PIHP	All contracted in-state acute hospitals	306	334	226	226	226

*1 reflects estimated payment per year for the Clinical Quality Incentive through managed care vehicles. Total payment through both managed care and FFS vehicles is $250 million per year, however the actual portion paid per year through managed care will be based on managed care utilization only.

**7 reflects estimated payment for the Rate add-on for acute hospitals through managed care vehicles. Total anticipated payment through both managed care and FFS vehicles is as follows: DY 28, $650 million; DY 29, $710 million; DY 30, $480 million; DY 31, $480 million; DY 32, $480 million. The actual portion paid per year through managed care will be based on managed care utilization only.

The Commonwealth may propose an increase or decrease of 20 percent of the maximum payment amounts listed in the table above. The payments will be incorporated as a component of the MMCE/ACO capitation amounts and are therefore subject to CMS approval under the review and approval process described in the next section.

7. CMS Review and Approval

The Commonwealth shall submit to CMS for approval any payment mechanisms that direct payments as described in 42 CFR 438.6(c) in a format and template as specified by CMS. Such submission shall include the payment amounts and the performance measures and scoring benchmarks. In addition, the Commonwealth shall clearly identify the specific goals and objectives described in the Commonwealth's managed care quality strategy that the incentive payment mechanism is designed to achieve. Materials submitted for approval shall be consistent with this Attachment in order to meet the requirements of 42 CFR 438.6 and may be submitted for approval prior to the contract and rate certification submission under 42 CFR 438.3 and 42 CFR 438.7. CMS will provide written approval for all payment mechanisms.

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. <u>Flexible Services Assessment and Planning Process</u>

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.

Independent Evaluation Design Document

Massachusetts 1115 Demonstration Extension 2022-2027

Prepared by

The UMass Chan Medical School

for

The Massachusetts Executive Office of Health and Human Services

and

The Centers for Medicare and Medicaid Services

Submitted to CMS
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Evaluation Design Document (EDD) Acronyms

Acronym	Definition
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan
ACS	American Community Survey
AHRQ	Agency for Healthcare Research and Quality
APCD	All-Payer Claims Database
APM	Alternative Payment Methods
APTC	Advanced Premium Tax Credit
ASAM	American Society of Addiction Medicine
BBL	Basic Benefit Level
BCCDP	Breast and Cervical Cancer Demonstration Program
BH	Behavioral Health
BH-JI	Behavioral Health Supports for Justice-Involved Individuals
BRFSS	Behavioral Risk Factor Surveillance System
BSAS	Bureau of Substance Addiction Services
CARES	MassHealth Coordinating Aligned, Relationship-Centered, Enhanced Support
CBAT	Community-Based Acute Treatment for Children and Adolescents
CBHC	Community Behavioral Health Center
CCS	Community Crisis Stabilization
CDC	Centers for Disease Control and Prevention
CE	Continuous Eligibility
C&E	Coverage and Eligibility
CFIR	Consolidated Framework for Implementation Research
CG-CAHPS	Clinician and Group Consumer Assessment of Healthcare Providers and Systems
CHA	Cambridge Health Alliance
CHC	Community Health Center
CHIA	Center for Health Information Analysis
CHIP	Children’s Health Insurance Program
CHW	Community Health Worker
CIS-CH	Childhood Immunization Status

Acronym	Definition
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
CPT	Current Procedural Terminology
CSP	Community Support Program
CSP-HI	Community Support Program for Homeless Individuals
CSP-JI	Community Support Program for Individuals with Justice Involvement
CSP-TPP	Community Support Program for Tenancy Preservation Program
CTI	Comprehensive Theory of Integration
CY	Calendar Year
DCE	Discrete Choice Experiment
DEA	Drug Enforcement Administration
DMH	Department of Mental Health
DPH	Department of Public Health
DSH	Disproportionate Share Hospital
DSH-like	Disproportionate Share Hospital-like
DSR	Delivery System Reform
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
ED	Emergency Department
EDD	Evaluation Design Document
EHR	Electronic Health Record
ENS	Emergency Notification Systems
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESI	Employer-Sponsored Insurance
ESR	Evaluation Summative Report
FFCRA	Families First Coronavirus Response Act
FFP	Federal Financial Participation
FFS	Fee-For-Service
FG	Focus Group
FMCH	Family Medicine and Community Health

Acronym	Definition
FNP	Family Nurse Practitioner
FPL	Federal Poverty Level
FSP	Flexible Service Program
FUA-AD	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUA-CH	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17
FUH-AD	Follow-up After Hospitalization for Mental Illness
FY	Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCUP	Hospital Cost and Utilization Project
HIX	Health Insurance Exchange
HPC	Health Policy Commission
HQEI	Hospital Quality and Equity Initiative
HRSN	Health-Related Social Needs
HSN	Health Safety Net
ICC	Intensive Care Coordination
ICD	International Classification of Diseases
IE	Independent Evaluator
IEIR	Independent Evaluation Interim Report
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
ILC	Independent Living Center
IMD	Institution for Mental Diseases
ISA	Interdepartmental Service Agreement
ITS	Interrupted Time Series
KII	Key Informant Interview
LOS	Length of Stay
LTSS	Long-Term Services and Supports
MA	Medical Assistant
MA-APCD	Massachusetts All-Payer Claims Database
MAGI	Modified Adjusted Gross Income

Acronym	Definition
MAT	Medication for Addiction Treatment
MCO	Managed Care Organization
MD	Medical Doctor
MES	Member Experience Survey
MHQP	Massachusetts Health Quality Partners
MMIS	MassHealth Medicaid Management Information System
MOUD	Medication for Opioid Use Disorder
MSP	Medicare Savings Program
NCQA	National Committee for Quality Assurance
NIMH	National Institute of Mental Health
NP	Nurse Practitioner
NQF	National Quality Forum
NSDUH	National Survey on Drug Use and Health
NSS	Neighborhood Stress Score
O-E ratio	Observed-to-Expected Ratio
OUD	Opioid Use Disorder
PA	Physician Assistant
PACT	Program for Assertive Community Treatment
PCACO	Primary Care Accountable Care Organization
PCC	Primary Care Clinician (Used in context of plan, not defined)
PCDI	Payment and Care Delivery Innovation
PCP	Primary Care Provider
PE	Provisional Eligibility
PFAC	Patient and Family Advisory Committee
PHD	Public Health Data Warehouse
PHE	Public Health Emergency
PHTII	Public Hospital Transformation and Incentive Initiative
PMPM	Per-Member-Per-Month
PPC-CH	Prenatal and Postpartum Care: Timeliness of Prenatal Care
PSPIC	Provider and Staff Perceptions of Integrated Care
PY	Performance Year

Acronym	Definition
QED	Quasi-Experimental Design
QI	Qualitative Interviewing
RE	Retroactive Eligibility
RELDSOGI	Race, Ethnicity, Language, Disability, Social Orientation, Gender Identity
RF	Risk Factor
RFP	Request for Proposal
RN	Registered Nurse
RQ	Research Question
SAC	Scientific Advisory Committee
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Severe Emotional Disturbance
SFY	State Fiscal Year
SME	Subject Matter Expert
SMI	Serious Mental Illness
SNCP	Safety Net Care Pool
SNH	Safety Net Hospital
SNPP	Safety Net Provider Payments
SSO	Social Service Organization
STC	Special Terms and Conditions
SUD	Substance Use Disorder
SWI	Statewide Investments
TA	Technical Assistance
TCOC	Total Cost of Care
TJC	The Joint Commission
UC	Uncompensated Care
UCCR	Uncompensated Care Cost & Charge Report
WI	Workforce Initiatives
WONDER	Wide-ranging Online Data for Epidemiologic Research

1. Executive Summary

1.1. Demonstration Overview

MassHealth, a combination of the Massachusetts Medicaid and Children's Health Insurance Program (CHIP), serves over 2.16 million Massachusetts residents as of December 2022. Massachusetts has long used a Section 1115 Demonstration Project (Demonstration) to pilot innovative strategies for delivering and financing healthcare for many MassHealth members. Since its launch in 1997, the Demonstration has served as a vehicle to expand coverage, encourage better coordination and cost containment through managed care, and support safety net providers, among other innovations. A precursor to the coverage expansions under the Affordable Care Act, the Demonstration played a key role during the Commonwealth of Massachusetts' 2006 healthcare reform (also known as Chapter 58 of the Acts of 2006) that made coverage available across the income spectrum through changes to the individual marketplace and Medicaid. In 2012, the Commonwealth passed further legislation (Chapter 224 of the Acts of 2012) to address the high cost of healthcare and the need for better care integration. This legislation set healthcare cost benchmarks for the state and created a new independent state agency, the Health Policy Commission (HPC), to monitor healthcare costs. The legislation also directed MassHealth to implement new ways of paying for and delivering more integrated care.

In 2016, the Commonwealth requested a five-year extension of the Demonstration to improve care delivery, control costs, and address the opioid epidemic. On November 4, 2016, the Centers for Medicare and Medicaid Services (CMS) approved the sixth extension of the Demonstration for the period of July 1, 2017, through June 30, 2022. On June 9, 2022, CMS approved a three-month Demonstration extension through September 30, 2022.

In the extension of the Demonstration awarded on November 4, 2016, CMS approved the Commonwealth's plan to implement significant new components to support a value-based restructuring of MassHealth's healthcare delivery and payment system and a Delivery System Reform Incentive Payment (DSRIP) Program to transition the MassHealth delivery system into accountable care models. The extension's Safety Net Care Pool (SNCP) provisions aligned funding with MassHealth's broader accountable care strategies and expectations to establish a more sustainable structure for necessary and ongoing funding support to safety net providers.

In March 2022, the Commonwealth submitted the Independent Evaluation Interim Report (IEIR) to CMS for the 2017-2022 Demonstration period.[1] The primary finding from the IEIR was that MassHealth and its partners collaborated extensively and made valuable, measurable progress in the early years of the implementation toward transforming healthcare delivery and improving care processes at the organizational

[1] Commonwealth of Massachusetts. (2022, September 29). Revised Draft Independent Evaluation Interim Report. Massachusetts Medicaid 1115 Demonstration Extension 2017-2022. Mass.gov. https://www.mass.gov/doc/cms-approved-interim-evaluation-report/download

level. Findings from the first 18 months showed substantial progress in implementing the program as designed and early evidence of progress on outcomes of interest.

Early signs of improvement in clinical outcomes and progress in shifting utilization from high-cost to lower-cost outpatient settings while maintaining high member satisfaction levels were especially encouraging. With support from MassHealth, participating organizations have overcome many challenges associated with developing new relationships, enhancing technology infrastructure, and operating under an integrated and accountable care model.

Among other findings reported in the IEIR, it is notable that the Demonstration successfully kept the Commonwealth's uninsurance rate the lowest in the country — 2.4 percent as of 2021. The IEIR also found that overall, aggregate uncompensated care (UC) costs across the 14 participating safety net hospitals (SNH) that received Safety Net Provider Payments (SNPP) decreased during the Demonstration. In addition, the preliminary findings in the IEIR were generally positive for members diagnosed with a substance use disorder (SUD), such as decreases in the rate of opioid overdoses and increases in the number of providers treating SUD. However, findings were mixed related to the initiation and engagement of MassHealth members in SUD treatment.

As shown by budget neutrality calculations reported by MassHealth, the Demonstration has lower costs than would otherwise be accrued without the Demonstration. An internal analysis by MassHealth confirms that per-member-per-month (PMPM) costs for MassHealth beneficiaries will continue to be lower than they would have been without the Demonstration.

On September 28, 2022, CMS approved Massachusetts' request — entitled "MassHealth" (Project Number 11-W-00030/1 and 21-W00071/1) — to extend the Demonstration for another five years to enable the Commonwealth to achieve the following Demonstration goals:

1. Continue the path of restructuring and reaffirming accountable, value-based care — increasing expectations for how Accountable Care Organizations (ACOs) improve care and trend management and refining the model;
2. Make reforms and investments in primary care, behavioral health (BH), and pediatric care that expand access and move the delivery system away from siloed, fee-for-service (FFS) healthcare;
3. Continue to improve access to quality and equity of care with a focus on initiatives addressing health-related social needs (HRSN) and specific improvement areas relating to health quality and equity, including maternal healthcare and healthcare for justice-involved individuals who are in the community;
4. Support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care; and

5. Maintain near-universal coverage, including updates to eligibility policies to support coverage and equity. This Demonstration is effective October 1, 2022, through December 31, 2027.

The approval will extend many longstanding authorities and allow the Commonwealth, through various new and revised waiver and expenditure authorities, to test the efficacy of innovative practices aimed at promoting consistently high-quality, equity-promoting, evidence-based, coordinated, and integrated care. These practices are designed to address the combined goals of providing medical assistance, addressing HRSN, and improving the health of the communities served through the Demonstration. The extension will also lead to additional populations being served by Medicaid and additional services being furnished to Medicaid beneficiaries.

1.2. Selection of the Independent Evaluator and Assurance of Independence

Based on previous performance and familiarity with MassHealth programs, policies, and data systems, Massachusetts has selected the University of Massachusetts Chan Medical School (UMass Chan) as the Independent Evaluator (IE) for the 2022-2027 Demonstration. The independent evaluation will also be informed by review and guidance from a Scientific Advisory Committee (SAC) and external reviewers comprised of nationally recognized experts in Medicaid systems transformation, program evaluation, and health services research. Further detail on UMass Chan's qualifications, key personnel, lack of conflict of interest, and the SAC and external reviewers can be found in Appendix A.

1.3. Overview of the 2022-2027 EDD

The development of this EDD has been guided by the Demonstration's Special Terms and Conditions (STC) dated September 28, 2022, and subsequent communications and guidance from CMS.[2] STC 17 Evaluation of the Demonstration and the CMS technical assistance memo identified multiple "policy components" and subject areas for evaluation that overlapped with the state's five Demonstration goals. The IE team worked with MassHealth subject matter experts to crosswalk the CMS required and recommended evaluation components with the Massachusetts Demonstration goals to identify seven "policy domains" that include the policy components for evaluation identified by CMS (see Table 1-1).

The following policy domains will be the subject of the Independent Evaluation:

- See Coverage and Eligibility
- See Delivery System Reform
- See Behavioral Health
- See Safety Net Care Pool
- See Workforce Initiatives

[2] Centers for Medicare & Medicaid Services. (2022, September 28). Technical Assistance on MassHealth Section 1115 Demonstration; 1115 MassHealth Demonstration ("Waiver") | Mass.gov and https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html

- See Hospital Quality and Equity Initiative
- See Health-Related Social Needs

Table 1-1: Crosswalk of EDD Policy Domains, MH Goals, CMS Evaluation Components, and Corresponding STCs

EDD Chapter and MassHealth Policy Domains	MH Goal(s)	CMS Required and Recommended Evaluation Components[2]	New, Revised, or Continuing 1115 Policy	Corresponding STCs
2. Coverage and Eligibility	5	Waiver of Retroactive Eligibility	Revised	4.2, 8.13, 16.5.vi, 17.6h
2. Coverage and Eligibility	5	Streamlined Eligibility Redetermination	Continuing	4.4
2. Coverage and Eligibility	5	Provisional Coverage for Individuals who Self Attest to Eligibility*	Continuing	4.7
2. Coverage and Eligibility	3, 5	Continuous Eligibility	New	4.10, 4.11, 16.5.iv, 17.6f
2. Coverage and Eligibility	5	Waiver of Early and Periodic Screening, Diagnostic, and Treatment Services	Continuing	5.3, 5.6
2. Coverage and Eligibility	3, 5	Breast and Cervical Cancer Demonstration Program	Continuing	4.8, 5.5
2. Coverage and Eligibility	3, 5	MassHealth CommonHealth	Continuing	5.6
2. Coverage and Eligibility	3, 5	MassHealth Family Assistance	Continuing	5.7
2. Coverage and Eligibility	5	Extended Eligibility for Out-of-State Former Foster Care Youth Residing in Massachusetts*	Continuing	5.9
2. Coverage and Eligibility	1, 5	Premium Assistance for Marketplace and Employment Sponsored Insurance (ESI)	Continuing	8.12, 10.1, 16.5.v, 17.6g
2. Coverage and Eligibility	5	Beneficiary Cost Sharing (Premiums and Copayments)	Continuing	9.1, 17.6g
2. Coverage and Eligibility	5	Medicare Savings Program Expansion	Revised	5.3c
3. Delivery System Reform	1, 2, 4	Managed Care Delivery System, including (1) Accountable Care Partnership Plans, (2) Community Partner Program, and (3) the Authority to Allow Primary Care Service Payment Rates for Accountable Care Organization Participating Providers	Revised	8.1-8.13, 17.6i
4. Behavioral Health	1, 2	Diversionary Behavioral Health Services	Continuing and Revised	5.11, 17.6

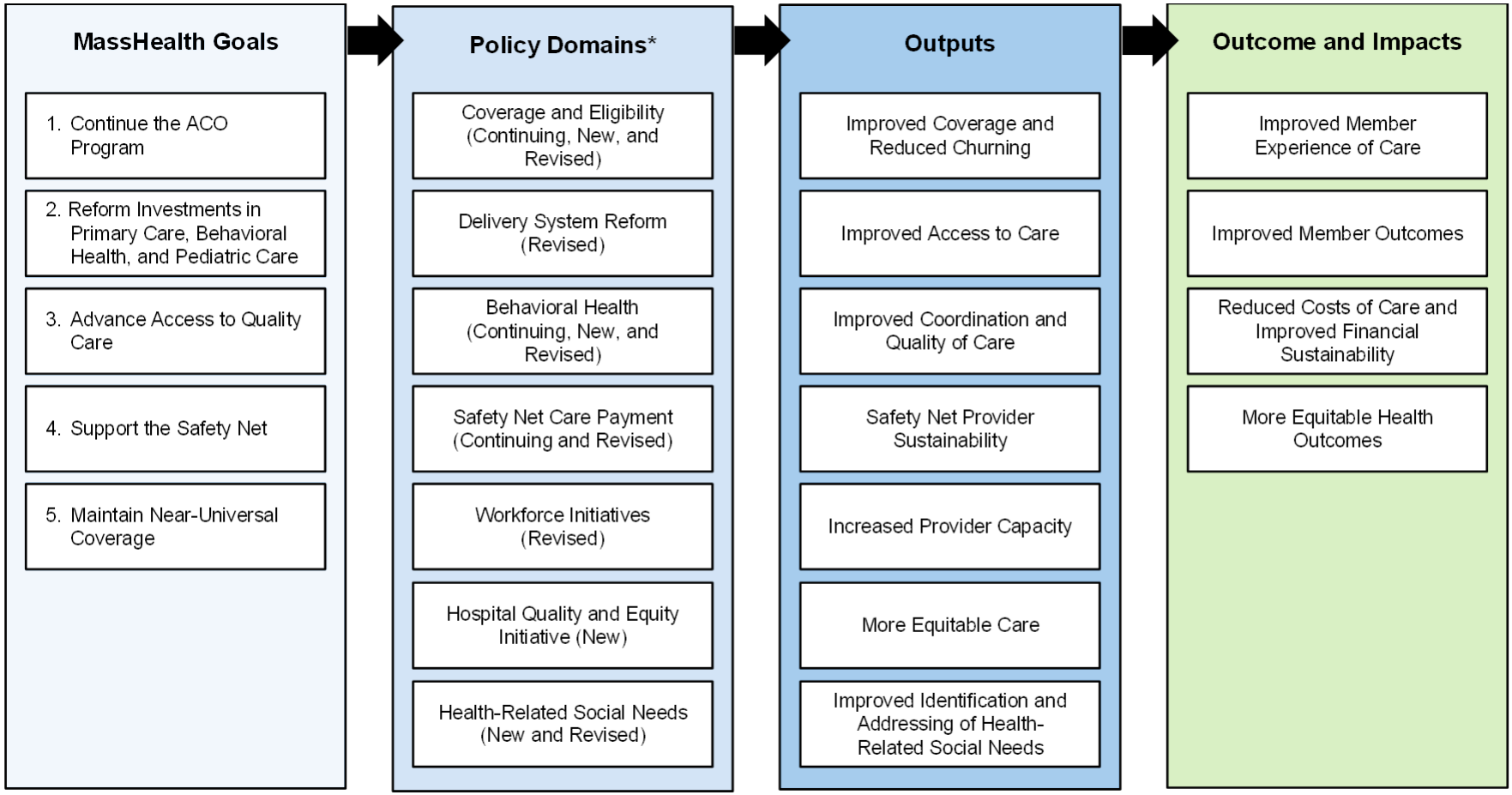
EDD Chapter and MassHealth Policy Domains	MH Goal(s)	CMS Required and Recommended Evaluation Components[2]	New, Revised, or Continuing 1115 Policy	Corresponding STCs
4. Behavioral Health	1, 2	Opioid Use Disorder (OUD)/Substance Use Disorder Program (SUD)	Continuing and Revised as of August 2022	6.1, 17.6a
4. Behavioral Health	1, 2	Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Programs	New as of August 2022	7.1, 17.6b
5. Safety Net Care Pool	4	Safety Net Care Pool (SNCP)	Continuing and Revised	11.1-11.6
6. Workforce Initiatives	2	Workforce Initiatives	Revised	13.1 - 13.8, 14.5a, 15.17, 17.6d
7. Hospital Quality and Equity Initiative	3	Hospital Quality and Equity Initiative	New	14.1 -14.23, 17.6c
8. Health-Related Social Needs	1, 3	Provision of Services to Address Health-related Social Needs, Including Infrastructure Costs	New and Revised	15.1 -15.18, 17.6e

*These two policies were designated as optional for evaluation and are not included in the evaluation design.

Each chapter includes a logic model that illustrates the relationships between policy inputs, implementation activities, outputs, and outcomes for a specific policy domain. We recognize that these policy domains and their overlapping components are designed to work together to achieve the overall goals of the Demonstration. In Figure 1-1, the overarching Demonstration Logic Model summarizes the process by which the Demonstration goals informed several policy initiatives designed to jointly affect a common set of outputs and ultimate outcomes. As illustrated in Table 1-1, for example, continuous eligibility, a component of the Coverage and Eligibility policy domain (Chapter 2, Coverage and Eligibility), is also key to the success of the Demonstration goals of improving access to high-quality care and improving health equity. Likewise, the Delivery System Reform policies (Chapter 3, Delivery System Reform), most notably the MassHealth ACOs, are directly linked to accountability for safety net hospitals (Chapter 5, Safety Net Care Pool) and all acute care hospitals participating in the Hospital Quality and Equity Initiative (Chapter 7, Hospital Quality and Equity Initiative). The ACOs have a lead role in implementing HRSN programs (Chapter 8, Health-Related Social Needs), while ACOs share HRSN screening and data reporting requirements with hospitals participating in the HQEI. Policies to promote recruitment and retention of a robust community-based primary care and BH workforce (Chapter 6, Workforce Initiatives) will support the safety net practice sites, hospitals, and community-based organizations (many of whom will be part of or contracted with the ACOs) responsible for delivering integrated and accountable care across the continuum. The alignment and joint effects of these policies across domains will be critical to the success of the Demonstration goals related to expanding access to primary care, Behavioral Health (Chapter 4, Behavioral Health), and pediatric services while supporting the Commonwealth's safety net and continuing to move the system away from a siloed FFS model.

Figure 1-1: Demonstration Logic Model

Connecting 1115 Demonstration Waiver Policies to Demonstration Goals and Desired Outcomes



*Parentheticals indicate whether policies in each domain are continuing unchanged, revised and continuing, and/or are new since the prior 2017-2022 Demonstration period.

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1.4. Summary of the Evaluation Design, Data Sources, and Limitations

The body of the EDD addresses the evaluation of the seven policy domains. Each chapter begins with an introductory section providing background and context for the policy domain before describing the policy domain logic model, evaluation research questions, and evaluation plans. The domain chapters also include information on the impacted population or study groups and appropriate comparison groups, along with the measures, data sources, and analytic approach for evaluating that policy domain. For each research question, the most appropriate qualitative, quantitative, and mixed methods approach will be deployed. The domain chapters also highlight the limitations of the evaluation related to data availability, comparison populations, and potential confounding factors.

The evaluation plans for each policy domain have been designed to account for the variable timing of policies and program implementation. Implementation timelines for the policy components of the policy domains are described in Chapters 2 through 8. After describing the cross-domain data sources and analytical approaches below, we offer our perspective on the potential limitations of the evaluation design for making causal inferences, including the impact of overlapping policies.

1.4.1. Summary of Data Sources

This section summarizes the data needed for the evaluation, including traditional administrative data, program-specific data, publicly available data, document review data, key informant interviews (KII), case studies, and survey data. The methods used to evaluate specific policy domains and components will be addressed in subsequent EDD Domain chapters.

Table 1-2 summarizes the data sources that will be used to evaluate the seven Demonstration policy domains. Table 1-3 illustrates the timeline for data collection, management, and analysis during the Demonstration.

Table 1-2: Summary of Data Sources by Policy Domain

Data Source Types	C&E	DSR	BH	SNCP	WI	HQEI	HRSN
Traditional Administrative Data:							
MassHealth Member Eligibility and Enrollment	X	X	X	X	X	X	X
MassHealth Claims & Encounters	X	X	X	X	X	X	X
MassHealth Provider File	X	X	X	X	X	X	X
All-Payer Claims Data			X				
Program-specific Data:							
Accountable Care Organization		X	X			X	X
Flexible Services Program		X				X	X
Hospital Quality and Equity Initiative Enhanced Demographics Files						X	X
Coverage & Eligibility Program Enrollment	X						
Specialized Community Support Programs		X	X			X	X
Workforce Initiative Program					X		
Publicly Available and Other Data:							
Massachusetts Death Records			X				
American Community Survey	X						
Uncompensated Care Reports				X			
Program-Specific Enrollment Data	X		X	X	X		
National Survey on Drug Use and Health			X				
Behavioral Risk Factor Surveillance System			X				
National Mental Health Services Survey			X				
National Survey of Substance Abuse Treatment			X				
Opioid Overdose Data			X				
Qualitative Data:							
Document Review	X	X	X	X	X	X	X
Key Informant Interviews, Focus Groups, or Case Studies	X	X	X	X	X	X	X
Representatives of Participating Entities*		X	X	X	X	X	X
State Staff	X	X	X	X	X	X	X

Data Source Types	C&E	DSR	BH	SNCP	WI	HQEI	HRSN
MassHealth Members	X	X	X	X	X	X	X
Survey Data:							
Accountable Care Organization Provider & Community Partner Staff Survey		X					
Practice Site Administer Survey		X					
Member Surveys		X	X	X		X	X
Workforce Survey		X	X		X		
Other Data**			X				

* Entities include Accountable Care Organizations, Community Partners, Practice Sites, Hospitals, and Social Services Organizations – See Section 1.4.3 KI Interviews

** Other data sources include Bureau of Substance Abuse Services Program Data, CDC Wide-ranging Online Data for Epidemiologic Research (WONDER), and the Massachusetts Department of Public Health's Public Health Data Warehouse - See Chapter 4 (Behavioral Health).

Table 1-3: Anticipated Timeline for Data Collection, Management, and Analysis, MassHealth Demonstration Project

State Fiscal Year	23 Q1	23 Q2	23 Q3	23 Q4	24 Q1	24 Q2	24 Q3	24 Q4	25 Q1	25 Q2	25 Q3	25 Q4	26 Q1	26 Q2	26 Q3	26 Q4	27 Q1	27 Q2	27 Q3	27 Q4	28 Q1	28 Q2	28 Q3	28 Q4	29 Q1	29 Q2
Calendar Year	22 Q3	22 Q4	23 Q1	23 Q2	23 Q3	23 Q4	24 Q1	24 Q2	24 Q3	24 Q4	25 Q1	25 Q2	25 Q3	25 Q4	26 Q1	26 Q2	26 Q3	26 Q4	27 Q1	27 Q2	27 Q3	27 Q4	28 Q1	28 Q2	28 Q3	28 Q4
Demonstration Project	X	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c						
Develop Key Informant (KI) Individual or Group interview protocols						X	c			X	c			X	c			X	c							
KI interview protocols and documents to MassHealth for review								X	c			X	c			X	c			X	c					
Respond to emerging foci for in-depth KI interviewing via protocol development and data collection									X	c	c	c	c	c	c	c	c	c	c	c	c					
Schedule and perform KI interviews									X	c	c	c	c	c	c	c	c	c	c	c	c	c				
Transcribe, code, and analyze KI interview text										X	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c
Design CP staff and provider survey																	X	c								
CP survey protocols and documents to MassHealth for review																		X								
Administer CP survey																			X	c						
Analyze CP survey																					X	c	c	c	c	c
Design Practice Site Administrator (PS Admin) survey							X	c																		
PS Admin survey protocols and documents to MassHealth for review								X																		
Administer PS Admin survey									X	c																
Analyze PS Admin survey											X	c	c	c	c	c	c	c								
Provide input for development of Member survey			X																							
Survey Member vendor fields surveys*			X	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c	c				
Receive data from Member survey						X				X				X				X				X				X
Analyze Member survey data							X	c			X	c			X	c			X	c			X	c		
Design WI survey							X	c	c	c					X	c	c	c								
WI survey protocols and documents to MassHealth for review								X	c	c						X	c	c								
Administer WI survey											X	c							X	c						
Analyze WI survey													X	c	c	c	c	c			X	c	c	c	c	c

Key: Initiation of activity= X, Continuation of activity=c

*The actual timeline will be updated in accordance with the approval date of the EDD by CMS

1.4.2. Quantitative Data

For programs implemented during MassHealth's 2017-2022 Demonstration and continuing in the 2022-2027 Demonstration, data from January 2015 through December 2022 will be considered. Specific study periods will be customized to reflect implementation timelines: for delivery system reform, we generally plan to use calendar years (CY) 2015 through 2017 as a pre-implementation baseline, 2018 through 2022 as the first phase of implementation, and 2023 through 2027 as the current Demonstration period of interest. For new programs being implemented during the 2022-2027 Demonstration, we expect to use more recent data (e.g., 2018-2022) as a baseline, as appropriate, with consideration given to the impact of the COVID-19 pandemic. In each of the Research Questions and Hypotheses tables within each domain chapter, we have specified the expected evaluation periods for each data source and research question. We have listed approximate sample sizes for surveys (i.e., those who will be invited to take the survey) and population sizes for analyses of administrative data that include all eligible members of a population. Time periods and sample sizes will be updated as needed in the methods sections of the Independent Evaluation Interim and Summative Reports.

Text descriptions and summary tables describing the target population(s), data sources, outcome measures, and planned analytic approaches for each policy domain are included in policy domain chapters, as are comparison groups when appropriate. Technical specifications for all quantitative measures to be derived from existing data sources are detailed in Appendix B.

Traditional Administrative Data

Medicaid administrative data from the Medicaid Management Information System (MMIS) and MassHealth Data Warehouse will be used by the IE team to conduct analyses for the evaluation. Working with its contractors, MassHealth routinely conducts extensive quality checks and provides CMS with annual data quality reports on its MMIS data. This administrative data is the most integrated and comprehensive, and since it is available as part of the routine administration of the Medicaid program, there is no additional burden to members, providers, and other stakeholders when using it for evaluation. Data in MMIS and the Data Warehouse are used in program administration, including tracking program eligibility for members and providers, setting rates, paying providers, and monitoring trends in utilization and costs.

The IE is familiar with MMIS and Data Warehouse data through a longstanding collaboration with MassHealth on projects, including the independent evaluation of MassHealth's 2017-2022 Demonstration. Administrative data relating to traditional services and benefits data includes:

- Member Eligibility and Enrollment: These files contain dates when a member is enrolled in or receives benefits from various programs, such as when they are a client of the Massachusetts Department of Mental Health (DMH) or enrolled with a specific ACO or other health plan. MMIS reads and interprets data from the state's Health Insurance Eligibility Verification Database and from other state agencies.

Enrollment data will be collected on individuals in specific programs (e.g., those in an employer-sponsored insurance program, CommonHealth 65+, Health Connector subsidies).

- Claims and Encounter Records Stored in the Data Warehouse: Both kinds of records use the same format and are regularly checked for completeness and accuracy. These records contain information about utilization and services rendered by whom and in what location, members' diagnoses, and costs. In addition to their use for rate setting and settlement, they support the calculation of total costs of care and cost within healthcare service categories, such as hospital admissions, ambulatory care, Emergency Department (ED) visits, and Long-Term Services and Supports (LTSS). Supports delivered by BH and LTSS Community Partners (CPs) are also captured in encounter records.
- Providers: These data include the National Provider Identifier, the provider type and specialty, and, for primary care doctors, the health plan with which they are affiliated. These data are collected as part of the process for being accepted as a Medicaid provider.

It is important to note that there are significant limitations in the member demographic data in MMIS; for example, only 40 to 50 percent of members report their race and ethnicity as part of their MassHealth application process, and "limited English proficiency" and "homelessness" were rarely coded. MassHealth has increased its focus on demographic data (see Chapter 6 ,Workforce Initiatives), including incorporating Z-codes related to homelessness (Z59.01, Z59.02) into the risk adjustment model in 2017. This led to an increase in the use of those codes. More recently, MassHealth has begun efforts to improve the completeness of its race and ethnicity data in its Data Warehouse.

Program Specific Data

In cases where administrative data is insufficient, UMass Chan will utilize additional data to supplement the evaluation. For example, there will be new or augmented data streams relating to the Flexible Services Program (FSP), the Hospital Quality and Equity Initiative (HQEI), and Primary Care payment reform. While some relevant data specifications and workflows are still being finalized, the current assessment of what data will be available is described below. More details of programmatic data will be included in specific policy domain chapters.

- ACO Data: We will supplement claims and encounter data use with data from other sources when evaluating quality and costs of care in the ACO program. In addition to programmatic documentation submitted to MassHealth (e.g., participation plans for ACO FSPs), ACOs submit member-level data consistent with quality measure specifications for hybrid quality measures (e.g., blood pressure, HbA1c) and to meet program requirements. MassHealth will also have practice site data on the clinical service delivery tier as part of the primary care sub-capitation program that will be made available for the evaluation.
- Flexible Services Data: Both housing and nutritional FSP data currently lie outside the scope of traditional claims and encounter data but may be incorporated into claims and encounters during the latter years of the Demonstration period. As of the

start of the Demonstration, ACOs will report to MassHealth lists of members receiving Flexible Services by type of service, risk factor, and health needs-based criteria and associated conditions qualifying the individual for services, household level data (if receiving allowable nutritional supports for the household), plus baseline and follow-up data on self-reported mental and physical health, food insecurity (if receiving nutritional supports) and their housing situation (if receiving housing supports).

- HQEI Data: MassHealth will incentivize the collection of self-reported data on demographics and HRSNs. Participating hospitals will be responsible for reporting demographic and HRSN data to MassHealth in a unified way. Participating hospitals also will report on quality and equity measures to measure progress in improving access to care and reducing disparities. Finally, hospitals will be assessed on their ability to meet rigorous standards for service capacity, access, and culturally and linguistically appropriate care, including those outlined by The Joint Commission (TJC).
- Workforce Initiative Data: Workforce Initiative (WI) program data, including applicants, awardees, and other information (e.g., service obligation compliance) will be obtained from MassHealth or its program managing partner.
- Specialized Community Support Program for Justice-Involved (CSP-JI) Data: the specialized CSP for Individuals with Justice Involvement (CSP-JI) providers that are also Behavioral Health Supports for Justice-Involved Individuals (BH-JI) providers, per the BH-JI Contracts, submit monthly lists of referred and enrolled members to MassHealth. These lists will include the following data that are not redundant to other MassHealth data collection efforts, such as demographics, referral source, enrollment date, disenrollment date, the reason for disenrollment, and housing and employment status at enrollment.

Publicly Available and Other Data

The following publicly available survey data will be used: the American Community Survey (ACS), the National Survey on Drug Use and Health (NSDUH), the Behavioral Risk Factor Surveillance System (BRFSS), the National Mental Health Services Survey, and the National Survey of Substance Abuse Treatment. UC reports (containing cost data from Medicare cost reports, in addition to data provided by MassHealth on supplemental payments to safety-net hospitals) will be analyzed. Massachusetts death records will be analyzed along with Bureau of Substance Abuse Services (BSAS) data and state data on opiate overdoses collected in the Public Health Data Warehouse and overseen by the Massachusetts Department of Public Health (DPH) will be used, if available. The BH domain may use data from the All-Payer Claims Database (APCD) maintained by the Center for Health Information and Analysis (CHIA), an independent state agency. We expect to use data from the Hospital Cost and Utilization Project (HCUP) for the HQEI domain.

1.4.3. Qualitative Data

Document Review

A range of existing documents (e.g., FSP participation plans, state-generated reports on funding allocations, HQEI reports submitted by hospitals) are expected to provide data on participating entities' plans and progress in implementing Demonstration programs. Additional documents reflecting change or innovation in the delivery system or other program/policy context will be inventoried and reviewed, for example, as was essential during the COVID-19 pandemic.

Key Informant Interviews (KIIs)

Interviews will be conducted with at least three groups of stakeholders at two points in the Demonstration period. Sample sizes are specified for each group in each domain chapter as the number of interviewees (i.e., total number of participants, not interviews). Interviews may be conducted with individuals and in focus groups, within and across organizations and roles, and will include:

- Representatives of participating entities (e.g., administrative and program staff from ACOs, CPs, Social Service Organizations (SSOs), staff from participating hospitals, primary care practices, safety net providers, community health centers (CHCs), and justice entities) to assess the process of implementing investments, progress developing and adapting essential organizational infrastructure, capacity, and procedures to promote integrated and accountable care, and perceived effectiveness of state actions to support transformation, among other topics.
- A range of MassHealth personnel responsible for various aspects of the Demonstration will be interviewed to understand the implementation of the policy domains from the state's perspective.
- MassHealth members will be interviewed to, among other things, understand how they experience the process and impact of, and satisfaction with delivery system transformation (e.g., care coordination and integration processes, the identification and meeting of HRSN, efforts to address health disparities) and experience of transitions of care upon discharge from treatment services delivered in an Institute for Mental Diseases (IMDs).

In-depth interviews and/or focus groups with personnel from ACOs, CPs, and other relevant entities (e.g., hospitals, primary care practice sites, etc.) and/or with individuals in selected roles (e.g., care coordinators, members) will be conducted to obtain a more nuanced understanding of how the Demonstration is operating; to integrate perspectives from multiple, diverse sources; and/or to explore ways in which emerging contextual issues contribute to systems transformation. These in-depth interviews will allow the IE to pursue topics of interest that emerge in initial KIIs or are drawn from context-related developments (e.g., the COVID-19 pandemic in the past Demonstration evaluation). Several potential foci of in-depth interview data collection include: (1) to examine a sub-sample of entities as they implement organizational change (i.e., adopt core ACO and CP competencies, develop and adapt essential partnerships to support coordinated, integrated care) as compared with a different sub-sample of entities; and

(2) to study participating entities, staff, and/or member groups, selected from across entities to address specific evaluation questions, explore further needs, suggest remedies, and provide examples of innovation and success. As elaborated in subsequent domain chapters, in-depth interviews regarding new target populations or initiatives will be particularly informative as efforts are implemented to meet new or emerging needs.

1.4.4. Survey Data

Member Experience Surveys

MassHealth has worked with Massachusetts Health Quality Partners (MHQP), a survey vendor, to annually field six Member Experience Surveys (MES) for ACO members since 2018 and a primary care survey for members enrolled in MassHealth's Primary Care Clinician (PCC) plan. Distinct surveys for adults and children address three populations defined by service categories: Primary Care, BH, and/or LTSS. Members are included in sample frames based on their service utilization during a given measurement period, typically a calendar year. MHQP takes random samples of members in the sample frame and determines which survey a given member will receive (Primary Care, BH, or LTSS); a given household does not receive more than one survey.

MassHealth's Primary Care MES is based on the MHQP-adapted Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS). The BH and LTSS surveys were developed by the Massachusetts Executive Office of Health and Human Services (EOHHS) in 2018 through workgroups, which included subject matter experts (SMEs), stakeholder input, and focus groups of both providers and consumers. The domains and questions were identified, assessed, and selected by the workgroup from existing surveys, including the MassHealth One Care survey (of dual eligible members), the Massachusetts DMH Consumer Survey, and the BRFSS. Additional customized questions were developed and tested with members through cognitive testing and piloting of the surveys. The surveys were fielded using multiple modalities, including paper and email. In addition, the telephone was utilized to survey members receiving LTSS services. Members were surveyed between the first and second quarters following the measurement year (e.g., February–May). It is anticipated that the surveys will continue to be fielded annually for measurement years 2023-2027 for the new Demonstration by MassHealth's vendor. The survey cycle timing is anticipated to be similar to prior years, although options for more rapid survey cycles or enhanced modalities may be considered.

Practice Site Administrator Survey

Two waves of online surveys of ACO primary care practice site administrators were performed during MassHealth's 2017-2022 Demonstration and will provide baseline data for a single online survey of practice site administrators to be conducted during the first half of the evaluation of MassHealth's 2022-2027 Demonstration. The sampling frame will again include group practices, CHCs, and hospital practices participating in the ACO program. The following sites will be excluded from the survey: solo physician practices, sites that only provide acute care, practice sites located outside of

Massachusetts, sites with fewer than 50 MassHealth members, and sites with an unknown number of MassHealth members. From within the sampling frame, we expect all sites within each ACO will be selected.

After a thorough literature review, the questionnaire used for the survey in the 2017-2022 evaluation was drafted collaboratively by the Independent Assessor, IE, and a research group administering similar surveys. The survey was shared with stakeholders to gather feedback, field-tested with ACO administrators, and further refined before administration. The survey instrument includes questions about care integration, screening, access, social services referrals, risk stratification, performance management, engagement with the ACO, and payment arrangements, among other topics. The survey instrument for the 2022-2027 evaluation is expected to be a modified version of the instrument used in the 2017-2022 evaluation. For any new survey questions, the questions will be piloted with a convenience sample of practice site administrators using cognitive testing and assessments for clarity, completeness, and respondent burden. We will retire survey questions that are no longer relevant or informative.

Provider and Staff Surveys

Two waves of online surveys of ACO primary care providers (PCPs) and CP staff were performed during MassHealth's 2017-2022 Demonstration and will provide baseline data for one wave of surveys of ACO PCPs and CP front-line staff to be conducted in the second half of the Demonstration period. The survey respondents are expected to be consistent with the sampling frame for the 2022-2027 surveys of ACO/CP providers and staff is expected to be similar to MassHealth's 2017-2022 Demonstration provider and staff survey respondents, including medical doctors (MDs), nurse practitioners (NPs), registered nurses (RNs), physician assistants (PAs), medical assistants (MAs), and community health workers (CHWs).

The survey instrument is expected to be a modified version of the instrument used in the 2017-2022 evaluation. A core component of the instrument is the Provider and Staff Perceptions of Integrated Care (PSPIC), a validated survey instrument comprising 21 questions across seven care integration constructs, including within care team care coordination, across care team care coordination, and coordination between care teams and community resources. It is anticipated that validated survey questions will again be supplemented with questions specifically tailored to the new and modified programs (e.g., perceived effectiveness of CP and FSP). For any new survey questions, the questions will be piloted with a convenience sample of provider staff using cognitive testing and assessments for clarity, completeness, and respondent burden. ACO PCPs will be drawn from the sampling frame of primary care practice sites surveyed in the first half of the Demonstration period. Other details of the sampling plan remain under development and will be informed by pending data (e.g., ACO practice site affiliations and provider distributions).

Workforce Surveys

Two cross-sectional surveys of clinicians who are eligible for WI programs (including those participating and others who could have participated) and prospective clinicians

(students) who will be eligible for Demonstration WI programs will be conducted in SFY25 and SFY27. These surveys will elicit providers' preferences for scenarios of financial and non-financial incentives to meet the workforce development initiative objectives using a conjoint design. A conjoint analysis tool will be developed according to recommendations from the International Society for Pharmacoeconomics and Outcomes Research.[3] The survey will be administered online and include a lottery voucher of three gifts for those who complete the survey. The survey will be field-tested and modified as needed. The survey will also explore participating clinicians' experiences with the WI programs. Details of the survey are described in Chapter 6 (Workforce Initiatives).

1.5. Evaluation Limitations

This section discusses limitations inherent in evaluating the multiple public policies and programs enabled by the 2022-2027 Demonstration. Individual Demonstration activities overlap in time, will occur in the presence of (likely large, but currently unknown) secular change, and will affect various subsets of a large and diverse Medicaid population. There will be no randomized controls to compare observed changes to what would have happened absent these programs. In this context, our Evaluation is designed to accurately describe the changes that occurred and to use both analytic methods and qualitative fact-finding to shed maximal light on program effectiveness, while acknowledging the fundamental fact that true causal inference regarding the effects of specific Demonstration components will be challenging.

Broadly, our analytic approach will be to exploit naturally occurring variation in policy exposure over time (before and after implementation) and between groups (that were differentially exposed) to estimate policy effects. However, there will be limited opportunity to estimate the effect of some programs. For example, it will be difficult to estimate the effect of programs that are offered continuously and without baseline data to entire populations (with no control population left unserved). It will also be a challenge to estimate the effect of one program when there are multifaceted programmatic efforts that cannot be isolated. Comparisons within individuals over time without a comparison group are at risk of bias from time-varying confounding (e.g., from secular trends) and regression to the mean, while comparisons between groups without baseline data cannot distinguish policy effects from pre-existing between-group differences.

Due to systematic differences between Medicaid members and commercial enrollees and between interstate policy environments, we plan to primarily draw comparison groups from within the MassHealth program while also exploring opportunities to obtain and leverage data from other Medicaid programs. Accessing individual-level member data from other states is challenging due to privacy and security rules, unique considerations with each state's data structure and quality, capacity constraints and competing priorities for Medicaid staff, and requirements that sharing such data produces information that is deemed important to the other state sharing data. We will

[3] Bridges, J.F.P., Hauber, A.B., Marshall, D., Lloyd, A., Prosser, L.A., Regier, D.A., Hood, F.R., & Mauskopf, J. (2011). Conjoint Analysis Applications in Health – a Checklist: A Report of the ISPOR Good Research Practices for Conjoint Analysis Task Force. Value in Health. 14: 403-413

explore the feasibility of creating synthetic controls from other states with the most similar policy environments using aggregated and publicly available data. However, aggregate data may not be publicly available for many measures. Moreover, the appropriateness of a synthetic control approach is uncertain because Massachusetts has a unique policy environment and a healthcare system that falls in the tails of the distribution (i.e., either above or below most other states) for coverage, delivery system reform efforts, cost, and quality. This raises concerns that a pool of other states cannot satisfy assumptions of the method needed to represent a true counterfactual and may introduce interpolation bias.[4]

Concurrent non-Demonstration-related policy changes at the state and federal levels will introduce time-varying confounding. The Massachusetts Roadmap for Behavioral Health Reform (BH Roadmap), for example, is a multi-year plan with a range of activities designed to make outpatient treatment more accessible for all residents with BH conditions. We expect to see improved access, treatment, and outcomes for MassHealth members with BH conditions, and note that the state's implementation of the BH Roadmap (with certain major components starting in January 2023) will impact our ability to identify the effects of Demonstration activities targeting the same population. We will use qualitative methods, including interviews with program administrators and program recipients, to mitigate this fundamental limitation.

Public health challenges and policy responses to the COVID-19 pandemic are another source of time-varying confounding. Throughout the federal Public Health Emergency (PHE), for example, many organizations have experienced financial, workforce, and technology challenges affecting their performance. MassHealth enrollment increased throughout the PHE due to the continuous enrollment provision of the Families First Coronavirus Response Act, helping many members maintain continuous coverage. The Consolidated Appropriations Act, 2023 detached the continuous enrollment provision from the PHE as of April 1, 2023, requiring redeterminations of member eligibility to maintain enrollment. Program membership is expected to decline during PHE "eligibility unwinding" as members are redetermined, and the resulting effects on the experience of continuing members will be difficult to disentangle from the effects of Demonstration coverage and eligibility policies. Changes in the enrolled member population are not random and introduce confounding into longitudinal analyses that may only partially be addressed analytically when evaluating other Demonstration policies. It is particularly challenging to isolate and evaluate coverage and eligibility policies in the context of the unwinding time period. This evaluation will capture the trend of changes, including utilizing pre-PHE data as a baseline to minimize the bias of estimates impacted by PHE.

Finally, we recognize that certain data sources used for evaluation activities are subject to uncertainty regarding availability. Each data source has its own potential sources of bias, which will be discussed in the relevant chapters.

[4] Abadie, Diamond, and Hainmueller: Synthetic Control Methods for Comparative Case Studies. Journal of the American Statistical Association (June 2010). Vol. 105, No. 490 McClelland R, Gault S. The Synthetic Control Method a Tool to Understand State Policy. Urban Institute. March, 2017.

1.6. EDD Timeline, Milestones, Deliverables and Budget

Key milestones and deliverables for the evaluation are mapped out in Table 1-4. The draft IEIR is due to CMS by December 31, 2026. The IEIR will include primary data collected through CY2025 and secondary data through CY2024. The IEIR will primarily be focused on addressing research questions regarding the implementation of new policies and descriptive analyses of changes in processes, outcomes, and costs over time. The draft Independent Evaluation Summative Report (IESR) is due to CMS by June 30, 2029 and will address all research questions and analyses specified in the evaluation design. The draft Evaluation Budget and Budget Narratives are included in Attachment 1.

*Table 1-4: Independent Evaluation Timeline, Milestones, and Deliverables**

State Fiscal Year	23 Q1	23 Q2	23 Q3	23 Q4	24 Q1	24 Q2	24 Q3	24 Q4	25 Q1	25 Q2	25 Q3	25 Q4	26 Q1	26 Q2	26 Q3	26 Q4	27 Q1	27 Q2	27 Q3	27 Q4	28 Q1	28 Q2	28 Q3	28 Q4	29 Q1	29 Q2	29 Q3	29 Q4	30 Q1	30 Q2
Calendar Year	22 Q3	22 Q4	23 Q1	23 Q2	23 Q3	23 Q4	24 Q1	24 Q2	24 Q3	24 Q4	25 Q1	25 Q2	25 Q3	25 Q4	26 Q1	26 Q2	26 Q3	26 Q4	27 Q1	27 Q2	27 Q3	27 Q4	28 Q1	28 Q2	28 Q3	28 Q4	29 Q1	29 Q2	29 Q3	29 Q4		
Demonstration	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X										
Submit EDD to CMS 4/14/23				X																										
Submit revised EDD to CMS 12/4/23						X																								
Draft IEIR to CMS 12/31/26																		X												
Final IEIR 60d after CMS feedback*																			X											
Draft IESR to CMS 6/30/29																												X		
Final IESR 60d after CMS feedback*																													X	
Draft Close Out Report to CMS 4/30/28																								X						
Final Close Out Report to CMS*																							X							

* Delivery of final document or report contingent on receipt of CMS feedback.

2. Coverage and Eligibility

2.1. Overview of Coverage & Eligibility (C&E) Policy Domain

Massachusetts continues to lead the nation with near-universal health insurance coverage. Only 2.4 percent of residents in the Commonwealth were uninsured in 2021, well below the national rate of 9.2 percent.[5] During the COVID-19 Public Health Emergency (PHE) period, Medicaid enrollment peaked because MassHealth implemented the continuous coverage provision of the Families First Coronavirus Response Act (FFCRA) to allow individuals not to lose coverage or have a decrease in benefits during this period except for special circumstances.[6]

2.1.1. Policy Domain Goals

With the 2022-2027 Demonstration, the Commonwealth seeks to continue programs begun under previous Demonstrations as well as implement new ones with the goals of (1) Increasing insurance coverage and access; (2) Improving health outcomes; and (3) Maintaining the sustainability of Medicaid resources.

2.1.2. C&E Policy Domain Components and Desired Outcomes

The policy components center on continuous eligibility (CE) policies (to cover individuals for a longer period), policies to cover more populations, premium assistance and cost-sharing policies, and waiver of retroactive eligibility (RE) policies, alongside several continuing policies from the prior Demonstration period.

Continuous Eligibility (CE) Policies

Coverage for a Longer Period

MassHealth will introduce new CE programs for justice-involved individuals and those experiencing homelessness that will limit churn (defined as the temporary loss of coverage in which beneficiaries are disenrolled from and reenrolled in MassHealth within 12 months) and reduce verification procedures to once every 12 months. Special Terms and Conditions (STCs) 4.11 and STC Attachment O[7] (the CE Implementation Plan) describe the requirements for annual verification and beneficiary contact information updates for these two populations.

Beginning in April 2023, justice-involved individuals who are Medicaid eligible and under 65 years of age will be continuously eligible for coverage during the 12 months following their release from correctional settings, regardless of income or other changes that would affect eligibility. Individuals who are experiencing homelessness, qualify for Medicaid, are under 65 years of age, and have a confirmed status of homelessness for at least six months will be continuously eligible for coverage for 24 months, regardless

[5] CHIA. *Massachusetts Health Insurance Survey*. (n.d.). *Massachusetts Health Insurance Survey*. Chiamass.gov. Retrieved January 01, 2023, from https://www.chiamass.gov/massachusetts-health-insurance-survey/

[6] Commonwealth of Massachusetts. (2020, August) *MassHealth Eligibility Flexibilities for COVID-19*. Mass.gov. Retrieved February 20, 2023, from download (mass.gov)

[7] Attachment O. Continuous Eligibility Implementation Plan;

of income or other changes that would affect eligibility. Further details about both programs are available in STC 4.10.

Coverage of More Populations

To maintain near-universal health insurance coverage and improve insurance access, MassHealth will continue or expand coverage eligibility to several populations through three programs. First, MassHealth will continue the CommonHealth program with two modifications in this Demonstration period. Qualifying non-working adults (19-64 years of age) with total and permanent disabilities will no longer be required to pay a one-time deductible.[8] Additionally, disabled adults over 65 years of age who have had CommonHealth for 10 or more years will retain coverage regardless of their work status.[8]

MassHealth will continue the Breast and Cervical Cancer Demonstration Program (BCCDP), whereby individuals are determined financially eligible if they have income between 133.1 percent and 250 percent of the Federal Poverty Level (FPL). Eligibility may be determined by qualified hospitals' data,[9] data hub verification,[10] or self-attestation.[10]

Family assistance programs for children (non-disabled children with incomes between 150 percent and 300 percent of the FPL who are insured at application) and people with HIV/AIDS[11] (individuals with HIV not otherwise eligible with income between 133 percent and 200 percent of the FPL) will continue in this Demonstration.[12]

In addition, the expansion of the Medicare Savings Program (MSP) has increased the income limit for MSP benefits (i.e., Medicare Part B premium) without an asset test to MassHealth Standard members of any age with income up to 165 percent of the FPL.[13] This policy was approved on August 11, 2022, as part of the amendment to the 2017-2022 Demonstration, effective on September 1, 2022; the policy continues through the current Demonstration.

Premium Assistance and Cost-Sharing Policies

MassHealth is committed to providing flexibility in coverage access by providing premium assistance, cost-sharing, and marketplace subsidies, as described in STC 8.12 Premium Assistance, STC 9 Cost-Sharing, and STC 10 Marketplace Subsidies. These programs are described below.

As set forth in STC 8.12, all MassHealth-eligible individuals in Standard, CarePlus, Family Assistance, or CommonHealth may receive Premium Assistance to support

[8] STC Table 3 "CommonHealth Adults" ; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[9] STC 4.6; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[10] STC 4.7, 4.8; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[11] STC 4.8; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[12] STC 5.7, 5.7.a, 5.7.b; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[13] Centers for Medicare & Medicaid Services. (August 11, 2022). *Amendment of 1115 MassHealth Demonstration: STC, page 106.* Mass.gov.: download (mass.gov)

enrollment in cost-effective private insurance such as employer-sponsored insurance (ESI) that meets the basic benefit level (BBL). MassHealth will provide wraparound services to ensure these individuals receive no less coverage than they should have through their MassHealth coverage type.

Under MassHealth's cost-sharing policy (STC 9), specific populations, including children under 21 years of age, pregnant individuals, Native American/Alaska Native members, and individuals with income under 50 percent of the FPL, will not be charged co-pays. Additionally, individuals whose gross income is less than 150 percent of the FPL and Native American/Alaska Native members will not be charged premiums. Attachment C details the "full description of cost-sharing and premiums under the Demonstrations for MassHealth-administered programs" of STC 9.1.[14]

Under STC 10, the Commonwealth will provide Marketplace premium and cost-sharing subsidies for individuals who purchase health insurance through the Health Connector's ConnectorCare program. Eligible individuals are those who (1) are not Medicaid or Children's Health Insurance (CHIP) eligible; (2) have income at or below 300 percent of the FPL; and (3) are eligible for coverage with an Advanced Premium Tax Credit (APTC). Gap coverage for ConnectorCare is supported through the state-operated Health Safety Net (HSN) program. Annual reporting must include the number of individuals served, the size of the subsidies, and a comparison of projected and actual costs.[15]

Waiver of Retroactive Eligibility (RE) Policies

In the 2022-2027 Demonstration period, MassHealth will continue to use the RE Waiver, allowing a period of 10 days of RE prior to the date of application for most individuals. However, individuals who are under 19 years of age or pregnant will instead be eligible for a RE period of 90 days prior to the date of application.[16]

Additional Policies Recommended for Evaluation by CMS

In addition to the C&E policies described above, the Centers for Medicare and Medicaid Services (CMS) recommends evaluating four policies: (1) streamlined eligibility determination, (2) waiver of early and periodic screening, diagnostic, and treatment services, (3) provisional coverage for individuals who self-attest to eligibility, and (4) extended eligibility for out-of-state former foster care youth residing in Massachusetts. The latter two policies were ongoing and included in the 2017-2022 Demonstration evaluation. Reevaluating them is not expected to generate substantial new information, so we do not plan to do so. Below are the descriptions of the first two policies.

Streamlined Eligibility Redetermination

There is a streamlined eligibility redetermination process in this Demonstration whereby certain members who have not had changes in circumstances are not required to

[14] STC 9.1, page 76; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[15] STC 10.1; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[16] STC 4.2, STC 8.13 Table 9; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

submit an annual eligibility form but instead attest to their eligibility. This policy applies to the following groups:

- Families with children under 19 years of age who have gross income, as verified by MassHealth, at or below 150 percent of the FPL and who are receiving Supplemental Nutrition Assistance Program (SNAP) benefits with SNAP-verified income at or below 180 percent of the FPL;
- Families with children under 21 years of age whose SNAP-verified income is at or below 180 percent of the FPL, effective to the extent that the state uses an Express Lane eligibility process under its state plan for children under 21 years of age;
- Childless adults whose SNAP-verified income is at or below 163 percent of the FPL; and
- Families with children, notwithstanding sunset dates for Express Lane Eligibility applicable to the companion state plan amendments.[17]

Waiver of Early and Periodic Screening, Diagnostic, and Treatment Services

As described in STCs 5.3 and 5.6, children under 21 years of age enrolled in MassHealth Standard and CommonHealth are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits. Under the Waiver of EPSDT, children enrolled in Family Assistance are not eligible for EPSDT.

Desired Outcomes

The policies and programs under the Demonstration provide coverage to new populations and extend the range of coverage to current members. These policies also allow for flexibility of coverage through premium assistance for specific populations enrolled in MassHealth and through subsidies for individuals meeting eligibility requirements to purchase health insurance through the Massachusetts Health Insurance Connector Authority (Health Connector). It is expected that those members now eligible for the 90-day RE will experience less financial burden related to health expenditures.

If implemented effectively, the CE policies are expected to streamline administrative processes around enrollment and eligibility determinations. In turn, it is hoped that the CE policies in the Demonstration will minimize coverage gaps and disruption of services and have a positive impact on the uninsurance rate in Massachusetts.

Through these programs and policies, members may experience improved access to care, increased satisfaction with coverage and services, and an improvement in overall health status. Through better access to insurance coverage, members may maintain or increase their use of primary and preventative care and decrease utilization of emergency or specialty services. These policies are designed to improve members'

[17] STC 4.4; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

health outcomes. Ultimately, improved health status can reduce healthcare utilization and contribute to the sustainability of Medicaid program resources.

2.1.3. C&E Policy Domain Implementation Plan and Timeline

STC Attachment O details the implementation plan regarding CE policies for justice-involved individuals and individuals experiencing homelessness. MassHealth is creating a systematic enrollment process for justice-involved individuals that should be online by July 2024, while a manual process will be available as of April 2023.[18] Similarly, automation of existing processes to verify eligibility for those experiencing homelessness is expected to be in place by December 2023, and CE for those individuals will not be available until that date.[19]

The removal of the RE Waiver for pregnant members and children was effective on October 1, 2022. The MSP expansion was effective on September 1, 2022.

Several other policies will continue from the prior Demonstration, including coverage through MassHealth CommonHealth and Family Assistance programs, BCCDP, premium assistance, cost-sharing, and the waiver of EPSDT for children on Family Assistance.

2.2. Logic Model

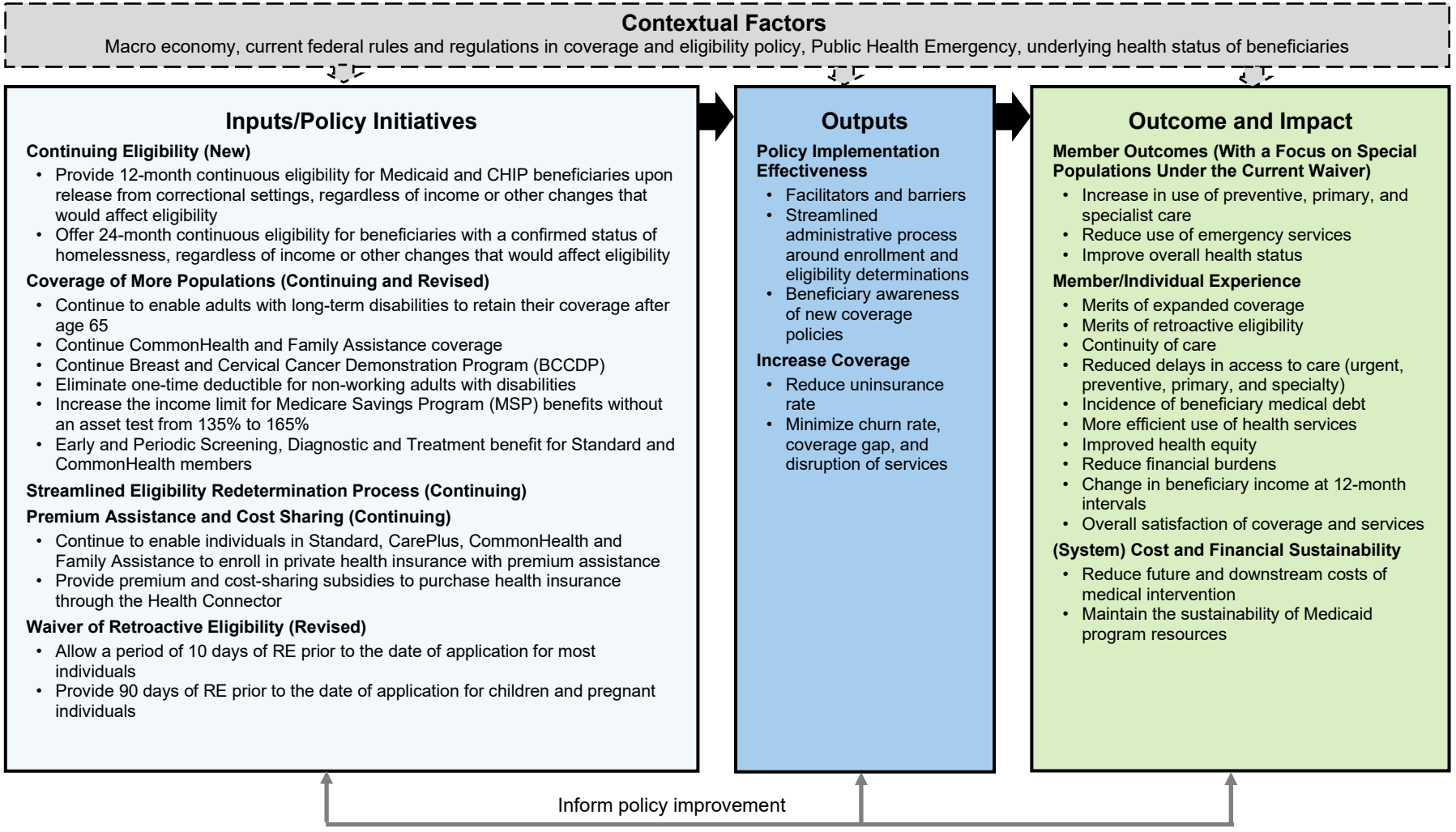
The C&E logic model in Figure 2-1 links the C&E Demonstration Goals to the Demonstration Inputs, Implementation Activities (e.g., funding pool), Outputs, and Outcomes and Impact (e.g., member access, quality of care, amount of uncompensated care use, and financial sustainability). This logic model guides the research questions (RQs) and hypotheses that follow.

[18] Attachment O. Continuous Eligibility Implementation Plan, page 3; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[19] Attachment O. Continuous Eligibility Implementation Plan, page 4; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

Figure 2-1: Logic Model for the C&E Component of the Demonstration

Goals: (1) Increase insurance coverage and access; (2) Improve health outcomes; and (3) Maintain the sustainability of Medicaid resources



2.3. Research Questions and Hypotheses

Table 2-1 summarizes the C&E evaluation RQs and associated hypotheses. It includes the study populations, data sources, measures, and analytic methods, detailed in Section 2.4. As guided by the logic model, the RQs explore policy impacts in areas such as MassHealth member enrollment and enrollment continuity and their access to and utilization of healthcare over time.

Table 2-1: Research Questions and Hypotheses for C&E

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ1-1 Have C&E policies collectively maintained Medicaid enrollment and enrollment continuity?	H1-1.1 C&E policies have collectively maintained Medicaid enrollment and reduced churning among MassHealth members. H1-1.2 CE policy for justice-involved and homeless populations has increased coverage and reduced the churn of these populations. H1-1.3 MassHealth enrollment for special populations has been maintained or expanded. H1-1.4 The streamlined eligibility redetermination has increased auto-renewal in Medicaid.	American Community Survey (ACS) (2018 – 2027) Medicaid enrollment and eligibility data; MassHealth programmatic enrollment reports (2018 – 2027); Health Insurance Exchange (HIX) data (2018 – 2027); Qualitative interviews with members (2025, 2027)	Massachusetts residents; MassHealth members (including those with justice involvement or confirmed status of homelessness); MassHealth CommonHealth members; MassHealth Family Assistance members; MassHealth members in the BCCDP program; MassHealth members newly receiving MSP through the MSP expansion; MassHealth members who are auto-renewed during the re-determination process	Number (%) of MassHealth members with a coverage gap 45 days or longer (churning) in one calendar year (CY); Number (%) of MassHealth members who disenrolled and re-enrolled within 12 months; Number of MassHealth members remaining enrolled at the 12th, 18th, and 24th month Number (%) of MassHealth members with 12-month CE upon release from correctional settings (unless they voluntarily disenroll, have moved out of state, are deceased, are enrolled due to agency error or fraud, abuse or perjury attributed to the individual, or become reincarcerated) with a coverage gap of 45 days or longer; Number (%) of MassHealth members eligible for 12-month C&E upon release from correctional settings who remain enrolled at the 18th and 24th month; Number (%) of MassHealth members with a confirmed status of homelessness for at least six months who have maintained 24-month CE (unless they voluntarily disenroll, have moved out of state, are enrolled due to agency error or fraud, abuse or perjury attributed to the individual, or are deceased); Number (%) of MassHealth members with a status of homelessness for at least six months who are eligible	Descriptive statistics (frequency and percentages) (member); Subgroup analysis (member); Thematic analysis (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				for 24-month CE remain enrolled at the 36th and 48th month Number (%) of MassHealth members in CommonHealth program (by age) over time; Number (%) of MassHealth members in the Family Assistance Program over time; Number(%) of MassHealth members in the BCCDP program over time; Number (%) of MassHealth members newly receiving MSP through the MSP expansion over time; Number (%) of MassHealth members who are auto-renewed in MassHealth during the re-determination process; The level of churn between those auto-renewed and not auto-renewed	
RQ1-2 Have premium assistance and cost-sharing programs supported continued coverage in the Demonstration?	H1-2.1 The enrollment in private health insurance through MassHealth's premium assistance and/or cost-sharing has been maintained.	Medicaid enrollment and eligibility data MassHealth programmatic enrollment reports;	MassHealth members enrolled in private health insurance (e.g., employer-sponsored insurance); Individuals enrolled in ConnectorCare	Number (%) of MassHealth members in Standard, CarePlus, CommonHealth, and Family Assistance receiving premium assistance for ESI over time; Number (%) of individuals enrolled in ConnectorCare through cost-sharing subsidies over time;	Descriptive statistics (frequency and percentages) (member)
RQ1-3 Has RE coverage of 90 days for children and pregnant individuals impacted an individual's	H1-3.1 Increasing the RE coverage from 10 to 90 days for children and pregnant members increased the likelihood of enrollment and enrollment continuity.	MassHealth programmatic enrollment reports (2015 – 2027);	MassHealth members who receive 90 days of RE coverage	Number of children and pregnant Medicaid members by eligibility group and their probability (%) of remaining enrolled in Medicaid for 12-, 18-, and 24-consecutive months	Descriptive statistics (frequency and percentages; interrupted time series) (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
MassHealth enrollment?					
RQ1-4 What is the impact of the RE waiver on the level of medical bills for members subject to the RE waiver?	H1-4.1 Increasing the RE coverage from 10 to 90 days for children and pregnant members will result in a lesser financial burden on those members. H1-4.2 Members subject to the RE waiver of 10-day retroactive coverage will have higher debt levels than MassHealth members and members in states without an RE waiver who receive 90-day retroactive coverage (if feasible to recruit Medicaid members from other states and/or interview with stakeholders)	Qualitative member interviews/focus groups (if data feasible to collect, 2025, 2027); Program staff/stakeholder interviews; Document review	MassHealth members with 10 and 90 days of RE coverage (n ≤ 30); Other states' Medicaid members who receive 90 days or less than 90 days' RE coverage (n ≤ 30, *if feasible*); Stakeholders (e.g., MA and other states' program staff and key informants f (n ≤ 10)	Level of unpaid medical bills at the time of application; Level of third-party payment for healthcare before Medicaid enrollment; Experiences with knowing and benefiting from the policy	Thematic analysis (member & stakeholder)
RQ1-5 Has continuous eligibility streamlined Massachusetts' administrative process for	H1-5.1 Continuous eligibility has streamlined Massachusetts' enrollment and eligibility administrative processes.	Member interviews/focus groups (2025, 2027); Interviews with MassHealth program staff (2025, 2027)	MassHealth members who have gone through eligibility redetermination (n ≤ 30); MassHealth program staff (n ≤ 5)	Member experience in eligibility redetermination and continuity of coverage; Staff's experience with the administrative burden on eligibility review, the processing time of applicants, etc.	Thematic analysis (member, program staff)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
enrollment and eligibility?					
RQ1-6 Did C&E policies change MassHealth members' healthcare utilization?	H1-6.1 MassHealth members have increased preventive, primary, and medically necessary specialist care. H1-6.2 MassHealth members subject to the new & ongoing C&E policies have reduced emergency and inpatient services.	Medicaid administrative data (2018 – 2027)	MassHealth members subject to the C&E policies	Adult access to preventive/ambulatory health services; Annual primary care visits; Immunization for adults and children; Adolescent well-care visits All-cause inpatient admissions; All-cause Emergency Department (ED) visits; Preventable ED visits; Primary care-sensitive ED visits	Descriptive statistics (frequency and percentages); Interrupted time series (ITS) (member)
RQ1-7 What have been members' overall experiences with the new and ongoing C&E policies/ programs?	H1-7.1 The new and ongoing C&E programs/policies have improved members' experiences.	Member interviews/focus groups (2025, 2027)	MassHealth members enrolled in new or ongoing programs under the Demonstration (n ≤ 30)	Examples of topics: Awareness of new and revised C&E policies (including facilitators and challenges in understanding the policies and how policies impact their application for and use of benefits); getting needed care; likelihood and frequency of income changes at 12-month intervals; overall experiences, etc. (and by program type)	Thematic analysis (member)

a. RQs developed based on STC sections 4.2, 4.10, 4.11, 8.13, 9.1, 10.1, 16.5.b.iv, 16.5.b.v, 16.5.b.vi, 17.6.f, Ta"ble 1, Table 9. (1115 MassHealth Demonstration ("Waiver") | Mass.gov)
b. Data sources are described in section 2.4.2 "Data Sources and Collection Methods" below and section 1.4.1 "Summary of Data Sources".
c. Analytic methods are described below in section 2.4.4 "Analysis Methods"

2.4. Data and Methods

2.4.1. Study Populations

The study population to examine insurance rates will consist of all Massachusetts residents. Annual estimates of the percentage insured will be obtained from the annual American Community Survey (ACS) (described below). For supporting analyses tracking enrollment in specific C&E policies/programs, the study populations will consist of members in those respective programs.

The evaluation will track estimates from Calendar Year (CY) 2018 — baseline estimates — to the most recently available data for ongoing programs. The evaluation will track enrollment as of the program start date for programs that begin during this Demonstration.

2.4.2. Data Sources and Collection Methods

The evaluation will use mixed quantitative and qualitative methods, as described in Table 2-1. The data sources for these measures are the following:

American Community Survey

The ACS is a national survey conducted by the U.S. Census Bureau. The ACS collects information about health insurance coverage nationwide and by the state annually, disseminated by the Census Bureau for public use. Data will be available for three years prior to the PHE through the current Demonstration period.[20]

Program Enrollment Reports

Program reports and summary data will allow the Independent Evaluator (IE) to track enrollment in MassHealth programs. Data will be obtained from MassHealth and the Health Connector.

Medicaid Administrative Data

Medicaid Management Information Systems (MMIS) enrollment data will be used to evaluate study population enrollment and continuity/churning.

Member Interviews and Focus Groups

The IE will randomly select approximately 30 members across MassHealth programs for one-on-one interviews or focus groups to learn about their experiences with these programs. The final number will depend on the saturation of data (i.e., whether interviewees share consistent feedback). The IE will look into possible ways to gauge members' awareness of policies through possible engagement with members and program staff. This data collection will be conducted during State Fiscal Year (SFY) 25 and SFY27. If feasible, the IE will identify Medicaid members from other states that do

[20] While the ACS is considered an appropriate data source for comparing insurance coverage by state, the validity of the ACS in identifying health insurance coverage will be assessed by comparing estimates of MassHealth coverage via ACS and MassHealth enrollment numbers. If there is a measurable discrepancy, the evaluation will describe and discuss the extent to which the estimates of overall insurance coverage in Massachusetts may be under or overestimated by survey data.

not have RE policies (e.g., California, Oregon). Recruiting these Medicaid members may be achieved through collaboration with other state Medicaid agencies — through the assistance of MassHealth — or through advocacy organizations that serve a large number of Medicaid members.

Program Staff and Stakeholder Interview

The IE will also conduct interviews with MassHealth program staff who oversee specific C&E programs/policies to understand staff experiences administering these programs/policies. These interviews will be conducted during SFY25 and SFY27. In addition, if feasible, the IE will aim to identify program staff or organizations that serve a lot of Medicaid members in other states to discuss the perceived impact of RE policy on members' financial wellbeing and experiences with knowing and using the policy. Qualitative interviews with MassHealth members not receiving 90 days' RE coverage may be conducted as an alternative.

2.4.3. Measures

The measures are described in Table 2-1 and fall into three categories:

Quantitative Measures about Coverage and Enrollment

The quantitative measures generally focus on the number and percentage of enrollment and length of enrollment in Medicaid or the Health Connector and in specific MassHealth programs (e.g., Family Assistance, MSP). The IE will work with MassHealth to collect enrollment data across programs. Measures will be presented annually over the analysis period.

Quantitative Measures about Healthcare Utilization

These measures will be created from MassHealth administrative data (e.g., claims/encounter data).

Qualitative Measures about Member and Staff Experiences

The member interview/focus groups will examine topics such as access to care; the likelihood and frequency of income changes at 12-month intervals; the likelihood of third-party payment for healthcare before Medicaid enrollment; and experiences with MassHealth's eligibility determination processes. In addition, program-specific questions will be asked of interviewees as appropriate. Staff interviews will explore their experiences with program administration, such as application and eligibility review processes, facilitators and barriers of data systems, and program-related successes and challenges.

2.4.4. Analysis Methods

The IE will present descriptive statistics for quantitative measures regarding coverage, enrollment, and coverage continuity. For example, the number and percentage of uninsured Massachusetts residents will be tabulated and graphed for each CY. Additional analyses will be performed across populations and by program and other individual characteristics (e.g., age, gender, race, disability status, primary language,

and geography), as appropriate.[21] To examine the change in the uninsurance rate and Medicaid enrollment (e.g., churn) over time, a time-series approach will be used to evaluate the trends before, during, and after the Demonstration period. The trend will be interpreted appropriately. For instance, a decrease in the total number on MassHealth does not always suggest a negative finding (e.g., if the number of the justice-involved population has reduced over time, that is an encouraging trend).

MassHealth offered many flexibilities to members during PHE, including implementation of the continuous coverage provision of the FFCRA, which skewed the enrollment, eligibility, and healthcare utilization patterns during this period. Therefore, our analyses will examine data from before, during, and after the PHE. Pre-COVID-19 data (from 2018) will be included to set a more realistic baseline for outcomes under this Demonstration.

For quantitative measures of healthcare utilization (e.g., annual primary care visits and adult immunizations), the Interrupted Time Series (ITS)[22] approach will be used to examine trends over time. ITS is a quasi-experimental method used to track outcomes over a long-term period to determine the impact of an intervention or policy. The measures will be regression-adjusted to account for individual and other organizational characteristics with trends presented before, during, and after the start of the Demonstration period. The analyses will draw on a few covariates; the examples are member demographic and clinical characteristics (e.g., age, sex, disability status, rating categories, homeless status, justice involvement, federal poverty level), regional characteristics (e.g., region, healthcare resources), and indicators of time and whether the member is subject to C&E policy. The IE will explore the use of imputation method or sensitivity analysis related to race/ethnicity data and include these demographic characteristics in our analysis, as appropriate.

For the qualitative data, analyses will identify consistent themes arising from interviews (or focus groups) with members and program staff. The interview data will be transcribed and uploaded to Dedoose, a web-based qualitative data management software designed to support data analysis. A draft codebook will be developed based on the logic model, interview topics, and themes that arise during the interviews and applied to each interview transcript. Coding will be conducted in multiple rounds, first by pairs and then independently, to ensure the shared understanding and consistent application of the codes to the transcripts. In addition, the team will meet regularly to discuss the coding process, resolve discrepancies, and identify emerging themes.

Using an embedded mixed methods approach, we will synthesize the quantitative and qualitative data. We will solicit an in-depth nuanced understanding of members' and staff experiences, examine how those experiences may be related to policy and practice innovation, and use these findings to explain pertinent trends and outcomes. For example, understanding members' experiences and staff perspectives on C&E policies

[21] The race and language information are not always complete; The analyses by these demographic characteristics will be limited.

[22] Cook, T. D., Campbell, D. T., & Shadish, W. (2002). *Experimental and quasi-experimental designs for generalized causal inference* (pp. 103-134). Boston, MA: Houghton Mifflin.

can help contextualize enrollment trends.[23] Conversely, preliminary quantitative findings from the analysis of data from early in the Demonstration period can generate interview/focus group questions in subsequent qualitative data collection and analysis.

2.4.5. Limitations

This evaluation design of C&E policies includes several limitations broadly described in Section 1.5. Most importantly, these C&E programs and policies are state-wide, meaning that no in-state (unexposed) comparison group exists. Furthermore, given the current Demonstration's multiple C&E programs and policies, we cannot find a comparison group of states with C&E policy portfolios that are well-matched to ours at baseline, due to varying data privacy and security rules, data quality, policy environment, etc. Also, we have no control over other policies or events (e.g., an economic recession) external to the Demonstration that may affect C&E.

Although their evaluation is required, it will be particularly challenging to assess the impact of individual C&E programs that have had no substantive changes from prior years. Substantial new or statistically significant effects from programs that continue unaltered from a prior period throughout the Demonstration are unlikely. Some programs and policies have varying start and end dates within and beyond the Demonstration period, with some coverage being new (e.g., CE for justice-involved populations). Programs coming online during this Demonstration may experience an initial period of engagement, enrollment, and initiation that will delay analytical evidence of program impact. Member experience data will be used to augment our limited ability to analytically interpret observed changes in this chapter.

Finally, enrollment rates peaked during COVID-19, making it difficult to interpret changes from the Demonstration baseline. Therefore, we will measure uninsurance rates and other healthcare utilization before COVID-19 to examine changes over a longer time to distinguish the impact of C&E policies from COVID-19 effects.

[23] Creswell, J. W., & Clark, V. L. P. (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: *Sage Publications.*

3. Delivery System Reform

3.1. Overview of Delivery System Reform (DSR) Policy Domain

The Delivery System Reform (DSR) evaluation domain includes the Commonwealth's efforts under 1115 Demonstration authority to enact payment and delivery system reforms that promote member-driven, integrated, coordinated care; hold plans and providers accountable for the quality and total cost of care (TCOC); and advance health equity. Policy components in this evaluation domain also include new or re-authorized aspects of the Accountable Care Organization (ACO) Program and the Community Partners (CP) Program, and interact with and are supported by safety net support and workforce development initiatives.[24,25,26,27]

3.1.1. Recap of DSR in the 2017-2022 Demonstration

Under the Massachusetts 2017-2022 Section 1115 Demonstration, MassHealth used $1.8 billion in federal Delivery System Reform Incentive Payment (DSRIP) program funding to support infrastructure and capacity building to achieve the following goals. Additional details on the design of MassHealth's DSRIP program are available in the Commonwealth's DSRIP Protocol.

2017-2022 DSRIP Program Goals:[26]

1. Enact payment and delivery system reforms that promote integrated, coordinated care and hold providers accountable for the quality and TCOC; and
2. Improve integration of physical, behavioral, and long-term services.

At the center of MassHealth's 2017-2022 payment and delivery system reforms were 17 new ACOs that launched in 2018. As of the end of the Demonstration, more than 1.2 million members were enrolled with ACOs, constituting more than three-quarters of eligible members. MassHealth ACOs were built on a foundation of primary care, with expectations and incentives for care to be well-coordinated across a member's physical, behavioral, and social needs. MassHealth required ACOs to engage primary care practice sites with value-based payments tied to cost and quality performance and sought to improve care coordination and reduce potentially avoidable and costly healthcare utilization through:

a) Investments in inter- and intra-organizational relationship-building
b) New services and supports for ACO members
c) Two-sided financial risk
d) Accountability for the quality of care

[24] STCs Section 5.2, 5.8, 8.1 – 8.13, 12.1, 17.6i; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[25] Centers for Medicare & Medicaid Services. (2022, September 28). *CMS Guidance, Approval Letter, Waiver Authority, Expenditure Authority, Special Terms and Conditions*. Mass.gov. https://www.mass.gov/doc/masshealth-extension-approval/download

[26] Centers for Medicare & Medicaid Services. (2017, December 14). *MassHealth Section 1115 Waiver Demonstration Approval 2017-2022*. Mass.gov. download (mass.gov)

[27] Massachusetts Delivery System Reform Incentive Payment (DSRIP) Protocol; https://www.mass.gov/doc/dsrip-protocol-amended-january-10-2018/download

ACOs were required to collaborate with community-based organizations through the CP program to provide care coordination supports for members with complex behavioral health (BH) and long-term service and support (LTSS) needs. ACOs were also expected to partner with social services organizations (SSOs) to implement the Flexible Services Program (FSP) to address health-related social needs (HRSNs).

The 2022-2027 Demonstration authorizes Massachusetts to claim up to $253.2 million (Table 3-1) of remaining DSRIP funds from the previous 2017-2022 Demonstration period. DSRIP funds will be used to support ACOs, ACO FSP, LTSS CP infrastructure and capacity building, and CP care coordination. DSRIP funding allocation per year is as follows:

Table 3-1: DSRIP Funding Allocation (In Millions) by Calendar Year (CY)

CY22	CY23	CY24	CY25	CY26	CY27	Total
$45.7M	$98.6M	$56.1M	$52.4M	$0.5M	$0	$253.2M

*This table is subject to change and will be updated as applicable.

3.1.2. 2022-2027 DSR Policy Domain Goals[28]

In the 2022-2027 extension of its Demonstration, MassHealth declared its ongoing commitment to continue the path of delivery system reform. Of MassHealth's five goals for its 2022-2027 Demonstration, the following four are either focused on or directly linked to DSR.

1. Continue the path of restructuring and reaffirming accountable, value-based care — increasing expectations for how ACOs improve care and trend management and refining the model;
2. Make reforms and investments in primary care, BH, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service (FFS) healthcare;
3. Continue to improve access to and quality and equity of care, with a focus on initiatives addressing HRSN and specific improvement areas relating to health quality and equity, including maternal health and healthcare for justice-involved individuals who are in the community;
4. Support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care.

[28] Centers for Medicare & Medicaid Services. (2022, September 28). *CMS Guidance, Approval Letter, Waiver Authority, Expenditure Authority, Special Terms and Conditions*. Mass.gov. https://www.mass.gov/doc/masshealth-extension-approval/download

3.1.3. DSR Policies[28]

The primary vehicle for delivery system reform is the ACO program. A description of the program, followed by descriptions of new and enhanced policies related to the program that support 2022-2027 DSR goals, are described below.

Accountable Care Organization (ACO) Program

ACOs are provider-led organizations held contractually responsible for the quality, coordination, and total cost of members' care. The ACO program was re-authorized and approved by CMS with the intent to move MassHealth providers from a primarily FFS system that pays for volume to one that rewards value. As such, ACOs are accountable and at financial risk for the total cost of members' care and quality measures across multiple domains. Members are attributed to ACOs based on primary care providers (PCPs); members choose or are assigned their PCP and are assigned to the plan in which that provider is enrolled. In the MassHealth ACO program, a given PCP may only participate as a PCP in one ACO.

Massachusetts has procured two ACO models for an operational start date of April 1, 2023, running through the end of the Demonstration in 2027.[29]

Accountable Care Partnership Plan (ACPP)

An ACPP is an integrated partnership between a Managed Care Organization (MCO) and a provider-led entity (also referred to as an ACO Partner). Members who enroll in an ACPP have the ACPP as their health plan and receive ACO Covered Services through the ACPP's Provider Network, including its exclusive group of PCPs. ACPPs are responsible for administrative health plan functions (such as claims payment and network development) and coordinated care delivery for the full range of ACO Covered Services. ACPPs are paid capitation rates and bear risk for members' cost of care. The ACPP is also held accountable for quality through a series of Quality Measures. ACPPs are expected to pilot different alternative payment methodologies, maintain close provider relationships, access real-time claims data, and leverage enhanced administrative dollars.

Primary Care Accountable Care Organization (PCACO)

PCACOs are advanced provider-led entities with an exclusive group of participating PCPs. Members who enroll in a PCACO receive primary care through these participating PCPs, BH services through the MassHealth BH Vendor, and other covered services through MassHealth's FFS network. PCACOs and their participating PCPs contract directly with MassHealth. PCACOs are paid a monthly administrative rate. PCACOs are accountable through shared savings and shared losses payments based on TCOC and a TCOC benchmark, as well as on quality through a series of quality measures.

[29] MassHealth ACO RFR Section 1.4, page 7; https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410&external=true&parentUrl=bid

New and Enhanced Expectations of ACOs in the 2022-2027 Demonstration

Value-based Payment in Primary Care[30]

While the Massachusetts delivery system as a whole has made progress in moving away from FFS payment, the experience of individual providers is still often that they are paid for volume and not value. In the 2022-2027 Demonstration, MassHealth is increasing the amount of funding for primary care and implementing a primary care sub-capitation payment model that will bring payment reform to the provider level. Payments to participating PCPs will be calculated on a per-member-per-month (PMPM) basis, based on attributed population and a defined set of services/codes, with appropriate risk adjustment. Rates will reflect the enhanced clinical expectations for providers participating in the primary care sub-capitation program and will increase for higher tier practices, commensurate with enhanced care delivery expectations. These expectations will incentivize specific care delivery improvements, including BH integration, enhanced team-based models of primary care, bolstered care coordination services, and more. The primary care sub-capitation program will provide flexible and predictable revenue via prospective, panel-based payments and incentivize population health improvements while moving providers off of an FFS model.[31]

Care Coordination[32,33]

ACOs will be responsible for providing baseline care coordination support for all their members. Several required elements of baseline care coordination are specified in the ACO contracts, such as:

1. Assigning members to PCPs
2. Screening for physical health, BH, LTSS, and HRSNs
3. Ensuring appropriate referrals are made
4. Ensuring appropriate and timely follow-up
5. Coordinating with service providers, community-based organizations, and state agencies to improve integration of care

ACOs must have a methodology to predictively model, stratify, and assign their member populations into risk categories and use their risk stratification process to identify high- and rising-risk members. ACOs must then evaluate such high- and rising-risk members to determine their appropriateness for Enhanced Care Coordination.

Enhanced Care Coordination can be delivered through ACO Care Management or the CP program. CPs[34] are community-based organizations that provide care coordination

[30] STCs 8.5-8.6, page 64-67; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[31] Commonwealth of Massachusetts. (2021, August 18). *1115 Waiver Demonstration Extension Request 2022-2027*, page 18. Mass.gov. download (mass.gov)

[32] ACO RFR Attachment A, ACPP Contract; https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410&external=true&parentUrl=bid

[33] ACO RFR Attachment B, Primary Care ACO Contract; https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410&external=true&parentUrl=bid

[34] STCs Section 8.8, pages 68-69; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

for members with complex BH and long-term care needs 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, coordinating the member's care team, navigation to social and community services, and health promotion and wellness activities to their enrolled members. During the 2022-2027 Demonstration, MassHealth will shift the program's structure from a state-managed Demonstration to an ACO/MCO-administered program. Massachusetts has procured two types of CPs that partner with ACOs and MCOs:

- Behavioral Health Community Partners (BH CPs): These CPs support eligible adult members (18-64 years of age) with a diagnosis of or need for services to treat a serious mental illness (SMI), serious emotional disturbance (SED), or substance use disorder (SUD).
- Long-term Services and Supports Community Partners (LTSS CPs): These CPs support eligible pediatric and adult members (3-64 years of age) with LTSS needs, including those with physical disabilities, traumatic brain injuries, development or intellectual disabilities, or other eligible diagnoses. LTSS CPs will have enhanced expectations and an increased scope of responsibilities compared to the 2017-2022 Demonstration. Responsibilities include conducting comprehensive assessments, coordinating the member's care team, and serving as the lead responsible entity and care coordination home for their enrolled members.[35] LTSS CPs will also have increased programmatic expectations in technology, workforce, and operations. MassHealth may 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.[36]

Enhanced Care Coordination provides a main point of contact and "first line" coordinator for the member. It includes maintaining high-functioning relationships and open communication with members' PCPs, health systems, community and specialty care team members, schools and early education programs, and other state agencies in order to facilitate care coordination. Additionally, all members enrolled in an Enhanced Care Coordination program must receive a comprehensive assessment and member-centered care plan. As necessitated by the members' needs, Enhanced Care Coordination also provides intensive supports for transitions of care and HRSN coordination. ACOs will be required to enroll a percentage of members in ACO Care Management programs and the CP program. If a member is enrolled in both ACO Care Management and in a CP, the CP serves as the lead care coordination entity.

Additionally, ACOs shall ensure that their providers refer members who meet medical necessity criteria to certain ACO Covered Services that provide additional care coordination, including Community Support Programs (CSP), Intensive Care

[35] Commonwealth of Massachusetts. (2021, August 18). *1115 Waiver Demonstration Extension Request 2022-2027*, *page 32*. Mass.gov. download (mass.gov)

[36] STCs Section 8.8; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

Coordination (ICC), and MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids, as appropriate.

CSP services include outreach and support that enables beneficiaries to use clinical treatment services and other supports in relation to HRSN. Specialized CSPs include a program for homeless individuals (CSP-HI), a program for individuals with justice involvement (CSP-JI), and a tenancy preservation program (CSP-TPP). See Chapter 8 (Health Related Social Needs) for more information and details regarding specialized CSP services. ICC is a Targeted Case Management benefit through the Children's BH Initiative, which provides care planning and coordination services for youth under 21 years of age with SED. MassHealth's CARES for Kids Program is a Targeted Case Management benefit, which provides care planning and coordination services for the highest risk youth under 21 years of age with medical and social complexity.

BH Integration

ACOs will also be responsible for implementing a variety of changes resulting in expanded access and services in BH. Among these will be contracting with newly created Community Behavioral Health Centers (CBHCs), as a part of the Massachusetts Roadmap for Behavioral Health Reform (BH Roadmap), to serve as an entry point for timely, flexible, person-centered, high-quality mental health and addiction treatment on an urgent and ongoing basis.[37] BH CPs will be required to facilitate integration with CBHCs, either by having a CBHC in their organizational structure, as an Affiliated Partner or Consortium Entity, or by holding formalized agreements with all CBHCs in their service area(s).[38] This expectation will ensure alignment between members' care coordination home and BH providers, where appropriate, and support better treatment access for the highest risk members, more clinically robust care planning, and better communication between the BH CP and other providers involved in the member's care (e.g., PCPs, acute hospitals). See Chapter 4 (Behavioral Health) for additional details.

Implementation of Health Equity-focused Policies[39,40]

MassHealth has several new and enhanced expectations of ACOs relating to health equity. ACOs must maintain a Health Equity Committee with diverse representation that has responsibilities including developing and steering the implementation of the ACO's health equity strategy. Information from a population and community needs assessment and input from the Health Equity Committee and ACO stakeholders must be used to develop a Health Equity Strategic Plan. As part of this plan, ACOs must describe any plans for partnering with affiliated hospitals to further shared health equity goals as part of the Hospital Quality and Equity Initiative (HQEI); see Chapter 7 for additional details.

[37] Commonwealth of Massachusetts. (2021, August 18). *1115 Waiver Demonstration Extension Request 2022-2027*, *page 26.* Mass.gov. download (mass.gov)

[38] Commonwealth of Massachusetts. (2021, August 18). *1115 Waiver Demonstration Extension Request 2022-2027*, *page 32.* Mass.gov. download (mass.gov)

[39] ACO RFR Attachment A, ACPP Contract; https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410&external=true&parentUrl=bid

[40] ACO RFR Attachment B, Primary Care ACO Contract; https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410&external=true&parentUrl=bid

As part of their contracts, ACOs will also be required to ensure meaningful and appropriate training to advance health equity is periodically received by all staff and providers. ACOs must obtain accreditation from the National Committee on Quality Assurance (NCQA)'s Health Equity Accreditation program.

In addition to a quality incentive arrangement, ACOs will participate in the Health Equity Incentive Arrangement. For the purposes of the Health Equity Incentive arrangement, ACO performance will be assessed on three domains:

1. Social Risk Factor Data Domain: Achievement of complete, self-reported, member-level social risk factor data
2. Reporting Domain: Reporting on readiness for health equity disparities reduction, including by reporting performance on certain ACO quality measures stratified by social risk factors
3. Disparities Reduction Domain: Reduction of identified disparities in performance on ACO quality metrics between subgroups stratified by social risk factors

Safety Net Support Linked to Accountable Care[41]

A key goal of the overall Demonstration includes supporting the Safety Net by funding safety net providers in continuous ways while creating and strengthening associations with accountable care. As such, the Demonstration aligns funding by conditioning certain safety net payments on participating in an ACO. See Chapter 5 (Safety Net Care Pool) for additional details.

Workforce Initiatives (WI)[42]

WI aim to support workforce recruitment and retention and to promote the increased availability of certain healthcare practitioners to serve Medicaid beneficiaries. These initiatives aim to address shortages in qualified providers serving MassHealth members. See Chapter 6 (Workforce Initiatives) for additional details. Three programs under the 2022-2027 Demonstration are similar to some of the Statewide Investment (SWI) programs under the 2017-2022 Demonstration with either similar or higher levels of financial incentives. In data collected for our Interim Evaluation of the 2017-2022 Demonstration, these initiatives were described by ACOs and CPs as beneficial for recruiting and retaining staff as they increased capacity for implementing delivery system reform activities. We hypothesize that these initiatives will again be especially useful for ACOs and CPs seeking to retain and increase capacity to meet enhanced expectations for the 2022-2027 Demonstration.

3.1.4. DSR Policy Domain Implementation Plans and Timeline

These aspects of the ACO program are specified in contracts with EOHHS. The contract term is the duration of time for which the contract is in effect, starting with the contract's effective date and lasting until December 31, 2027, or as otherwise specified

[41] STCs Section 11 STCs; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[42] Section 13, pages 99-102; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

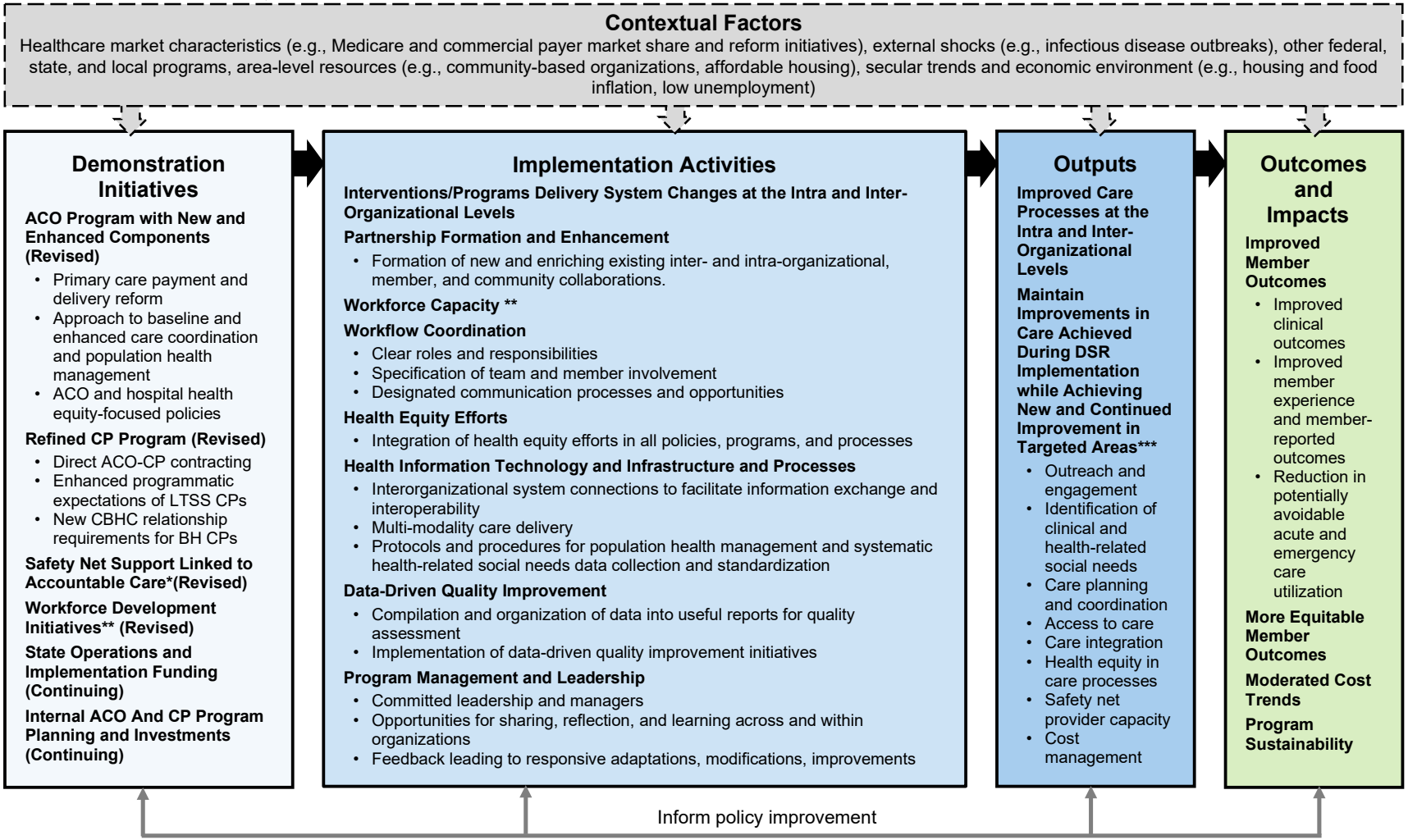
by EOHHS. Cost and quality accountability is reconciled to contract (i.e., performance) years. Program Year 1 is anticipated to be a nine-month period commencing April 1, 2023, and ending December 31, 2023, unless otherwise specified by EOHHS. Other Program Years will span a 12-month period commencing January 1 and ending December 31 unless otherwise specified by EOHHS.

3.2. Logic Model

The DSR logic model in Figure 3-1 links the Demonstration Goals to the Demonstration Inputs, Implementation Activities, Outputs, and Outcomes and Impact of the Demonstration. This logic guides the RQs and hypotheses that follow.

Figure 3-1: Logic Model for the DSR Component of the Demonstration

Goals: (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



* Safety net support linked to accountable care represented in SNCP Model
** Workforce development initiatives represented on Workforce Model
*** Hypotheses will specify areas where maintenance versus improvement is expected

3.3. Research Questions and Hypotheses

Table 3-2 provides an overview of the RQs, hypotheses, data sources, study populations, measures, and analytic methods that will be used to evaluate the DSR domain. The elements are described in detail below in Section 3.4 Data and Methods.

Table 3-2: Research Questions and Hypotheses for DSR

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ2-1 How did ACOs respond to enhanced expectations for quality, equity, and integrated care?	H2-1.1 ACOs will implement organizational changes to increase their capacity to deliver high-quality, equitable, and integrated care. H2-1.2 ACOs will form and strengthen relationships with hospitals, primary care practices, and PCPs to jointly deliver high-quality, equitable, and integrated care. H2-1.3 The number of ACO providers (health systems, practices, and individuals) accepting value-based payments and the amount of such payments will increase	Document review; (Ongoing) Key Informant individual and/or group interviews and/or open-ended surveys; (2024-2025; 2026-2027) Practice site administrator (pre-2019, pre-2021, post-2024) and ACO provider surveys (pre-2020, pre-2022, post-2026)	ACO and practice level providers and staff: • Providers survey (n=~5,000); • Practice site administrator survey (n=~350); • Leadership and Other staff interviewees (n ≤ 50); • MassHealth staff interviewees (n ≤ 10-15)	Changes to organizational structures, activities, and processes to promote quality, equity, and integration; Reported increases in capacity to deliver high-quality, equitable, and integrated care; Formation of new and strengthening of existing relationships between ACOs and their hospitals, primary care practices, and PCPs; Implementation of strategies by ACOs to increase the level of quality and cost accountability for PCPs and practices; Number of ACO providers (health systems, primary	Qualitative analysis of existing documents; Qualitative analysis of data collected through key informant interviews (KIIs); Analysis of surveys of ACO practice sites (practice site) and ACO providers (provider)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				care practices, and individuals) accepting or incentivized by value-based payments, and the amount of such payments Type and amount of quality accountability accepted by health systems, primary care practices, and individual providers	
RQ2-2 How did ACOs and their primary care practices respond to enhanced expectations for clinical service delivery and financial incentives for primary care reform included in MassHealth's sub-capitation program?	H2-2.1 ACOs and their primary care practices will invest in staff and infrastructure to increase their clinical service delivery capacity and decrease staff burnout. H2-2.2 ACOs and their primary care practices will implement strategies to increase access, quality, and continuity of primary care. H2-2.3 ACOs and their primary care practices will implement strategies to reduce inappropriate or potentially avoidable service utilization for their members.	Document review; (Ongoing) Key Informant Individual and/or group interviews and/or open-ended surveys; (2024-2025; 2026-2027) ACO practice site (pre-2019, pre-2021, post-2024) and provider surveys (pre-2020, pre-2022, post-2026)	ACO and practice level providers and staff: • Provider survey (n=~5,000); • Practice site administrator survey (n=~350); • Leadership and other staff interviewees (n ≤ 50); • MassHealth staff interviewees (n ≤ 10-15)	Reported changes to primary care practice staffing, infrastructure, and delivery of clinical services; Reported changes to the types and amounts of primary care practice and provider payment and cost accountability arrangements; Implementation of strategies to increase access, quality, and continuity of primary care; Implementation of strategies by primary care practices to manage the cost of care for members	Qualitative analysis of existing documents Qualitative analysis of data collected through KIIs Analysis of surveys of ACO practice sites (practice site) and providers (provider)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ2-3 How did access to and continuity of primary care change for ACO members receiving care from primary care practice sites participating in MassHealth's sub-capitation program?	**H2-3.1** Access to and continuity of primary care will increase.	ACO practice site (pre-2019, pre-2021, post-2024) and provider surveys (pre-2020, pre-2022, post-2026); Administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027); Member surveys (pre-2018-2022, post-2023-2027)	ACO practice site administrator survey (n=~350); ACO members (n=~1.3 million; comparison group of MCO/PCC members n=~152,000); Subgroups defined by member, practice site (e.g., sub-capitation clinical tier), and ACO characteristics	Prevalence of primary care practices in each sub-capitation clinical tier; Continuity of BH care; Continuity of primary care; Access measures reported by practice sites; Member-reported access to care	Descriptive analysis (member); Observed vs expected (member); Quasi-experimental methods (member); Analysis of surveys of ACO practice sites (practice site)
RQ2-4 How did integration between physical, behavioral, social, and long-term services change over time for ACO members?	**H2-4.1** Integration across the care continuum (e.g., physical health, BH, LTSS, acute care, social services) will increase.	Key Informant Individual and/or group interviews; (2024-2025; 2026-2027) ACO Practice Site (pre-2019, pre-2021, post-2024), ACO provider (pre-2020, pre-2022, post-2026), CP staff (pre-2020, pre-2022, post-2026), and Member Surveys (pre-2018-2022, post-2023-2027); Administrative data (baseline 2015-2017, pre-	ACO and practice level providers and staff: • Providers survey (n=~5,000); • Practice site administrators survey (n=~350); • Leadership and other staff interviewees (n ≤ 50); • Care management staff Interviewees (n ≤ 20-30)	Changes to organizational structures, activities, and processes to promote integration; Member experience of physical, social, behavioral, and long-term services integration; Practice site manager, ACO provider, and CP staff perceptions of changes in integration; Diabetes screening for individuals with schizophrenia or bipolar	Qualitative analysis of existing documents; Qualitative analysis of data collected through KIIs; Analysis of survey of ACO practice site (practice site), ACO providers (provider), and CP staff (staff); Analysis of member survey (member); Descriptive analysis (member) Observed vs expected (member);

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
		2018-2022, post-2023-2027)	CP staff: • Administrators interviewees (n ≤ 60); • Front-line staff survey (n=~600) Members: • Managed care eligible members (n=~1.3 million); • ACO members (n=~1.3 million; comparison group of MCO/PCC members n=~152000); • CP (n=~35,000) and ACO care management members (n=~110,000) Subgroups defined by member (e.g., adults, children, chronic conditions) and ACO characteristics (e.g., type)	disorder who are using antipsychotic medication; Physician visit within 30 days of hospital discharge; Follow-Up after Emergency Department (ED) visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD); Follow-up after hospitalization for mental illness; Follow-up with CP after acute or post-acute stay; Follow-up with CP after ED visit (BH CP)	Quasi-experimental methods (member)
RQ2-5 To what extent did enhanced expectations for quality and equity change care for ACO members?	**H2-5.1** The identification of individual members' unmet needs (including health-related social needs) for ACO members will improve	Document review; (Ongoing) Administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027);	ACO and practice level providers and staff: • Providers survey (n=~5,000);	Perceived improvement in identifying unmet member needs; Perceived improvement in member care processes;	Qualitative analysis of existing documents; Descriptive analysis (member); Observed vs expected (member);

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	H2-5.2 Care processes for ACO members will improve. **H2-5.3** Healthcare inequities will decline in targeted measures.	Key Informant Individual and/or group interviews and/or open-ended surveys; (2024-2025; 2026-2027) Member surveys (pre-2018-2022, post-2023-2027);	• Practice site administrators survey (n=~350); • Leadership and other staff interviewees (n<50); • Managed care eligible members (n=~1.3 million); • ACO members (n=~1.3 million; comparison group of MCO/PCC members n= 152,000); • MassHealth staff interviewees (n ≤ 10-15) Subgroups defined by member (e.g., adults, children, chronic conditions) and ACO characteristics (e.g., type)	Developmental screening in the first three years of life; Immunizations for adolescents; Childhood immunization status; Timeliness of prenatal care; Topical fluoride for children at elevated caries risk; Asthma medication ratio; Initiation and engagement of alcohol or other drug abuse or dependence treatment; Metabolic monitoring for children and adolescents on antipsychotics; Antidepressant medication management; Oral health evaluation; Screening for depression and follow-up plan; HRSN screening; Annual primary care visit; Other metrics targeted by ACOs for quality	Quasi-experimental methods (member); Qualitative analysis of data collected through KIIs;

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				improvement and disparities reduction	
RQ2-6 How did ACOs and CPs respond to expectations for Enhanced Care Coordination Programs (CP and ACO Care Management)?	**H2-6.1** Changes to the CP program will strengthen existing and new partnerships between ACOs and CPs. **H2-6.2** The ACOs and CPs will develop new or updated care coordination processes in alignment with enhanced CP expectations. **H2-6.3** LTSS CPs will use infrastructure payments to build an infrastructure and develop the workforce to support enhanced care coordination and to meet higher expectations in the current Demonstration period. **H2-6.4** ACOs will implement new or refine existing care management programs to meet the needs of their enrolled population.	Document review; (Ongoing) Key Informant Individual and/or group interviews and/or open-ended surveys (2024-2025; 2026-2027)	ACO and practice level providers and staff: • Providers survey (n=~5,000); • Practice site administrators survey (n=~350); • Care management staff interviewees (n ≤ 20-30); • Leadership and other staff interviewees (n ≤ 50) CP staff • Administrators interviewees (n ≤ 60); • Administrators and front-line staff survey (n=~600); MassHealth staff Interviewees (n ≤ 10-15)	Factors related to the implementation of changes to care coordination and management processes and programs; Perceived effectiveness of changes to CP program to support development of new partnerships and strengthen existing partnerships; Perceived alignment of care coordination processes with enhanced CP expectations; Development of enhanced infrastructure and workforce by LTSS CPs; Perceived value of LTSS CP direct payments to effectively support enhanced care coordination and efforts to meet higher expectations; Perceived effectiveness of changes to ACO care management programs	Qualitative analysis of existing documents; Qualitative analysis of data collected through KIIs

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ2-7 To what extent did access to and quality of care coordination supports change for members of ACO Enhanced Care Coordination Programs (CP and ACO Care Management)?	**H2-7.1** Coordination of care will improve. **H2-7.2** The quality-of-care coordination supports delivered by CPs and ACOs will increase.	Key Informant Individual and/or group interviews; (2024-2025; 2026-2027) ACO Practice Site (pre-2019, pre-2021, post-2024), ACO provider (pre-2020, pre-2022, post-2026), CP staff (pre-2020, pre-2022, post-2026), and Member Surveys (pre-2018-2022, post-2023-2027); Administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	ACO and practice level providers and staff: • Providers survey (n=~5,000); • Practice site administrators survey (n=~350); • Leadership and other staff interviewees (n ≤ 50); • Care management staff interviewees (n ≤ 20-30) CP staff: • Administrators interviewees (n ≤ 60); • Front-line staff survey (n=~600) CP (n=~35,000) and ACO care management members (n=~110,000) Subgroups defined by member (e.g., adults, children, chronic conditions) and ACO characteristics (e.g., type)	Perceived changes in how well care is coordinated; Perceived changes in access to and quality-of-care coordination supports; Rate of enrollment in ACO enhanced care coordination programs; Annual primary care visit; Initiation/engagement of alcohol, opioid, or other drug abuse or dependence treatment; Antidepressant medication management; Treatment plan completion; Care plan completion; Oral health evaluation (LTSS CP); Metrics selected corresponding to ACO care management program target populations	Descriptive analysis (member); Observed vs expected (member); Quasi-experimental methods (member); Qualitative analysis of data collected through KIIs

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ2-8 How did the volume and mix of services change for ACO members?	**H2-8.1** The volume and mix of services utilized will shift, when clinically appropriate, in the direction of lower-cost sites and types of care. **H2-8.2** Rates of potentially avoidable emergency care and inpatient utilization will decrease. **H2-8.3** Utilization of outpatient LTSS, BH, and physical care services will increase or remain consistent for members.	Administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Managed care eligible members (n=~1.3 million); ACO members (n=~1.3 million; comparison group of MCO/PCC members n=~152,000); CP (n=~35,000) and ACO care management members (n=~110,000) Subgroups defined by member (e.g., adults, children, chronic conditions) and ACO characteristics (e.g., type)	Primary care utilization; Post-acute care and LTSS utilization; Outpatient utilization; Pharmacy utilization; Inpatient utilization; ED visits and boarding; ED visits for individuals with mental illness, addiction, or co-occurring conditions; All-cause readmissions; Hospital admissions for ambulatory care-sensitive conditions; Pediatric asthma admissions; Imaging for low back pain	Descriptive analysis (member); Observed vs expected (member); Quasi-experimental methods (member)
RQ2-9 How did member outcomes and member experience change for ACO members?	**H2-9.1** Clinical outcomes will improve. **H2-9.2** Members will report improved experiences of healthcare services and supports. **H2-9.3** Inequities in health outcomes will decline in targeted measures.	Member interviews and/or focus groups; (2024-2025; 2026-2027) Member surveys (pre-2018-2022, post-2023-2027); Administrative data (baseline 2015-2017, pre-	Member interviewees (n ≤ 30) Managed care eligible members (n=~1.3 million) ACO members (n=~1.3 million; comparison group of MCO/PCC members n=~152,000)	Member experience of healthcare services and supports; Person-centered primary care measure; Unnecessary C-Section; Maternal morbidity; NICU utilization;	Descriptive analysis (member); Observed vs expected (member); Quasi-experimental methods (member); Qualitative analysis of data collected through KIIs

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
		2018-2022, post 2023-2027)	CP (n=35,000) and ACO care management members (n=~110,000) Subgroups defined by member (e.g., adults, children, chronic conditions) and ACO characteristics (e.g., type)	Controlling high blood pressure; Comprehensive diabetes care: HBA1c poor control; Other metrics targeted for disparities reduction	
RQ2-10 How were Medicaid total cost of care trends affected for ACO members?	**H2-10.1** The rate of increase in the total cost of care for ACO members overall and for those receiving enhanced care coordination will decrease.	Administrative data (baseline 2015-2017, pre-2018-2022, post 2023-2027); ACO financial reconciliation reports (pre-2018-2022, post-2023-2027)	Managed care eligible members (n=~1.3 million) ACO members (n=~1.3 million; comparison group of MCO/PCC members n=~152,000) CP (n=~35,000) and ACO care management members (n=~110,000) Subgroups defined by member (e.g., adults, children, chronic conditions) and ACO characteristics (e.g., type)	TCOC; Cost by service category; Shared savings and shared losses	Descriptive analysis (member); Observed vs expected (member); Quasi-experimental methods (member)
RQ2-11 To what extent can observed changes in care processes, outcomes, and costs be attributed to DSR programs?	**H2-11.1** Improvements in outcomes will be associated with delivery system changes (e.g., changes in program design, organizational activities, and processes).	Key Informant Individual and/or group interviews; (2024-2025; 2026-2027) ACO Practice Site (pre-2019, pre-2021, post-2024), CP staff and ACO	ACO and practice level providers and staff: • Care management staff Interviewees (n ≤ 20-30);	Select quality, utilization, and outcome measures listed in other RQs; TCOC; Cost by service category	Mixed methods to synthesize results across RQs and examine how delivery system changes (e.g., new partnerships, increased accountability or capacity, better integration) are likely causes of

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	H2-11.2 Cost of care trends will be associated with delivery system changes.	Provider (pre-2020, pre-2022, post-2026), and Member Surveys (pre-2018-2022, post-2023-2027); Administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	• Leadership and other staff interviewees (n ≤ 50) CP staff: • Administrators Interviewees (n ≤ 60); Managed care eligible members (n=~1.3 million) ACO members (n=~1.3 million; comparison group of MCO/PCC members n= ~152,000) CP (n=~35,000) and ACO care management members (n=~110,000) Subgroups defined by member (e.g., adults, children, chronic conditions) and ACO characteristics (e.g., type).		changes in outcomes and costs (member)

a. Research questions developed in response to Special Terms and Conditions sections 17.6i; 8.1-8.13; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

b. Data Sources are described in section 3.4.2 “Data Sources and Collection Methods” and section 1.4.1 “Summary of Data Sources.” Evaluation periods reflect the anticipated year of data collection for primary data and the expected baseline, prior demonstration (“pre”), and current demonstration (“post”) policy periods, as appropriate, for quantitative analyses of secondary data. The timing of data collection and all details regarding evaluation periods will be updated and provided in the Interim and Summative Evaluation Reports.

c. Analysis methods are described in section 3.4.5 “Analysis Methods”

3.4. Data and Methods

3.4.1. Study Populations

The relevant populations to be studied by RQs are presented along with hypotheses, data sources, and measures in Table 3-2.

ACO Staff

- ACO leadership: Includes executive-level employees at each MassHealth ACO.
- ACO care management staff: Includes non-executive staff employed by the ACO responsible for delivering care management or coordination to ACO members.
- ACO staff: Includes non-executive level employees at each MassHealth ACO with responsibilities other than care management or coordination.

Primary Care Practice Sites and Providers

- PCPs: Includes physicians, nurses, physician assistants (PAs), nurse practitioners (NPs), pharmacists, and social workers delivering primary care services at ACO primary care practice sites.
- Practice Site Administrators (i.e., managers)*:* Includes ACO primary care practice site managers. Practice managers may be providers.
- Practice Care Management Staff: Includes staff embedded at specific primary care practice sites who are responsible for delivering enhanced care coordination to ACO members.

CP Staff

Includes staff or executive level employees providing and/or supporting care management and coordination services for MassHealth members at each CP.

MassHealth Members

MassHealth, the Massachusetts Medicaid and Children's Health Insurance Program (CHIP), serves over 2.16 million Massachusetts residents as of December 2022.[43] We will study the MassHealth members eligible for enrollment in ACOs (i.e., managed care eligible), the primary vehicle for the state's DSR efforts. As of December 2022, the managed care eligible population included approximately 1.48 million members, of whom about 1.22 million were enrolled with one of the state's 17 ACOs. Managed care eligible MassHealth members who were not enrolled with ACOs were either enrolled with one of two MCOs (about 127,000 members), or with the Commonwealth's primary care case management delivery system (i.e., the PCC plan, about 142,000 members). As described above, two ACO models will be in effect during the 2023-2027 contracting period, and we expect to perform stratified analyses to examine differences in experience and performance by type of ACO and potentially other ACO characteristics

[43] MassHealth Snapshot Enrollment Summary of December 2022 Caseload. Unpublished report; https://www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-december-2022-0/download

that emerge as important during preliminary analyses of our mixed methods data sources.

We will be studying several subgroups of interest. To understand the impact of enhanced programmatic expectations of ACOs, LTSS CPs, and new CBHC requirements for BH CPs, we will study members with BH and LTSS needs, including those receiving ACO care management (when data are available to identify members) and CP care coordination supports. Consistent with the DSR policy domain's emphasis on integration and care coordination, health equity-focused policies, and primary care payment reform, we also expect to examine subgroups of adult and pediatric members with complex health or social needs or linguistically, ethnically, or racially diverse members for whom these Demonstration initiatives are expected to be particularly beneficial. To understand associations between DSR programs and potential effects, we will also study members with conditions that place them in the denominator of accountability measures (e.g., members with hypertension). Members from the described subgroups may be sampled to participate in key informant interviews (KIIs) or the target of survey recruitment efforts.

Comparison Groups[44]

We will use several comparison groups, following the general principles of selecting comparator populations that most closely resemble the populations exposed to specific Demonstration policies and programs. Due to systematic differences between Medicaid members and commercial members and between interstate policy environments, we plan to primarily draw comparison groups from within the MassHealth program while also exploring opportunities to obtain and leverage data from other state Medicaid programs. MassHealth managed care eligible members enrolled in MCOs and the PCC Plan with similar characteristics will serve as comparison groups for analyses of ACO members, including analyses studying members in ACO care management programs. MassHealth members who are not enrolled with CPs but who have similar sociodemographic and clinical characteristics as members enrolled with CPs will serve as comparison group members for CP members. We will use one or both historical comparison groups and contemporary comparison groups when data for a pool of members with similar characteristics and who are unexposed to programs are available. We will seek to leverage situations conducive to quasi-experimental methods that support stronger levels of inference, such as phased implementation, when possible.

3.4.2. Data Sources and Collection Methods

Our prior evaluation of MassHealth's Demonstration focused on systems transformation/implementation processes and outcomes, informed by the Consolidated

[44] Reschovsky, J., Heeringa, J., & Colby, M. (2018, June). Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations *(White Paper)*. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/comparison-grp-eval-dsgn.pdf

Framework for Implementation Research (CFIR).[45,46] The CFIR model, with its focus on facilitators and barriers to implementation and implementation strategies, suggests that implementation is an ongoing process, with continued adaptations, given changes in the external context, organizations involved, and member/population needs. We will continue to monitor the DSR implementation process, using quantitative and qualitative data and methods to study existing and new activities.

An additional focus of the 2022–2027 Demonstration is the ongoing shift toward the integration of care processes, given the progress in organizational infrastructure, workforce development, and care coordination. As part of this Demonstration, to comprehensively and specifically document the implementation of more integrated care processes, we will draw on the Comprehensive Theory of Integration (CTI) conceptual model.[47,48] In this model, integration is defined as "a set of organizational and social features and course of action or activities requiring unification that may exist both within and between organizations."[48] The model provides a framework that specifies different types of integration, including organizational features (i.e., structural and functional integration), social features (normative and interpersonal integration), and activities (i.e., process integration). Organizational, social, and activity/process integration are conceptualized as interrelated and mutually reinforcing but conceptually distinct. They are hypothesized to collectively result in more integrated patient care and to ultimately produce beneficial outcomes (i.e., technical quality, efficiency, patient experience, provider satisfaction, and patient health). This model has a foundation in the literature, has been applied and tested in several healthcare systems,[49] and is consistent with the vision, values, and components of the Demonstration.[50,51] In the proposed DSR logic model, we provide a framework for Demonstration initiatives, activities, outputs, and outcomes that takes advantage of the CTI model to support hypothesized relationships and anticipated outcomes.

Data for qualitative analysis will be obtained in two waves during the Demonstration and evaluation. The analysis of document and interview data from Wave 1 (Years 1 and 2 of the Demonstration) will inform the selection of topics and interviewees of interest in Wave 2 (Years 3 to 5 of the Demonstration). For example, in the evaluation of the

[45] Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation science, 4(1), 1-15.* PMID: 19664226; PMCID: PMC2736161.

[46] Kirk, M. A., Kelley, C., Yankey, N., Birken, S. A., Abadie, B., & Damschroder, L. (2015). A systematic review of the use of the Consolidated Framework for Implementation Research. *Implementation Science, 11(1), 1-13.* doi: 10.1186/s13012-016-0437-z. PMID: 27189233; PMCID: PMC4869309.

[47] Singer, S. J., Burgers, J., Friedberg, M., Rosenthal, M. B., Leape, L., & Schneider, E. (2011). Defining and measuring integrated patient care: promoting the next frontier in health care delivery. *Medical Care Research and Review, 68*(1), 112-127.

[48] Singer, S. J., Kerrissey, M., Friedberg, M., & Phillips, R. (2020). A comprehensive theory of integration. *Medical Care Research and Review*, *77*(2), 196-207.

[49] Kerrissey, M., Tietschert, M., Novikov, Z., Bahadurzada, H., Sinaiko, A. D., Martin, V., & Singer, S. J. (2022). Social features of integration in health systems and their relationship to provider experience, care quality and clinical integration. *Medical Care Research and Review*, *79*(3), 359-370.

[50] Singer, S. J., Kerrissey, M., Friedberg, M., & Phillips, R. (2020). A comprehensive theory of integration. *Medical Care Research and Review, 77(2), 196-207*. doi: 10.1177/1077558718767000. PMID: 29606036..

[51] Singer, S. J., Sinaiko, A. D., Tietschert, M. V., Kerrissey, M., Phillips, R. S., Martin, V., ... & Agniel, D. (2020). Care integration within and outside health system boundaries. *Health Services Research, 55,* 1033-1048.doi: 10.1111/1475-6773.13578. PMID: 33284521; PMCID: PMC7720712.

2017–2022 Demonstration, the facilitators and barriers for SSOs providing FSP in collaboration with ACOs and CPs to meet members' HRSNs emerged as an issue warranting further exploration. Consequently, in-depth interviews were conducted to explore facilitators and barriers to care coordination and delivery and members' experiences with planning, referral to, and receipt of FSP. Likewise, the COVID pandemic contributed to changes in context that warranted attention in later interviews (e.g., the impact and experience of telemedicine on the workforce and MassHealth members). Similarly, we will leverage Wave 1 data to inform the selection of topics and interviewees in Wave 2 of the evaluation of MassHealth's 2022-2027 Demonstration.

We will rely on six qualitative and quantitative data sources to evaluate the DSR policy domain. A summary of evaluation data sources can be found in Section 1.4.1 Summary of Data Sources. A description of the data sources and collection methods with details specific to the evaluation of DSR policies and programs follows.

Document Review

A range of existing documents (e.g., contracts, participation plans, progress reports) are expected to provide data on participating entities' plans and progress implementing initiatives and the state's progress implementing supports for the delivery system. These data are expected to include narrative descriptions provided by participating entities in their participation plans and progress reports (where required); DSR funding amounts and financial performance by entity, where applicable; and the state's documentation of DSR initiatives, including enrollment rates, contractual relationships, and quality performance. Relevant documents will include, but are not limited to, proposals, contracts and formal agreements between partners, participation plans, progress reports, public-facing annual reports, state-generated reports on funding allocations, and participation in/use of WI.

To standardize the review process, a template will be developed for each set of documents to be reviewed, providing a framework of topics related to targeted RQs and hypotheses (as informed by the CTI model). For example, templates will be developed, and documents will be reviewed as they relate to and provide evidence of partnership formation and enhancement, progress in building workforce capacity, investments in staff and infrastructure, quality improvement efforts, and the provision of opportunities to enhance and improve care processes particularly related to high-risk populations (e.g., homeless, criminal justice-involved). Initially, document reviews will be conducted by staff partner teams to come to a consensus on the definition, meaning, and interpretation of the template framework(s) and data to be extracted. Once consensus has been achieved, staff members will review documents independently, coming together in routine meetings to address questions, agree on a shared understanding of any emerging topics and data extracted, and offer impressions to inform any necessary revisions to the template or document review process. The document review process will be ongoing as organizations provide routine reports throughout the evaluation; additional documents (e.g., policy memos, relevant meeting minutes, etc.) will be reviewed as they become available and known to the evaluation team. For example, new or unexpected documents may emerge in response to changes in context (e.g., a pandemic or public health crisis). These will be reviewed as they relate to specific

research questions and larger contextual factors. These data will be obtained to provide insight into factors that may contribute to outcomes for organizations and members and facilitate an in-depth understanding of the relationships among implementation activities, outputs, and outcomes.

KIIs

Semi-structured individual and/or group interviews will be conducted virtually, using Zoom or a comparable platform, in two waves of data collection (Demonstration Years (DYs) 2–3 and 4–5) with six categories of key informants:

1. MassHealth staff
2. ACO leadership and other staff
3. Practice site administrators,
4. Care management staff (ACO and practice site-based)
5. CP leadership and staff
6. MassHealth members

Open-ended response surveys may be used in lieu of interviews with MassHealth staff for efficiency and informed by prior experience that suggests the information content will be similar between modalities. The perspectives of diverse informants will be obtained as they relate to implementation and integration activities, processes, and outcomes as outlined in the logic model and support an understanding of the Demonstration's impact and effectiveness. All interview participants will complete a background survey in addition to attending interviews to provide relevant information (e.g., demographic characteristics, discipline, role, responsibilities, years with the organization for staff and providers, demographic characteristics, ACO and practice enrollment, and CP services received for members). KIIs will focus on staff, provider, and member experience with the Demonstration; interview data will provide context for interpreting quantitative findings.

Wave 1:

In the first wave (DYs 2–3), we will focus on staff interviews and perspectives on key Demonstration activities within organizations and on members' experiences of integrated patient care processes generically and in groups of members specifically targeted by the Demonstration. In the first two years of the evaluation, we will conduct semi-structured interviews, focus groups, or open-ended surveys with representatives of three key informant groups: (1) MassHealth staff responsible for administering the DSR (n=10 estimated); (2) ACO (about five representatives at each of 17 ACOS) and CP staff (about three representatives at each of 20 CPs); and (3) MassHealth members (up to 30 representing those receiving BH, LTSS, and/or pediatric services and supports). For the MassHealth staff sample, we will identify and recruit MassHealth staff who are knowledgeable about DSR. This will come from MassHealth's Office of Payment and Care Delivery Innovation (PCDI), which oversees various teams, each focused on a specific aspect of DSR, including: ACOs; CPs; Data Governance, Reporting, and Systems; Medical Directors (including clinical and quality improvement); Investments and Social Service Integration; and Analytics. In total, an estimated 55 to 65

MassHealth staff are working across these units and teams. We will target unit and team leads for the interviews. In addition to PCDI staff, when appropriate, we will interview staff from other divisions of MassHealth, including staff from the Office of Behavioral Health.

We have successfully identified and recruited ACO and CP representatives from all participating entities in the evaluation of MassHealth's 2017-2022 Demonstration, using a combination of approaches including contact with MassHealth staff liaisons and direct outreach. By providing the ACO and/or CP liaisons with an overview of the interview protocol, they can assist in identifying and scheduling the relevant representatives for the topics to be queried. As part of the 2017-2022 evaluation, we established a Member Work Group, which advised us regarding member recruitment, interview protocols, and procedures. In addition, our prior interview procedures have been reviewed by a consultant with experience receiving and expertise in studying LTSS, who provided recommendations regarding the use of plain language, the presentation of materials, and the purposeful sampling of disability types. To develop the member experience interview protocols and tailor them for specific target populations, we will obtain consultation from community experts and advocates affiliated with the MassHealth initiative (e.g., members of Advisory Groups) and key advocates representing the member groups of interest. We will recruit our initial sample of members through ACO, CP, and provider organizations nominations and attend to diversity in sample selection. The analysis of Wave 1 interview data will inform the development of interview protocols, procedures, and sampling strategies for the second wave of in-depth data collection.

Wave 2:

In DYs 4 and 5, we will conduct in-depth, virtual individual and/or focus group interviews (e.g., several care coordinators or care team members from within or between one or more entities) regarding activities occurring within and between sites and organizations with strategically selected MassHealth, ACO, and CP staff, and with members reflecting different demographic factors or characteristics (e.g., race, disability), HRSN, and/or defined by other individual- or community-level markers or indices of social risk (e.g., homeless, justice-involved), particularly as these factors may be related to health inequities. As with Wave 1, we anticipate we may use open-ended response surveys in lieu of interviews with MassHealth staff. Wave 2 DSR data collection will include interviews with up to 100 individuals (i.e., staff and/or members) participating in individual or focus group interview sessions. The purpose of these interviews is to obtain in-depth information on a particular topic or issue identified in Wave 1 or that has emerged in the implementation process. The decision regarding individual versus group interview procedures will be made based on the focus or topic of the interview (e.g., care processes from multiple staff and agency perspectives) and the met or unmet needs of participants (e.g., members at risk of homelessness), and to minimize the burden to organizations and members. Consideration will be given to individuals' communication preferences, particularly members receiving LTSS services, who may prefer to be interviewed individually or using the video chat function rather than communicate verbally. While data collection with cross-agency staff teams or specific groups of members may be challenging in terms of scheduling, every effort will be made

to efficiently engage and reflect diverse perspectives while reducing the burden on participants.

Member Experience Surveys

Five rounds of member experience surveys (MES) were conducted by Massachusetts Health Quality Partners (MHQP) to assess change in MassHealth members' experience during the 2017-2022 Demonstration: primary care, BH, and LTSS surveys. Each round had a child (under 18 years of age) and an adult (18 years of age or older) survey for each surveyed population. These surveys will provide baseline data for member surveys to be conducted by MassHealth's vendor to evaluate the 2022-2027 Demonstration. These surveys will be conducted annually during the 2022-2027 Demonstration for members enrolled in ACO and/or CPs and for members enrolled in the PCC Plan. Although MHQP currently fields these surveys for a purpose that is distinct from the Independent Evaluation, these surveys will continue to be an important source of information on member experience. We will continue to provide recommendations to MassHealth and MassHealth's vendor(s) to enhance the value of future surveys for the purposes of evaluation without unduly increasing the burden on respondents.[52] This includes parsimoniously adding content (e.g., the person-centered primary care measure)[53] and leveraging readily available information from existing data sources that could be combined with survey responses.

The sample frame for the ACO/CP's primary care, BH, and LTSS surveys has historically contained members who received at least one of three types of service(s) during the measurement year: primary care, BH, and/or LTSS. Members were included in the sample frame if the following conditions were met:

1. The member was enrolled in one of the ACOs and potentially one of the CPs on the anchor date defined for each survey cycle.
2. The member received primary care, BH services, and/or LTSS services during the measurement year.
3. The sample frame for the PCC Plan will focus on primary care services only and include members who met the following conditions:
    - The member was enrolled in the PCC Plan on the anchor date defined for each survey cycle.
    - The PCC Plan member had at least one primary care visit at one of the PCC Plan practices during the measurement year.

From within the primary care, BH, and LTSS sampling frames, on average, 350,000 members will be surveyed annually: around 80 percent for the primary care survey, 14 percent for the BH survey, and 6 percent for the LTSS survey. The survey sampling

[52] Commonwealth of Massachusetts. (2022, June 2). *Comprehensive Quality Strategy*. Mass.gov. https://www.mass.gov/doc/masshealth-2022-comprehensive-quality-strategy-2/download

[53] Etz, R. S., Zyzanski, S. J., Gonzalez, M. M., Reves, S. R., O'Neal, J. P., & Stange, K. C. (2019). A new comprehensive measure of high-value aspects of primary care. *The Annals of Family Medicine, 17*(3), 221-230.

design will be stratified to collect information from adult members and from parents or guardians of pediatric members.

The primary care survey consists of 13 domains: communications, integration of care, knowledge of patient, adult BH, pediatric prevention, child development, organizational access, office staff, self-management support, telemedicine, child provider communication, overall provider rating, and willingness to recommend.

The BH survey consists of 11 domains: communications, needs for BH, care plan, care coordinator, service scheduling, teamwork, telemedicine, healthy living in the community, members' engagement with care team needs met, willingness to recommend, and overall rating.

The LTSS survey consists of 12 domains: communications, needs met LTSS core, needs met LTSS non-core, care plan, care coordinator, service scheduling, teamwork, telemedicine, healthy living in the community, members engagement with care team-needs met, willingness to recommend, and overall rating.

The surveys are expected to be fielded annually by web and mail in CY2023-2028 to assess member experience for CY2022-2027.

Practice Site Administrator Survey

Two waves of online surveys of ACO primary care practice site administrators were performed during the 2017-2022 Demonstration and will provide baseline data for a single online survey of practice site administrators to be conducted during the first half of the 2022-2027 Demonstration. The sampling frame will again include group practices, community health centers (CHCs), and hospital practices participating in the ACO program. The following sites will be excluded from the survey: solo physician practices, sites that only provide acute care, practice sites located outside of Massachusetts, sites with fewer than 50 MassHealth members, and sites with an unknown number of MassHealth members. From within the sampling frame, we expect all sites within each ACO will be selected. After a thorough literature review, the questionnaire used for the 2017-2022 evaluation was drafted collaboratively by the Independent Assessor, IE, and a research group administering similar surveys. The survey was shared with stakeholders to gather feedback, field-tested with ACO administrators, and further refined before administration. The survey instrument includes questions about care integration, screening, access, social services referrals, risk stratification, performance management, engagement with the ACO, and payment arrangements, among other topics. The 2022-2027 survey instrument is expected to be a modified version of the instrument used in the 2017-2022 evaluation. For any new survey questions, the questions will be piloted with a convenience sample of practice site administrators using cognitive testing and assessments for clarity, completeness, and respondent burden. We will retire survey questions that are no longer relevant or informative.

Provider and Staff Surveys

The IE will conduct a survey of ACO PCPs and CP front-line staff in the second half of the Demonstration period to assess how front-line staff experience delivery system

transformation. Survey respondents are expected to be consistent with the sampling frame for the surveys of ACO/CP providers and staff conducted as part of the independent evaluation of the 2017-2022 Demonstration, including MDs, NPs, RNs, PAs, MAs, and CHWs.

The survey instrument is expected to be a modified version of the instrument used in the 2017-2022 evaluation. A core component of the instrument is the Provider and Staff Perceptions of Integrated Care (PPICs), a validated survey instrument comprising 21 questions across seven care integration constructs, including within care team care coordination, across care team care coordination, and coordination between care teams and community resources. It is anticipated that validated survey questions will again be supplemented with questions specifically tailored to the new and modified programs. For any new survey questions, the questions will be piloted with a convenience sample of provider staff using cognitive testing and assessments for clarity, completeness, and respondent burden. We will retire survey questions that are no longer relevant or informative. The survey will be administered to providers' primary care sites that are included in the sampling frame for the practice site administrator survey. Other details of the sampling plan remain under development and will be informed by pending data (e.g., ACO practice site affiliations and provider distributions).

Administrative Data

Individual-level administrative data comprise of eligibility, enrollment, claims and encounter, and provider records for healthcare services delivered to the MassHealth member population. Since the CP program was implemented, in addition to traditional healthcare services (e.g., medical, pharmacy, laboratory) included in claims and encounters, MassHealth administrative data also include data on enrollment with and supports delivered by CPs (i.e., qualifying activities). This level of enrollment data is also planned to be collected and made available for members of ACO care management programs during this Demonstration period, at which point it will be used for the evaluation. Unique provider identification numbers included on billing records enable linkage to the MassHealth provider characteristics file, which contains provider type, demographics, and ACO affiliation information. Unique practice site identification numbers will allow linkage to practice site survey responses and information provided by the ACO (or publicly available) regarding practice site characteristics (e.g., clinical service tier attested to under MassHealth's sub-capitation program). The MassHealth administrative data are of research quality and have been used previously by the evaluation team.[54,55,56]

[54] Mick, E. O., Alcusky, M. J., Li, N. C., Eanet, F. E., Allison, J. J., Kiefe, C. I., & Ash, A. S. (2021). Complex patients have more emergency visits: don't punish the systems that serve them. *Medical care, 59*(4), 362.

[55] Alcusky, M., Mick, E. O., Clark, M. A., & Ash, A. S. (2020). Calibrating Medicaid payment to need for long-term services and supports. *The American Journal of Managed Care, 26*(12), e388-e394.

[56] Ash, A. S., Mick, E. O., Ellis, R. P., Kiefe, C. I., Allison, J. J., & Clark, M. A. (2017). Social determinants of health in managed care payment formulas. *JAMA Internal Medicine, 177*(10), 1424-1430.

3.4.3. Measures

The measures that will be used to evaluate the DSR policy domain are listed in Table 3-2 by RQ.

Qualitative measures will capture information on actions taken by ACOs and CPs in response to programmatic changes made by MassHealth for the 2022-2027 Demonstration, including further developing structures and processes for delivering integrated, equitable, and high-quality care. Qualitative analyses will also produce information on changes in the approach to identifying and addressing member needs, delivering services and supports, and improving health equity from the perspective of members, providers, staff, and organizational leaders. For ACOs and CPs, we will examine the facilitators and barriers to developing the inter and intra-organizational structures and processes put in place for the 2022-2027 Demonstration, plans for maintaining them, and what modifications are needed going forward.

Quantitative measures hypothesized to be affected by the Demonstration and that can be operationalized using available data or collected from primary sources (e.g., member and provider/staff surveys) will be studied. Quality measures were drawn from the following sources:

- MassHealth ACO Quality Slate
- MassHealth CP Quality Slate
- MassHealth HQEI Slate
- CMS Health Equity Slate (to be added once published)
- National quality measure stewards (e.g., Agency for Healthcare Research and Quality (AHRQ), National Committee for Quality Assurance (NCQA))

In addition to quality measures, we will examine administrative data to better understand changes in utilization patterns over time that may be driving the TCOC performance. We will describe utilization by service categories such as inpatient (e.g., non-maternity physical health, maternity, and BH), ED visits, outpatient non-BH (lab and radiology, non-BH outpatient hospital), outpatient BH (e.g., Adult/Youth Mobile Crisis intervention, and diversionary services), professional services, pharmacy, home health, durable medical equipment, emergency transportation, other medical services, and services not covered by ACOs but rather provided by MassHealth through its FFS program (e.g., LTSS). For services associated with new and enhanced elements of the ACO and CP programs, we will add measures to surveys (e.g., person-centered primary care measure,[57] prevalence and magnitude of quality, and cost accountability arrangements for primary care practice sites and providers). We will operationalize custom measures from administrative data to address relevant hypotheses (e.g., for RQ2-2 – RQ2-3: prevalence of primary care practices in Tier 1, 2, and 3 sub-capitation

[57] Etz, R. S., Zyzanski, S. J., Gonzalez, M. M., Reves, S. R., O'Neal, J. P., & Stange, K. C. (2019). A new comprehensive measure of high-value aspects of primary care. *The Annals of Family Medicine, 17*(3), 221-230.

clinical tier, continuity of primary care, and BH care). These measures will be interpreted in the context of other relevant knowledge generated in the course of the evaluation.

The overarching rationale for our hypotheses is that contract requirements, shared risk, and accountability provisions will lead organizations and their providers to implement strategies to increase quality, improve health equity, and shift utilization to lower-cost settings or services that will deliver equal or greater quality and experience for members. Progress in implementing such strategies is expected to vary across organizations depending upon past experience as MassHealth ACOs, participation in other alternative payment models and value-based payment arrangements, and other factors (e.g., staffing and capital resources).

3.4.4. Covariates

For analyses conducted at the individual (member) level using administrative data, we will draw from a consistent set of characteristics: age, sex (men or women), disability status (either a client of the Massachusetts DMH or the Department of Developmental Services (DDS), or are eligible for Medicaid due to disability), housing problems (either three or more addresses in the year or homelessness by International Classification of Diseases (ICD)-10 code), the Neighborhood Stress Score (NSS), the DxCG medical morbidity summary score, and the RxCG drug-based medical morbidity summary score. A narrower set of characteristics may be used for specific analyses as applicable (e.g., subgroup analyses among women would not use sex as a covariate).

For analyses conducted at the primary care practice site level, covariates will include practice type (solo practitioner, group practice, CHC, hospital licensed health center), size (number of MassHealth members attributed to the site), rurality, and service region. Additional practice site administrator characteristics available to be used as covariates in analyses restricted to survey respondents include age, gender, race/ethnicity, and years at the practice site. Provider-level covariates include type of provider (e.g., physician, social worker) and specialty. Additional provider-level covariates collected via surveys include age, gender, race/ethnicity, years in practice, years at the practice site, and panel size and composition. Analyses conducted at the ACO level (or that incorporate clustering at the ACO level) will include covariates such as ACO type (academic hospital-anchored, community hospital anchored, physician-anchored), ACO size (number of MassHealth members, number of total enrollees across all payers), region, and experience with risk-based contracts with Medicare and commercial payers.

3.4.5. Analysis Methods

Mixed qualitative and quantitative methods will be used to answer the RQs in the DSR policy domain and to evaluate the extent to which Demonstration initiatives and implementation activities promoted delivery system transformation and improved outcomes. Quantitative analyses will examine the impact of policy implementation and changes in outcomes. Qualitative approaches, including two rounds of semi-structured interviews and/or focus groups with key stakeholders, will support an understanding of stakeholder perspectives related to policy implementation activities, context, and

outcomes. Interviews will also provide a contextual understanding of factors that help to explain identified outcomes.

Quantitative Analyses

Descriptive

The demographic, clinical, and social characteristics will first be described by data source and CY for each study population and subpopulation of interest, including measuring specific populations (e.g., A1c and members with diabetes). Where feasible, process and outcome measures will then be calculated for each population in each CY during the baseline and Demonstration period. Certain survey and clinical quality measures will only have data available for the 2018-2022 and/or 2023-2027 periods. All analyses of survey data will use sampling and inverse probability of response weights to obtain results that are adjusted for the sampling approach and observed sources of non-response bias.

Observed versus Expected

The first type of comparison will be between observed and multivariable-adjusted estimates of expected values of each measure for each CY of the Demonstration period. Expected values will be estimated from multivariable models developed using pre-period data and applied to Demonstration period data to predict an individual's value for each measure based on a member's demographic and clinical characteristics (e.g., members with SMI will have a higher probability of ED utilization). These expected values will serve as a type of historical benchmark against which performance during the Demonstration will be compared. For dichotomous (i.e., yes or no) measures, the probability of success on a given measure will be predicted using logistic models. Rates (e.g., hospitalizations per 100 person-years) will be predicted using Poisson, negative binomial, or zero-inflated models, as appropriate. Continuous outcomes (e.g., expenditures) will be predicted using linear models. For each measure and year of the Demonstration period, the observed value for a measure will be divided by the expected value predicted by the model. When higher values of a measure are desired (e.g., a higher proportion of the population screened), a ratio of observed to predicted greater than one will suggest improved quality. When lower values of a measure are desired (e.g., readmission rates), a ratio of observed to predicted of less than one will suggest quality improvement.

Quasi-Experimental Methods

To estimate the counterfactual outcomes that would have occurred absent the Demonstration and which can support stronger inferences regarding program effects, analyses must address potential biases arising from 1) population and system characteristics that differ between plans, and 2) unrelated secular trends occurring between the baseline (2015-17), DSRIP (2018-2022), and the Demonstration (2022-2027) periods. Modern epidemiologic and quasi-experimental design and analysis methods will be applied for this purpose, including propensity score methods to balance

population characteristics,[58,59] and overlap weighting, which addresses the limitations of traditional inverse probability weighting.[60] Difference-in-difference comparisons will address secular trends,[61,62] and weighting will be used to address any violations of parallel trends assumptions. Difference-in-difference comparisons will be combined with interrupted time series (ITS) methods[63,64] for measures that can be calculated at quarterly or monthly frequencies, with seasonal adjustments. Generalized mixed effects linear models will be used for modeling each type of outcome (e.g., dichotomous, continuous, rate) as appropriate and based on observed distributions, with random effects to account for clustering within healthcare organizations, geographic units, and repeated measurements within individuals over time.[65] Bootstrap methods that reflect clustering adjustments will be used to calculate confidence intervals. Analyses spanning multiple COVID-19 time periods (i.e., before, during, and after) will incorporate time-varying terms to adjust for the confounding effects of the COVID-19 pandemic. Sensitivity analyses will be performed to examine the robustness of findings to varied assumptions regarding the onset and offset of COVID-19-related confounding effects.

Continuous Enrollee Analysis

The stable population of continuous MassHealth members, who may have disabilities or other criteria for eligibility for MassHealth that are likely to be permanent or semi-permanent, has been identified as a subpopulation of interest. The stability of this population also affords the opportunity to perform a self-controlled comparison, which contrasts member outcomes during the Demonstration period with their own outcomes during the pre-Demonstration period. A strength of this self-controlled design is that by comparing within individuals, it accounts for time-invariant member characteristics (i.e., those that do not change over time). We will again use difference-in-difference analyses to remove secular effects and mixed effects generalized linear models to account for clustering and repeated measurements while adjusting for demographic (e.g., aging) and disease trends. For each year of the Demonstration, we will conduct a continuous member subgroup analysis where members present in the population of interest during the Demonstration year will be evaluated if they were continuously enrolled in the MassHealth managed care eligible population beginning in 2021 or 2022.

[58] Rosenbaum, P. R., & Rubin, D. B. (1983). The central role of the propensity score in observational studies for causal effects. *Biometrika, 70*(1), 41-55.

[59] D'Agostino Jr, R. B. (1998). Propensity score methods for bias reduction in the comparison of a treatment to a non-randomized control group. *Statistics in medicine, 17*(19), 2265-2281.

[60] Li, F., Morgan, K. L., & Zaslavsky, A. M. (2018). Balancing covariates via propensity score weighting. *Journal of the American Statistical Association, 113*(521), 390-400.

[61] Vats, S., Ash, A. S., & Ellis, R. P. (2013). Bending the cost curve? Results from a comprehensive primary care payment pilot. *Medical Care, 51*(11).

[62] Lechner, M. (2011). The estimation of causal effects by difference-in-difference methods. *Foundations and Trends in Econometrics, 4*(3), 165-224. Retrieved from: https://EconPapers.repec.org/RePEc:now:fnteco:0800000014.

[63] Penfold, R. B., & Zhang, F. (2013). Use of interrupted time series analysis in evaluating health care quality improvements. *Academic pediatrics, 13*(6), S38-S44.

[64] Cook, T. D., Campbell, D. T., & Shadish, W. (2002). Experimental and quasi-experimental designs for generalized causal inference. *Boston, MA: Houghton Mifflin* (pp. 103-134).

[65] McWilliams, J. M., Hatfield, L. A., Landon, B. E., Hamed, P., & Chernew, M. E. (2018). Medicare spending after 3 years of the Medicare Shared Savings Program. *New England Journal of Medicine, 379*(12), 1139-1149.

Qualitative Analyses

Our use of document and KII data, qualitatively analyzed, reflects our commitment to an embedded design, integrating quantitative and qualitative data reflecting diverse perspectives to explore the implementation process and to contribute to the explanation of outcomes. [66]

Data systematically extracted from documents and recorded in standardized templates will be stored in secure files for qualitative analyses. The team will review document data templates as they are relevant to specific RQs and hypotheses being addressed. Team members will draft memos summarizing template data for routine review by the larger team. Document review data will be integrated with findings from other sources to address RQs and hypotheses.

Demographic data for the interview participants will be compiled in Microsoft Excel and analyzed descriptively. Descriptive demographic data will be uploaded into Dedoose, a web-based qualitative data management software, for use in conjunction with the analysis of interview data. Using a framework approach, the team will develop initial codes based on the evaluation logic model, related interview topics, and additional themes that arise organically during the interview process. Coding will be conducted in multiple rounds, first by pairs of research team members and then independently, to ensure the team shares an understanding of the codes and applies them consistently. The team will meet routinely to discuss coding until agreement on coding definitions and applications is reached and to address any issues during the coding process. Interrater reliability will be monitored at regular intervals during the coding processes. The Dedoose platform provides for the calculation of kappa coefficients.

Once the coding process is complete, researchers will extract reports of coded text from Dedoose, review the reports for patterns among themes, and summarize findings in memos drafted for review by the total team. Finally, the team will discuss the summary memos to ensure that themes are accurately conveyed and to add additional information as relevant (e.g., to integrate significant contextual factors as identified in the document review). Where relevant and useful, the team will compile analytic matrices with coded data to facilitate further analysis within and/or across participant or organization types, for example.

Using an embedded mixed methods approach, we will integrate the quantitative and qualitative data. We will solicit an in-depth and nuanced understanding of various stakeholder experiences, examine how those experiences may be related to DSR policy and practice innovation, and use these findings to offer explanations regarding pertinent trends and outcomes. For example, understanding stakeholder perspectives on program implementation may help contextualize trends seen in cost and clinical outcomes.[69] Conversely, preliminary quantitative findings from analysis of data obtained early in the Demonstration period can generate questions regarding underlying

[66] Creswell, J. W., & Clark, V. L. P. (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: *Sage Publications.*

mechanisms that can then be explored in subsequent qualitative data collection and analysis.

3.4.6. Limitations

Quantitative Analyses

Our quantitative data sources and analytic approaches utilizing these data have several limitations. We will cautiously interpret results from multiple analytic methods together with qualitative findings to arrive at robust conclusions.

Surveys

The MES have several limitations, including the potential for recall bias, low response rates, and residual non-response bias despite weighting adjustments that will be applied to correct for it, limited data on clinical conditions and healthcare utilization to adjust for non-response bias, and new items that may require further refinement and validation. Furthermore, members may have been surveyed in multiple years, but we do not have unique member identification numbers (i.e., member IDs) to account for repeated measurements within individuals, and large sample sizes increased the likelihood of detecting statistically significant differences between repeated measure results that are not of clinical or policy significance. Some member surveys (BH, LTSS) are only to be conducted among ACO members, and data will not be available for comparison groups enrolled with MCOs or the PCC Plan. Finally, the member surveys are conducted by a third party for a purpose distinct from evaluation, and the evaluation team has limited input into survey design and implementation.

The ACO provider and CP staff surveys may be subject to recall bias. The surveys are also susceptible to non-response bias. However, the response rate historically has been very good for CP staff surveys, while the ACO response rate was consistent with other provider surveys; for both surveys, we plan to apply weights to adjust for the sampling approach and observed sources of non-response bias.

Administrative Data Analyses

Analyses of administrative data are subject to limitations associated with the nature of such data being created for billing purposes, which may not reflect the actual presence of clinical conditions (e.g., if a member doesn't seek care or obtain a diagnosis) or use of a medication (e.g., if a drug is filled and not taken). Administrative data lack important clinical details such as laboratory values and non-billable services (e.g., certain forms of care coordination and management). For select quality measures and associated measurements, clinical data will be available. However, such data are expected only to be available for subsets of the populations and comparison groups of interest. Demonstration programs are only one of many factors affecting the measures we'll be studying.

Two prominent time-varying confounders include the COVID-19 pandemic and the policy changes enacted throughout the Public Health Emergency (PHE), which will end in the first year of our study period. Although rigorous quasi-experimental designs and statistical methods are planned, comparative analyses remain at risk of unmeasured

confounding. Another potential limitation will be missing data. In situations with substantial missing sociodemographic data (e.g., of self-reported race and ethnicity), we will explore options for conducting analyses using imputed data. We will perform extensive sensitivity analyses to examine the plausibility of alternative explanations for our findings under alternative assumptions about missingness mechanisms and how to account for them analytically.

Qualitative Analyses

Our qualitative data sources and analytic approaches utilizing these data have several limitations.

Document Review

Relevant documents for review will be provided by MassHealth as they become available and from other sources (e.g., relevant state-wide groups) as they are identified. The volume of available documents poses a potential challenge for staff to extract all necessary information within available capacity constraints. We will work with MassHealth to prioritize documents for the review process to ensure we review the most relevant and significant documents first before proceeding to other documents with potentially relevant information.

KIIs

We may confront several limitations during the primary data collection process. As with any self-reported data, information collected in KIIs may be subject to recall bias. KIIs may be conducted by video conference, which represents a strength in terms of consistency of interview format and data collected across sites. Another strength is the increased efficiency that we anticipate will enable us to successfully schedule and collect information from a larger pool of respondents. However, the video conference format limits our ability to view organizational contexts firsthand. We will solicit responses from a range of staff and probe for specifics about processes and workflows to achieve a nuanced understanding of each organization's activities. For member interviews, videoconferencing may pose difficulties related to technology availability. Furthermore, some members may initially express interest when recruited but may no longer be interested or could not participate in an interview due to various clinical or social factors. Our interview procedures have been reviewed by a consultant with experience receiving LTSS and expertise in studying LTSS, who provided recommendations regarding the use of plain language and the presentation of materials. Historically, we have had a sufficiently robust pool of potential interviewees to draw from for interviews; therefore, we anticipate we will be able to complete the planned number of interviews.

4. Behavioral Health

4.1. Overview of Behavioral Health (BH) Demonstration Policy Domain

Behavioral health (BH), defined here as serious mental illness (SMI), severe emotional disturbance (SED), and/or substance use disorders/opioid use disorder (SUD/OUD), remains a top priority in the 2022-2027 Demonstration period. The BH Demonstration domain has three main policy components: (1) diversionary BH services (Special Terms and Conditions (STC) 5.11), (2) a full range of SUD/OUD treatment services, including residential and inpatient treatment for individuals with SUDs/OUD (STC 6), and (3) residential and psychiatric inpatient treatment for individuals with SMI or SED (STC 7).

4.1.1. BH Policy Domain Goals

The overall goals of the BH Demonstration policy domain are to:

1. Strengthen the delivery of BH outpatient, urgent, and crisis care;
2. Increase rates of early identification, initiation, and engagement in BH treatment;
3. Increase access to community-based recovery support services to improve member health and increase rates of long-term BH recovery;
4. Improve access to high-quality, evidence-based BH treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Disease (IMD);
5. Increase adherence and retention to treatment for members with SUDs;
6. Improve access to care for physical health conditions amongst members with BH conditions;
7. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.
8. Reduce utilization of emergency departments (EDs) and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other services along the continuum of care services;
9. Improve the availability of crisis stabilization services;
10. Reduce time spent in EDs awaiting disposition to clinically appropriate placement;
11. Reduce preventable readmissions to acute psychiatric hospitals, 24-hour SUD treatment services, and residential settings; and
12. Reduce overdose deaths, particularly those due to opioids.

The BH policy domain is being implemented in the context of the Massachusetts Roadmap for Behavioral Health Reform (BH Roadmap),[67] which provides significant investments to (1) increase access to the appropriate BH treatment when and where people need it and (2) significantly strengthen the delivery of outpatient, urgent, and crisis treatment, and to improve the integration of BH care with primary care.

Overview of Diversionary BH Services

Diversionary BH services are home- and community-based mental health and SUD services provided as a clinically appropriate alternative to, and diversion from, inpatient services in more community-based, less structured environments. Diversionary services are 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 diversionary services: those provided in a 24-hour facility and those provided on an outpatient basis in a non-24-hour setting or facility. Both 24-hour and non-24-hour diversionary BH services are primarily provided by free-standing (community-based) or hospital-based programs licensed by the DMH or DPH.

Overview of SUD Services

Under prior Demonstrations, the Commonwealth has expanded access to SUD treatment services and ongoing recovery support to improve beneficiary health and increase rates of long-term recovery. Under the SUD Demonstration component, eligible MassHealth members 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 that are not otherwise reimbursable under section 1903 of the Social Security Act.[68] The Commonwealth will continue to be eligible to receive Federal Financial Participation (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 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.

MassHealth anticipates that the Massachusetts DPH Bureau of Substance Addiction Services (BSAS), the single state authority on SUD services, will continue to fund primary prevention efforts, including education campaigns and community prevention coalitions. Intervention and treatment will be available to MassHealth members, as described below, in several different settings and allow for a bio-psycho-social clinical assessment, based on the ASAM principles, to gain an understanding of addiction

[67] The Commonwealth's Roadmap for Behavioral Health is a multi-year blueprint, based on listening sessions and feedback from nearly 700 individuals, families, providers, and other stakeholders who identified the need for expanded access to treatment, more effective treatment, and improved health equity. See more details here: Commonwealth of Massachusetts. (2021). *Roadmap for Behavioral Health Reform*. Mass.gov. https://www.mass.gov/service-details/roadmap-for-behavioralhealth-reform

[68] Social Security. (n.d.). *Payment to the States*: *Compilation Of The Social Security Laws. Ssa.gov*. Social Security Act §1903 (ssa.gov)

severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability, and other issues.

Overview of SMI/SED Services

MassHealth aims to ensure that members have access to the full range of services, including those services provided in facilities that meet the definition of an IMD, such as acute inpatient psychiatric hospitalization services, community crisis stabilization for adults and youth (CCS), and community-based acute treatment for children and adolescents (CBAT). IMDs will ensure smooth transitions to clinically appropriate levels of community BH care, physical healthcare, and social services (as available) necessary to support individuals with SMI or SED in the community through transition planning and care coordination.

4.1.2. BH Policy Domain Components and Desired Outcomes[69]

Diversionary BH Services Domain Components

As outlined in the STCs, the following is a summary of Diversionary BH Services that the Commonwealth will cover under the Demonstration:

- Community Support Program (CSP)[70] (Non-24-hour facility)
- Transitional Care Unit Services (24-hour facility)
- Program for Assertive Community Treatment (PACT) (Non-24-hour facility)
- Partial Hospitalization[71] (Non-24-hour facility)
- Psychiatric Day Treatment (PDT)[71] (Non-24-hour facility)
- Intensive Outpatient Program (IOP)[71] (Non-24-hour facility)
- Structured Outpatient Addiction Program (SOAP)[71] (Non-24-hour facility)
- Emergency Services Program (ESP)[71] (Renamed Mobile Crisis Intervention as of January 2023)

SUD Services Domain Components

As outlined in the STCs, the following is a summary of SUD/OUD Services that the Commonwealth will cover under the Demonstration:

- ASAM Level 3.3 Clinically Managed Population-Specific High-Intensity (not currently implemented)
- ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services (24-hour Transitional Support Services)

[69] STCs Sections 5.11; 6.- and 7-7.10; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[70] Does not include specialized CSPs outlined in STC 15, HSRN; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[71] Services provided under the Medicaid state plan. Definition may change pursuant to any state plan amendment.

- ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services (24-hour Residential Rehabilitation Services and 24-hour community-based family, transition-age youth, and youth SUD treatment services)
- Recovery support navigator services
- Recovery coach services
- ASAM Level 3.5 Clinical Stabilization Services
- ASAM Level 3.7 Acute Treatment Services
- ASAM Level 4 Inpatient Medically Managed Addiction Treatment[72]

SMI/SED Services Domain Components

As outlined in the STCs, the following is a summary of SMI/SED Services that the Commonwealth will cover under the Demonstration:

- Community Crisis Stabilization (CCS)[73]
- Acute psychiatric inpatient services delivered in facilities that qualify as IMDs[72]
- Community-Based Acute Treatment for Children and Adolescents (CBAT)[74]

Desired BH Outcomes

The overall desired member outcomes for the BH policy domain of the Demonstration include the following:

- Reduce the time spent in EDs awaiting placement in a clinically appropriate level of care
- Shorten medically necessary inpatient lengths of stay
- Reduce overdoses and overdose deaths, particularly due to opioids
- Decrease 30-day all-cause readmissions to acute BH hospitals and residential programs
- Increase utilization of medically necessary community BH services
- Improve access to physical healthcare for members with BH diagnoses
- Increase rates of identification, initiation, and engagement in treatment for SUD
- Increase adherence to and retention in SUD treatment
- Reduce utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
- Balance the benefits and costs of Demonstration services

[72] New to the waiver (as of 8/1/22, under the prior demonstration) for IMD authority. Otherwise, services provided under the Medicaid state plan. Definition may change pursuant to any state plan amendment.

[73] These services are available for all members, except for those in MassHealth Limited. Moved under IMD authority in the prior demonstration (as of 8/1/22).

[74] This will be available for children and adolescents enrolled in managed care. Moved under IMD authority in the prior demonstration (as of 8/1/22).

4.1.3. BH Policy Domain Implementation Plans and Timeline

The evaluation of the BH domain will rely on a mixed methods approach to determine whether and how the investments made through the BH program are contributing to achieving the Demonstration goals as described in the STCs[75] and SMI/SED Implementation Plan, in particular STC 7.2.[76]

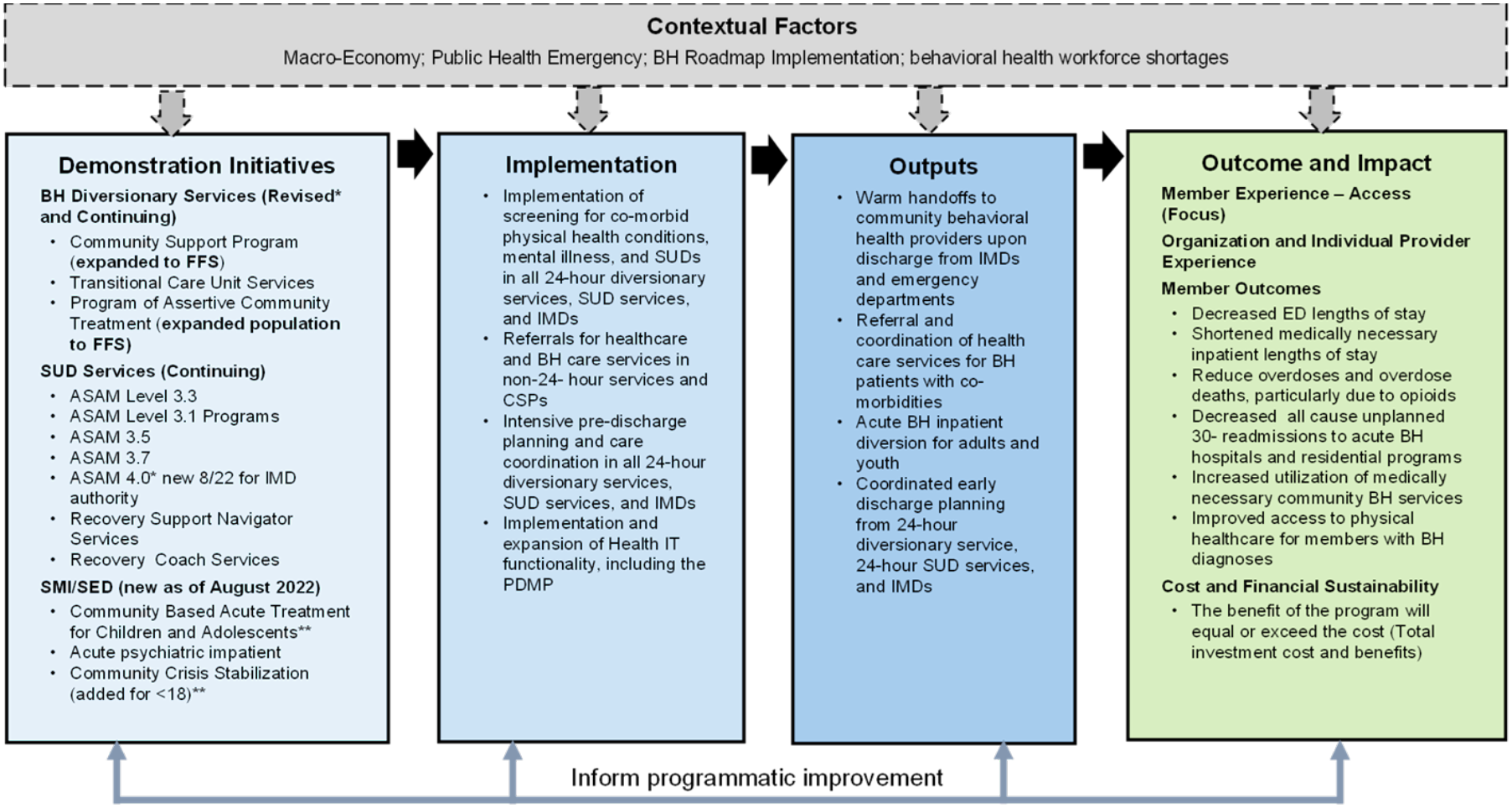
4.2. Logic Model

The BH logic model in Figure 4-1 links the Demonstration Goals to the Demonstration Inputs, Implementation Activities, Outputs, and Outcomes and Impact of the Demonstration. The research questions (RQs) and hypotheses that follow are guided by this logic.

[75] STCs Sections 5.11; 6.- and 7-7.10; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[76] STC 7.2, SMI/SED Implementation Plan;

Figure 4-1: Logic Model for the BH Component of the Demonstration



*ESP/MCI, structured outpatient addiction program (SOAP), psychiatric day treatment, partial hospitalization, intensive outpatient are state plan services. ASAM 4.0 is state plan except for IMD waiver authority. Transitional Care Unit is continuing.
**CCS (except for the <18 population) and CBAT are continued from the previous waiver under IMD authority as of August 2022.

4.3. Research Questions and Hypotheses

Figure 4-1 provides an overview of the RQs, hypotheses, data sources, study populations,[77] measures, and analytic methods that will be used to evaluate the BH domain. The elements are described in detail in Section 4.4 Data and Methods. [78,79,80,81]

Table 4-1: Research Questions and Hypotheses for BH

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ3-1 Do Demonstration diversionary services result in a reduction in ED use and length of stay (LOS)?	H3-1.1 A reduction in ED use will be observed over time after the implementation of the Demonstration. H3-1.2 A reduction in ED LOS will be observed over time after the implementation of the Demonstration.	MassHealth Medicaid Management Information System (MMIS) claims/ encounter data (baseline 2015-2017, pre-2018-2022, post-2023-2027); Provider and member interviews 2024-2025; 2026-2027	Quantitative: members with BH diagnoses (N=~275,000) Qualitative: providers (n ≤ 60) members (n ≤ 30)	ED visits for individuals with mental illness, addiction, or co-occurring conditions stratified by age (6-17, 18-64); ED boarding of members with BH conditions; Member report of support from peers and psychiatric consultants and perception of its reduction in LOS; Provider report of the usefulness of peer support and psychiatric consultation on reduced ED LOS and factors that support/impede use and effectiveness of peers and psychiatric consultants in EDs	Descriptive statistics (member); Interrupted time series (ITS) (member); Qualitative thematic analysis (providers/members)

[77] Please refer to 4.4.1 "Study Population" for a detailed description of the study populations.

[78] STC 17.6, Evaluation Questions and Hypotheses; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[79] Centers for Medicare & Medicaid Services. (n.d.). *Evaluation design guidance for section 1115 demonstrations for beneficiaries with serious mental illness/serious emotional disturbance and substance use disorders: SMI/SED and SUD Evaluation Guidance*.

[80] Centers for Medicare & Medicaid services. (n.d.). Goals, research questions, and analytic approaches for evaluating section 1115 serious mental illness/serious emotional disturbance demonstrations. SMI/SED and SUD evaluation design guidance: *Appendix A*.

[81] Centers for Medicare & Medicaid services. (n.d.). *SMI/SED and SUD Evaluation Design Guidance: Appendix B*

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ3-2 Do Demonstration diversionary services reduce the number of preventable acute psychiatric readmissions?	H3-2.1 Use of diversionary services will be associated with a small reduction in 30-day acute psychiatric readmissions[82]	MMIS claims/encounter data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Members with BH diagnoses (N=~275,000)	Plan all-cause readmissions for members with a SUD/SMI/SED; Number of beneficiaries in the Demonstration population who used any services related to mental health during the measurement period; Number of beneficiaries in the Demonstration population who used any services related to mental health during the measurement period; Number of beneficiaries in the Demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period; Follow-up after ED visit for mental illness	Descriptive statistics (member); Joint longitudinal and survival Analysis - ITS approach - segmented regression (member)
RQ3-3 What is the impact of Demonstration diversionary services on the overall cost of care	H3-3.1 Use of diversionary services will be cost-neutral.	MMIS claims/encounter data annual baseline (2015-2017, pre-2018-2022, post-2023-2027)	Members with BH diagnoses (N=~275,000)	Total cost of care (TCOC) (All Covered Services); Expenditures by service category broken down by individuals with any SUD-related diagnosis, OUD	ITS for cost analysis (member)

[82] Commonwealth of Massachusetts. (2019, May). *Acute Inpatient Hospital Bulletin 169*. Mass.gov. https://www.mass.gov/doc/acute-inpatient-hospital-bulletin-169-in-state-acute-hospital-30-day-readmissions-policy-0/download

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
for members with a BH diagnosis?				diagnosis, or SMI/SED diagnosis	
RQ3-4 How well did the Demonstration increase access to and utilization of SUD treatment services?	H3-4.1 The Demonstration's continuous coverage of OUD/SUD treatment services increased rates of identification, initiation, and engagement in treatment among individuals with SUD.	MMIS claims/encounter data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Members with SUD/OUD diagnoses (N=~260,000)	Initiation and engagement of alcohol and other drug dependence treatment (IET)	Descriptive statistics (member); ITS approach - segmented regression (member)
RQ3-5 What was the impact of the Demonstration on individuals with any SUD diagnosis (including, in particular, OUD diagnosis) adherence to and retention in treatment?	H3-5.1 The Demonstration's continuous coverage of OUD/SUD treatment services improved adherence to treatment among individuals with any SUD diagnosis (including, in particular, OUD diagnosis).	MMIS claims/encounter data (baseline 2015-2017, pre-2018-2022, post-2023-2027); BSAS program data, if available	Members with SUD/OUD diagnoses (N=~260,000)	Continuity of pharmacotherapy for OUD Follow-up after ED visit for mental illness Percentage of members with any SUD/OUD diagnosis who used the following per month: Outpatient SUD services; Intensive outpatient services; Medication-assisted treatment for SUD; Residential treatment (ASAM Level 3.1), including average length of stay; ASAM level 3.3 (once implemented); Clinical stabilization services (ASAM Level 3.5);	Descriptive statistics (member); ITS approach - segmented regression (member) Joint modeling of event counts and survival times analyses (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				Acute treatment services (ASAM Level 3.7); Inpatient withdrawal management; Outpatient detox; Recovery coach; Recovery support navigator	
RQ3-6 To what extent did the Demonstration 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?	H3-6.1 The Demonstration's continuous coverage of OUD/SUD treatment services reduced utilization of preventable or medically inappropriate care at ED and inpatient hospital settings among individuals with SUD and/or OUD-related diagnoses.	MMIS claims/encounter data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Members with SUD/OUD diagnoses (N=~260,000)	ED use for any SUD-related diagnosis and OUD diagnosis Inpatient admissions for any SUD-related diagnosis and OUD diagnosis	Descriptive statistics (member); ITS approach - segmented regression (member); Joint modeling of event counts and survival times analyses (member)
RQ3-7 To what extent did the Demonstration impact readmissions to the same or higher level of care where the readmission is preventable or	H3-7.1 The Demonstration's continuous coverage of OUD/SUD treatment services resulted in fewer readmissions to the same or higher level of care.	MMIS claims/encounter data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Members with SUD/OUD diagnoses (N=~260,000)	Plan all-cause readmissions for members with a SUD/SMI/SED	Descriptive statistics (member); ITS approach - segmented regression (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
medically inappropriate?					
RQ3-8 To what extent did the Demonstration impact overdose deaths, particularly those due to opioids?	H3-8.1 The Demonstration's continuous coverage of OUD/SUD treatment services reduced non-fatal overdoses and overdose deaths, particularly those due to opioids.	MMIS claims/encounter data State overdose data (baseline 2015-2017, pre-2018-2022, post-2023-2027); Massachusetts death records (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Members with SUD/OUD diagnoses (MMIS: N=~260,000) Massachusetts death records: (N=~58,000[83])	Use of opioids at high dosages in persons without cancer Nonfatal overdoses, overall And opioid-related Overdose deaths, overall and opioid-related	Descriptive statistics (member); ITS approach - segmented regression (member)
RQ3-9 To what extent did utilization of physical healthcare services for members with SUD improve due to the Demonstration focus on care coordination between physical and BH for SUD members with comorbidity?	H3-9.1 The Demonstration effort to improve care coordination between physical and for members with SUD with comorbidity improved access to physical healthcare for comorbid physical and BH conditions among members with any SUD diagnosis, including OUD diagnoses.	MMIS claims/encounter/ provider data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Members with SUD/OUD diagnoses (N=~260,000)	Medication for addiction treatment prescribers; See RQ3-5	Descriptive statistics (provider/member); ITS approach - segmented regression (provider/member)
RQ3-10 What is the impact of the Demonstration's continuous coverage of	H3-10.1 The Demonstration's continuous coverage of OUD/SUD treatment services across a	MMIS claims/encounter data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	Members with SUD/OUD diagnoses (N=~260,000)	TCOC (All Covered Services) Expenditures by service category for individuals with any SUD-related diagnosis or OUD diagnosis	Descriptive statistics (member/type of care); ITS approach - segmented regression (member/type of care)

[83] 2540 opioid-related deaths in 2019.

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
OUD/SUD treatment services on the TCOC per member with SUD?	comprehensive continuum of care and focus on coordinating physical and mental health reduced the TCOC for members with SUD diagnosis.				
RQ3-11 What is the impact of the SMI/SED Demonstration on access to the full range of community-based BH services, including adult and youth CCS?	H3-11.1 An increase in utilization of community-based services by MassHealth members will be observed following SMI/SED Demonstration implementation.	MMIS claims/encounter data (pre-2018-2022, post-2023-2027); Member interviews; (2024-2025; 2026-2027) Member Survey (2024-2027)	Adult and child MassHealth members with SMI/SED diagnoses (n=~ 90,000) Qualitative: providers (n ≤ 60) members (n ≤ 30) Survey: (n=~9,800 children; n=~20,000 adults)	Healthcare utilization; Total number of members with SMI/SED diagnoses who used BH services; Outpatient SUD professional visits; Inpatient visits; Outpatient BH visits; Member experience of access to services	Descriptive (member); Thematic analyses; Case study; ITS (member)
RQ3-12 Does increased access to SMI/SED Demonstration services reduce ED LOS hours?	H3-12.1 ED length of stay will be observed to decrease over time after implementation of Demonstration services.	MMIS claims/encounter data pre-2018-2022, post-2023-2027)	Adult and child members with SMI/SED diagnoses (n=~90,000)	ED visits for individuals with mental illness, addiction, or co-occurring conditions stratified by age (6-17, 18-64); ED boarding of members with BH conditions	Descriptive statistics (member); ITS (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ3-13 What is the impact of SMI/SED Demonstration services on preventable readmissions to acute psychiatric inpatient and residential facilities?	H3-13.1 A reduction in preventable readmissions to acute psychiatric services will be observed following the implementation of Demonstration services.	MMIS claims/encounter data pre-2018-2022, post-2023-2027);	Adult and child members with SMI or SED diagnoses (n=~90,000)	Plan all-cause readmissions for members with a SUD/SMI/SED	Descriptive statistics; Joint longitudinal and survival analysis - ITS approach - segmented regression (member)
RQ3-14 What is the impact of SMI/SED Demonstration services on continuity of care post discharge from acute psychiatric inpatient and residential facilities?	H3-14.1 Timely transitions of care from acute psychiatric inpatient services to community-based services will be observed following the implementation of the Demonstration. H3-14.2 Improved information sharing post discharge will be observed following the Demonstration.	MMIS claims/encounter data pre-2018-2022, post-2023-2027); Member interviews; (2024-2025; 2026-2027) Member Survey (2024-2027)	Quantitative: Adult and child members with SMI or SED diagnoses (n=~90,000) Qualitative: providers (n ≤ 60) members (n ≤ 30) Survey: (n=~9,800 children) (n=~20,000 adults)	Follow-up after hospitalization for mental illness: (6-17, 18-64); Number of beneficiaries in the Demonstration population who used any services related to mental health during the measurement period; Member report of continuity of care post discharge	Descriptive (member); ITS (member); Thematic analysis
RQ3-15 What is the impact of SMI/SED Demonstration services on the overall cost of care for members with a BH diagnosis?	H3-15.1 Costs for SMI/SED services will be observed to be stable following the Demonstration.	MMIS claims/encounter data pre-2018-2022, post-2023-2027);	Adult and child members with SMI or SED diagnoses (n=~90,000)	TCOC (all covered services); Expenditures by service category for individuals with any SUD-related diagnosis or OUDSMI/SED diagnosis; Inpatient psychiatric IMD inpatient or IMD residential	ITS cost analysis (member/type of care)

a. Research questions developed in response to STCs sections 5.1.1, 7.2.c.i.6, 7.2.c.ii, 17.6, 17.6b; 1115 MassHealth Demonstration ("Waiver") | Mass.gov
b. Data Sources are described in section 4.4.2 “Data Sources and CollectionMethods,” and section 1.4.1, “Summary of Data Sources.”
c. Analysis methods are described in section 4.4.4, “Analysis Methods.”

4.4. Data and Methods

The impact of the Demonstration cannot be fully separated from the Commonwealth's other efforts addressing BH challenges, including the BH Roadmap initiatives, such as Community Behavioral Health Centers (CBHC) and the BH Helpline, a 24-hour central access and resource service available via phone or text, which opened in January 2023, amongst others. Our evaluation will assess the impact of BH Demonstration services on outcomes and costs within the context of other system changes implemented as part of the BH Roadmap. Secondary data from the BH Helpline and BH Roadmap evaluation can be used to provide further context for Demonstration findings.

4.4.1. Study Population

Study Population

The study population will consist of MassHealth members (excluding MassHealth Limited members and dual-eligibles) with SMI/SED (See Appendix C for diagnoses with the MassHealth algorithm for determining SMI/SEDs) and/or SUD diagnoses, including alcohol use disorders and other SUD diagnoses but excluding tobacco. Members will be identified as having a SMI/SED or SUD if they have an International Classification of Diseases (ICD)-9/10 diagnosis on two or more medical claims/encounters in any position, excluding lab services. A member will be considered as having a SUD or SMI/SED starting with the first observed claim with a SUD or SMI/SED diagnosis through 11 additional months after the last observed SUD or SMI/SED claim or the end of Medicaid enrollment, whichever comes first. Given that people with SUDs or SMI/SEDs are often underdiagnosed, sensitivity analyses will be performed to identify members with SUD or SMI/SED based on the state's treatment manuals. A sub-group analysis will be conducted for members with an OUD.

Comparison Group

Because the expansion of SMI/SED and/or SUD services was implemented statewide for all MassHealth members, a clear comparison group (i.e., a group that would allow us to estimate a counterfactual scenario of what would have happened in the absence of the Demonstration activities) does not exist. When appropriate and accessible, the All-Payer Claims Database (APCD)[84] will be utilized to compare key care quality and healthcare utilization measures and cost trends among matched individuals with MassHealth, Medicare, and commercial insurance. This comparison would control for external factors at the state level that might impact the use of SMI/SED and/or SUD services.

Study Design

Mixed methods will be used to evaluate the BH component of the Demonstration. To capture the experience of members and their guardians with BH services, interviews will be conducted with a representative group of MassHealth members to map their care and highlight their care-seeking behavior, challenges, and satisfaction with healthcare.

[84] CHIA. (n.d.). *Massachusetts All-Payer Claims Database*. Chiamass.gov. https://www.chiamass.gov/ma-apcd/

Interviews with providers will be conducted to understand processes of care and discharge planning, if and how peer support specialists and psychiatric consultants assisted with connections to outpatient follow-ups after ED admissions.

Several quantitative methods will be used to capture changes in members' utilization, quality, and outcomes due to SMI/SED and SUD services. Interrupted Time Series (ITS), a quasi-experimental approach, will be used to compare trends in care quality measures, healthcare utilization, costs, and outcomes pre- to post-implementation of expanded SUD, SMI/SED, and diversionary services. This design is widely used and is considered one of the most robust quasi-experimental designs. If feasible and when appropriate, ITS models will be performed with controls (i.e., matched individuals with commercial or Medicare insurance) using the APCD. Joint modeling of event counts and survival time[85] will be used to analyze the impact of the diversionary services on reducing ED boarding (defined as ED stay >24 hours after disposition),[86] SUD/OUD services, SMI/SED services on preventable and medically inappropriate ED visits,[86] and preventable BH readmissions to acute inpatient hospitals and residential programs defined as 30-day readmissions to the same or higher level of IMD care.[87] In addition, a repeated cross-sectional design will be used to compare trends in opioid overdoses and opioid deaths in Massachusetts to the rest of the nation.

Study Period

The evaluation will cover the period of 2022-2027 for measures based on qualitative data, descriptive analysis, and measures evaluated using cross-sectional data. The evaluation period will extend from 2015 to 2027 for measures evaluated using ITS; data covering calendar years (CY) 2015 through 2017 will be used as a pre-implementation baseline, 2018 through 2022 as the first phase of implementation, and 2023 through 2027 as the Demonstration period of interest. See Chapter 1 (Executive Summary) Table 1-2 and Table 1-3 for more details.

4.4.2. Data Sources and Collection Methods

Data Sources

MassHealth Administrative Data

The primary data source that will be used to address hypotheses is the MassHealth Medicaid Management Information Systems (MMIS) enrollment, medical claims /encounter files, and pharmacy claims files. (See Section 1.4.1).

All-Payer Claims Database (APCD)[87]

To the extent possible, we will use MA-APCD to control for external factors that might impact SMI/SED and/or SUD services at the state level. MA-APCD is the most comprehensive source of health claims data from public and private payers providing

[85] Cowling, B. J., Hutton, J. L., & Shaw, J. E. H. (2006). Joint modelling of event counts and survival times. *Journal of the Royal Statistical Society: Series C (Applied Statistics)*, *55*(1), 31–39. https://doi.org/10.1111/j.1467-9876.2005.00529.x

[86] Lines, L. M., Li, N. C., Mick, E. O., & Ash, A. S. (2019). Emergency department and primary care use in Massachusetts 5 years after health reform. *Medical care*, *57*(2), 101-108.

[87] CHIA. (n.d.). Massachusetts All-Payer Claims Database. Chiamass.gov. https://www.chiamass.gov/ma-apcd/

insurance to Massachusetts residents and employees. It covers several services, including medical, pharmacy, dental, vision, BH, and specialty services. The database is released annually, and each release covers five years. For example, the current MA-APCD CY2021 dataset covers claims, eligibility, provider, and other required file types submitted for CY2017-2021, plus claims related to services provided in those years that are processed between January and June 2022.

Massachusetts Death Records

To evaluate hypothesis H3-8.1 ("The Demonstration will reduce overdose deaths"), claims data will be linked to Massachusetts Death records held by the Massachusetts Registry of Vital Records and Statistics.

Program Data

If available, BSAS will provide member-level data regarding the utilization of residential rehabilitation services and recovery coach services (i.e., services not covered by MassHealth in the pre-Demonstration period, 2015-2017), to be used in conjunction with MassHealth claims/encounter data to address H3-5.1 (adherence to SUD treatment).

The Public Health Dataset

To the extent possible, we will use the Public Health Data Warehouse (PHD) to evaluate SUD hypothesis H3-8.1 ("The Demonstration will reduce non-fatal overdoses"). The PHD dataset, maintained by the Massachusetts DPH, is a linked dataset created by state statute to facilitate data analysis to inform efforts to reduce opioid overdoses in the state. The dataset links individual-level data from various sources, including vital statistics, medical and pharmacy claims data, hospital discharge records, toxicology reports, ambulance transport records, DPH program enrollment, and BSAS service utilization. Non-fatal opioid overdoses are identified from various sources, such as ambulance transport data, which are unavailable in MassHealth claims data. If the PHD data set is unavailable during the analysis period, information on non-fatal overdoses will be obtained from MMIS data using ICD/Current Procedural Terminology (CPT) codes to identify overdoses, with the limitation that claims data will underestimate the number of opioid overdoses.

The Centers for Disease Control and Prevention (CDC) Wide-ranging Online Data for Epidemiologic Research (WONDER) Database

WONDER is an internet-based publicly available data system intended to further public health research and program evaluation. Information about fatal overdoses is available in the mortality and multiple causes of death databases, which are populated using information from death certificates. Additionally, trends can be stratified at the state level, by year, and/or by several other demographic characteristics. For the Demonstration, we plan to use the WONDER database to compare trends in fatal overdoses in Massachusetts to the rest of the nation. Data on non-fatal and fatal overdoses in Massachusetts will be analyzed from the DPH overdose statistics data.[88]

[88] Department of Public Health. (n.d.). *Current Opioid Statistics*. Mass.gov. https://www.mass.gov/lists/current-opioid-statistics

Member Interviews[89]

Interviews with members and their family members/guardians will provide an understanding of experiences with BH services, unmet service needs, including medical care and housing, barriers to care (including services that meet their linguistic, cultural, and BH needs), service integration, inclusion in discharge and crisis planning, care coordination and experiences with transitions in care. The interview guide will also be informed by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Mental Health Care Survey.

Provider Interviews[90]

Interviews with providers will provide an understanding of the extent to which the Demonstration facilitates the utilization of peer support specialists and psychiatric consultants in EDs to assist with transitions to clinically appropriate levels of care. Providers will also be interviewed to provide insights on discharge planning to facilitate timely transitions to clinically appropriate BH, physical health, and support services post-discharge from acute psychiatric facilities, 24-hour SUD diversionary services, and mental health diversionary services. Questions will seek to elicit information on processes for assessment of medical needs and HRSNs to be addressed in treatment and discharge planning and suggestions for improved care coordination, amongst other topics.

National Surveys

Utilization of national surveys, including the National Survey on Drug Use and Health, Behavioral Risk Factor Surveillance Systems (BRFSS), National Survey of Substance Abuse Treatment, and National Mental Health Services Survey, allows for a comparison of BH access to care and member's experience in Massachusetts compared other states.

4.4.3. Measures

Outcome measures will be identified in the MassHealth claims/encounter data along with death files and the Public Health data set, using ICD-9/10, CPT, revenue, and NDC codes, as appropriate. Measures align with those listed in the November 2017 State Medicaid Director's letter SMD#17-003 and include but are not limited to:

- Number and percentage of the study population meeting National Quality Forum (NQF) quality measures related to the initiation of treatment, pharmacotherapy use, and follow-up after ED discharge
- Number and percentage of the population utilizing SUD treatment
- Number and percentage of the population utilizing mental health treatment, both children and adults
- Number and percentage of the population utilizing other services (e.g., ED, hospital inpatient, ambulatory, pharmacy)
- Fatal and non-fatal overdoses, overall and opioid specific

[89] CAHPS Mental Health Care Surveys. (n.d.). *CAHPS Experience of Care & Health Outcomes (ECHO) Survey*. Ahrq.gov. https://www.ahrq.gov/cahps/surveys-guidance/echo/index.html

[90] Qualitative data collection and analysis will be conducted by the IE qualitative team.

- Number of medications for opioid use disorder (MOUD) for members with OUD and providers identified by MassHealth administrative data.
- Total cost of care (TCOC) to MassHealth, including costs of inpatient, outpatient (including ED), pharmacy, long-term care, and residential care (including IMD costs). All cost data will be obtained from claims/encounter data. Administrative costs will not be included because they would be constant across groups and years, and our focus is on the marginal change in costs due to BH services. Total costs will be categorized by:
    - Cost related to diagnosis and treatment of SMI/SED
        - SMI/SED IMD costs
        - Other SMI/SED costs
        - Non-SMI/SED medical services costs
    - Cost related to diagnosis and treatment of SUD
        - SUD IMD costs
        - Other SUD costs
        - Non-SUD costs medical services costs
    - Source of treatment cost drivers for beneficiaries in the target population
        - Outpatient costs, non-ED
        - Outpatient costs, ED
        - Inpatient costs
        - Pharmacy costs
        - Long-term care costs

4.4.4. Analysis Methods

Descriptive statistics will be performed for members, including diagnoses and other clinical and demographic characteristics. This analysis will be performed on a quarterly basis and include counts, percentages, means, standard deviation, medians, and 25th and 95th percentiles, as appropriate.

A time-series approach will be used to estimate the marginal changes in evaluation measures over time, starting with the pre-intervention period of 2015-2017, the period covering the 2017-2022 Demonstration, and the period covering the 2022-2027 Demonstration. Segmented regression analysis, using generalized estimating equations, will be used to evaluate trends prior to, between each phase of implementation, and after implementation (including lag periods if warranted, to allow for the full effect of the implementation to occur). Analyses will be conducted with and without adjusting for differences in the risk profile of MassHealth members with SMI/SED and SUD over time. Subgroup analyses will also be performed by geographic region and member risk profiles. For preventable or low acuity non-emergent ED visits and inpatient admissions where services are concentrated among a small number of members, as a primary analysis, a joint modeling of event counts and survival times analyses will be conducted to simultaneously analyze the impact of the SUD/OUD services on the counts and the time intervals between those services, using a Poisson

process framework which incorporates covariate effects and between-patient heterogeneity.[91,92,93] In addition, separate models will be considered to examine rates and survival time separately. To address uncertainties associated with the number of MassHealth members diagnosed with BH conditions, the IE will conduct sensitivity analyses to capture the state and CMS definitions of members with SUD/OUD and SMI/SED.

Member surveys and qualitative data from interviews with members and providers will provide context for quantitative findings. Using an embedded mixed methods approach,[94] we will synthesize themes derived from the qualitative data with the quantitative findings. We will delve into members' and providers' experiences, examining how those experiences may be related to BH policy and practice innovation. Integration of qualitative and quantitative findings will help the evaluation team to provide the context behind both cost and utilization trends and outcomes.

Measures, data sources, and analytic approaches that will be used to address each evaluation hypothesis are presented in Table 4-1. Details on the specifications, numerator, and denominator for key measures are presented in Appendix B.

4.4.5. Limitations

As mentioned above, due to other activities targeting improvements in BH services in the Commonwealth, isolating the impact of the Demonstration from other activities, including the BH Roadmap and ACO initiatives, may be difficult. The evaluation team will use mixed methods to map members' care-seeking behaviors, challenges, satisfaction, and outcomes and, when possible, attribute these changes to the Demonstration compared to other state initiatives.

The expansion of SMI/SED and/or SUD services at the statewide level for all MassHealth members limits the availability of a clear comparison group. When appropriate, and if access to data is feasible, the evaluation team will use the MA-APCD to compare key care quality and healthcare utilization measures and cost trends among matched individuals with MassHealth, Medicare, and commercial insurance. This would allow us to control for external factors at the state level that might impact the use of SMI/SED and/or SUD services.

[91] Cowling, B. J., Hutton, J. L., & Shaw, J. E. H. (2006). Joint modeling of event counts and survival times. Journal of the Royal Statistical Society: Series C (Applied Statistics), 55(1), 31–39. doi:10.1111/j.1467-9876.2005.00529.x

[92] Fleming, T.R., & Harrington, D. P. (1991). Counting Processes and Survival Analysis. Wiley Series in Probability and Statistics. https://doi.org/10.1002/9781118150672

[93] Wu, L., Meng, Y., Kong, X., & Zou, Y. (2022). Incorporating survival analysis into the safety effectiveness evaluation of treatments: Jointly modeling crash counts and time intervals between crashes. Journal of Transportation Safety &Amp; Security, 14(2), 338–358. https://doi.org/10.1080/19439962.2020.1786871

[94] Creswell, J. W., & Clark, V. L. P. (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: *Sage Publications.*

5. Safety Net Care Pool

5.1. Overview of Safety Net Care Pool (SNCP) Policy Domain

The Demonstration includes the continuation of many longstanding authorities and programs that the Commonwealth has implemented in previous Demonstrations. The SNCP policy domain of this Demonstration includes certain continuing programs that aim to provide uncompensated care payments to safety net providers that serve Medicaid members and low-income, uninsured individuals.[95]

Initiatives for the SNCP in previous Demonstrations have included "providing residual provider funding for uncompensated care, and care for Medicaid Fee-For-Service (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," all of which are described further in Attachment E of the STC.[96]

During the 2017-2022 Demonstration, the expenditure categories for the SNCP included the Disproportionate Share Hospital-like (DSH-like) Pool (which includes Safety Net Provider Payments (SNPP), the Uncompensated Care (UC) Pool for charity care for uninsured and underinsured, the Delivery System Reform Incentive Payment (DSRIP) Program, Public Hospital Transformation and Incentive Initiatives (PHTII),[97] and DSHP-Health Connector Subsidies.

As described in more detail below, MassHealth will continue to have expenditure authority of the DSH-like Pool and the UC Pool funding in the 2022-2027 Demonstration (as well as close-out expenditure authority for 2017-2022 Demonstration programs).[98]

5.1.1. SNCP Policy Domain Goals

A key goal of the 2022-2027 Demonstration includes supporting safety net providers in the Commonwealth with continuous funding through multiple mechanisms while furthering efforts to increase provider accountability. In addition, a significant objective of the overall Demonstration is for the SNCP to align funding with MassHealth's accountable care strategies and expectations and to create and promote a sustainable structure that allows ongoing funding to continue to support safety net providers.[99] The SNCP policy aims to increase access to care to serve vulnerable populations (particularly Medicaid-covered or uninsured populations) with quality healthcare within the Commonwealth by funding participating safety net providers.

[95] Text imported with modifications from page 2: Centers for Medicare & Medicaid Services. (2022, September 28). *CMS Guidance, Approval Letter, Waiver Authority, Expenditure Authority, Special Terms and Conditions.* Mass.gov. https://www.mass.gov/doc/masshealth-extension-approval/download

[96] See STC 11.1, page 77-78; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[97] See 2017-2022 Demonstration STC 63-64 (as included in final STC amendments approved August 11, 2022). ; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[98] See STC 11.1.(a) – 11.1.(e), page 78; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[99] See STC 2 on page 3; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

5.1.2. SNCP Policy Components and Desired Outcomes

The desired primary outcomes of the SNCP are to ensure the sustainability of various safety net providers and to maintain or increase members' ability to access accountable care. Better access to care may be evidenced by increased use of preventative, primary, and necessary specialist care. Ultimately, the SNCP will contribute to maintaining the Commonwealth's overall health status and improving health equity while reducing per-member-per-month (PMPM) costs and supporting the Medicaid program's financial sustainability.

Payment Policy Initiatives

As the SNCP policy continues through the 2022-2027 Demonstration, the SNCP funding and data sources have been adapted to better fit the needs of the Commonwealth. The SNCP policy initiatives for the 2022-2027 Demonstration include updated payment initiatives to align with the current policy goals. The DSH-like Pool will offset Medicaid underpayment and uncompensated care. This includes SNPP tied to Accountable Care Organization (ACO) quality and Total Cost of Care (TCOC) accountability. During this period, 20 percent of Safety Net Hospitals' (SNH) SNPP payments will be risk-based. From October 2022 to December 2027, the 23 SNHs[100] listed below will be eligible for SNPPs. There will also be a continuation of access to the Uncompensated Care (UC) Pool from the previous Demonstration.

SNHs

1. Baystate Franklin Medical Center
2. Baystate Medical Center
3. Baystate Noble Hospital
4. Baystate Wing Hospital
5. Berkshire Medical Center
6. Boston Medical Center
7. Heywood Hospital
8. Holyoke Medical Center
9. Lawrence General Hospital
10. Lowell General Hospital
11. Martha's Vineyard Hospital
12. Mercy Medical Center
13. MetroWest Medical Center
14. North Shore Medical Center
15. Signature Healthcare Brockton Hospital
16. Shriners Hospitals for Children – Boston
17. Shriners Hospitals for Children – Springfield
18. Southcoast Hospitals Group
19. Steward Carney Hospital Inc.
20. Steward Good Samaritan Medical Center
21. Steward Holy Family Hospital Inc.
22. Steward Morton Hospital
23. Tufts Medical Center

[100] This number was increased from 14 in the 2017-2022 Demonstration. Pay eligibility will be extended to 9 additional hospitals as Safety Net Provider funding increases by $125M annually.

DSH-like Pool

The expenditures from the DSH-like Pool support acute hospitals and health systems, non-acute hospitals, and other providers that support uncompensated care for Medicaid FFS, low-income uninsured individuals, and expenditures for individuals who are inpatient in an Institution for Mental Disease (IMD).[101] Specifically, the DSH-like Pool may include expenses for Public Service Hospital Safety Net Care payments; Health Safety Net Trust Fund payments to hospitals and community health centers (CHC)s; payments to IMDs, DPH hospitals, and DMH hospitals for uncompensated care; SNPPs to qualifying hospitals; and close-out SNPP expenditures.[102] SNPPs support hospitals serving many Medicaid and uninsured individuals; such payments are specifically intended to support the operational needs of these organizations.[103]

Uncompensated Care Pool

If the DSH-like funding is exhausted, participating SNHs and safety net providers will have access to the UC Pool to cover charity care costs, which can be utilized for specific low-income and uninsured members. This also includes the DPH and DMH hospital expenditures for uninsured members. Ultimately, the UC Pool payments are available to cover the cost of care provided free of charge to qualifying individuals who adhere to the provider's charity care policy.[104]

5.1.3. SNCP Policy Domain Implementation Plans and Timeline

The 2022-2027 Demonstration and its inclusion of the long-standing SNCP policy aim to support the Commonwealth's safety net sustainably. The hospital assessment covers programs linked to SNCP as well as other programs that are not listed in this domain; the Demonstration has been updated to support the outlined programs and initiatives related explicitly to SNCP from October 2022 to December 2027. This period overlaps with closeout payments for some SNCP expenditure authorities from the prior Demonstration: (1) the DSRIP payments will end on March 31, 2023, with close-out payments for SNPP tied to DSRIP accountability to end on December 31, 2024; and (2) the PHTII for Cambridge Health Alliance (CHA) will close out payment by December 31, 2023.

[101] See STC 11.2.(a), page 78; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[102] See STC 11.2.(a), page 79; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

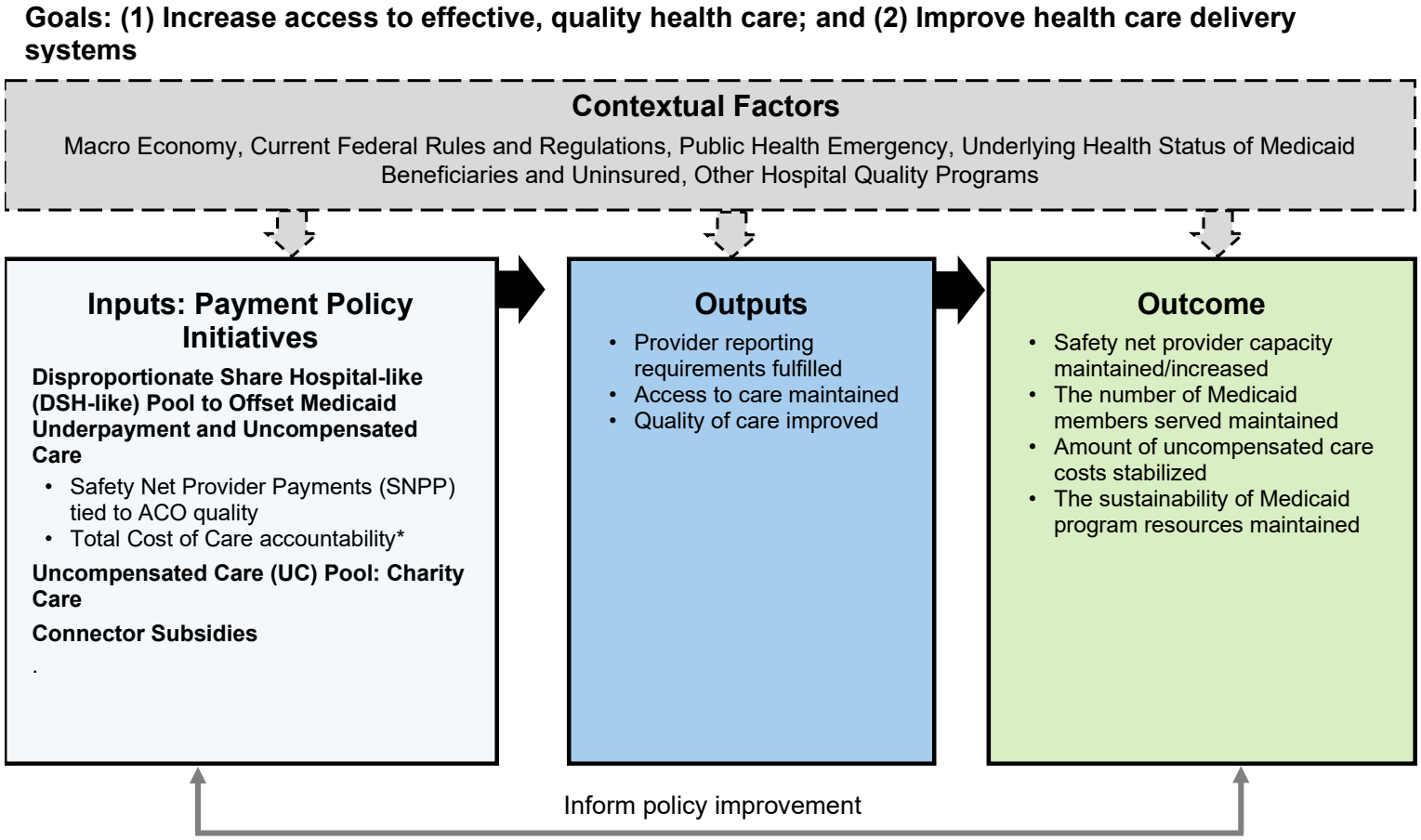
[103] See STC 11.2.(b), page 79; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[104] See STC 11.3, page 80; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

5.2. Logic Model

The logic model in Figure 5-1 links the SNCP Demonstration Goals to the Demonstration Inputs, Implementation Activities (e.g., funding pool), Outputs, and Outcomes (e.g., member access, quality of care, amount of uncompensated care use, and financial sustainability). This logic guides the RQs and hypotheses that follow.

Figure 5-1: Logic Model for the SNCP Component of the Demonstration



*The SNPP will continue for the 23 safety net hospitals from April 2023 to December 2027.

5.3. Research Questions and Hypotheses

Table 5-1 summarizes the SNCP evaluation RQs and associated hypotheses. It also includes the study populations, data sources, measures, and analytic methods, which are detailed in the following sections. As guided by the logic model, the research questions focus on how safety net providers' capacity is maintained and increased to allow access by Medicaid populations. Because some SNCP payment is tied to ACO quality measure and cost, the evaluation will identify if the SNCP payment supports better quality of care and member experiences at SNHs.

Table 5-1: Research Questions and Hypotheses for SNCP

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ4-1 What is the impact of safety net funding investments on SNHs' quality of services?	H4-1.1 The SNCP payment will result in improved care quality at SNHs.	Medicaid administrative data (2018-2027)	SNHs	ACO quality measures	Descriptive analysis; Observed-to-expected ratio (O-E ratio); Quasi-Experimental Design (QED)
RQ4-2 What were the overall experiences of members in receiving services from SNHs?	H4-2.1 Medicaid members will report better care experiences.	Member survey (if feasible, 2025, 2027); Member interviews (2024-2025; 2026-2027)	Medicaid members receiving care from SNHs (for interviews, n=~30; for surveys – if feasible, n=~1,200)	Topical areas: Overall and equitable access to services, Quality of care, Overall satisfaction	Descriptive analysis; QED; Thematic analysis
RQ4-3 How effective were supplemental payments authorized through the Demonstration in supporting safety net providers?	H4-3.1 The SNCP funding continued to maintain or improve safety net providers' capabilities to serve vulnerable individuals. H4-3.2 Supplemental payments to SNHs through the DSH	Provider interviews (2024, 2026); Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)* (2018-2027)	SNHs and other safety net providers (n ≤ 15)	Qualitative information about provider experiences (e.g., quality of care reporting requirements, quality improvement, adequacy of providers, UC); UC costs before and during the Demonstration	Thematic analysis; Program cost analysis

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	pool reduced the total amount of UC.				

*If MassHealth does not need to use UC pool funding, the analysis using UCCR will not be conducted.
a. Research questions developed in response to STCs sections 11.1-11.6; 1115 MassHealth Demonstration ("Waiver") | Mass.gov
b. Data Sources are described in section 5.4.2, “Data Sources and Collection Methods,” and section 1.4.1, “Summary of Data Sources.”
c. Analysis methods are described in section 5.4.4, “Analysis Methods.”

5.4. Data and Methods

5.4.1. Study Populations

The study population will be at two levels.

- Organization Level: The study population includes all SNHs and other safety net providers receiving SNCP funding. The focus will be on SNHs.
- Member Level: The population is MassHealth members who receive healthcare from SNHs during the Demonstration. Note that this evaluation focuses on the Medicaid population even if SNHs also treat uninsured members. Member-level analyses will be tied to the SNHs that are accountable for ACO quality of care and cost expectations.

No comparison group will be used since all Massachusetts SNHs and safety net providers are included in the Demonstration and will be evaluated.

5.4.2. Data Sources and Collection Methods

The evaluation design for SNCP will use mixed methods to understand how vulnerable populations' access to care and safety net providers' quality of healthcare change over time. The evaluation will also explore the impact of the SNCP in supporting the financial sustainability of the SNHs.

Data Sources

Five data sources will be used for the SNCP evaluation:

Medicaid Administrative Data

As discussed in earlier chapters, Medicaid administrative data (e.g., enrollment, encounter) will be used to evaluate the quality of care.

Member Interviews

The current ACO member survey does not explicitly target members receiving care from SNHs and other safety net providers. About 30 randomly selected MassHealth members from SNHs and other safety net providers will be interviewed to understand their experiences with providers, focusing on service access and quality of care. More or fewer members will be interviewed, depending on the data saturation when no new themes are identified by the data.

Member Experience Survey (If feasible)

Member survey data provides more population-based member experiences. The evaluation may utilize MassHealth member-level data from the existing ACO survey, based on the Clinician Group Consumer Assessment of Health Plan and Provider Systems (CG-CAHPS), administered through MassHealth. MassHealth also obtains hospital survey data (H-CAHPS) through CMS (an acute hospital requirement), which includes SNHs. The data, however, are all-payer, aggregated, and de-identified. It is

currently not possible to identify and obtain MassHealth member-level results. We are exploring options to obtain data or to survey MassHealth members in the hospital setting. At this stage, interview data will be the primary source for member experiences.

Safety Net Provider Organization Interviews

The evaluation will conduct interviews with the 23 SNHs and other safety net providers, involving key administrators (e.g., financial officers), staff, and others about their hospitals' services for Medicaid members and uninsured individuals. It will explore organizational experiences with fulfilling CMS and MassHealth reporting requirements, meeting quality standards (if applicable), serving vulnerable populations, and maintaining financial sustainability.

Uniform Medicaid and Uncompensated Care Cost and Charge Reports (UCCR)[105]

MassHealth requires hospitals to submit cost, charge, and member day data via UCCR. This data is used to ensure compliance with the Uncompensated Care Cost Limit Protocol approved by CMS on December 11, 2013. In addition, MassHealth uses the data to calculate the preliminary payment amounts for certain supplemental payments. These reports contain cost data from Medicare cost reports, in addition to data provided by MassHealth, on supplemental payments to SNHs.

5.4.3. Measures

Quantitative measures will be used to assess the quality of care among SNHs for Medicaid members. Qualitative measures will capture the perceptions of access and quality of care among Medicaid members receiving services from safety net providers, including SNHs. Qualitative measures will also be used to examine SNHs' organizational domains, such as fulfilling reporting requirements, adequacy of clinicians, and UC.

5.4.4. Analysis Methods

Quasi-Experimental Design (QED) will be used to analyze quantitative data for this evaluation. When Medicaid administrative data are used, the analysis will use the Observed-to-Expected ratio (O-E ratio) as described in Chapter 3 (Delivery System Reform). The O-E ratio can help determine whether there is a change in quality related to policy changes. Interrupted time series (ITS) analysis without a comparison group will also be conducted. Subgroup analyses will be conducted for adult and child members, respectively. The analyses will draw on covariates at member, organization/provider, and regional levels. The examples of covariates are member demographic and clinical characteristics (e.g., age, sex, disability status, rating categories, federal poverty level), provider characteristics (e.g., teaching status, ownership, size of beds), regional characteristics (e.g., region, healthcare resources), and indicators of time. The IE will explore the use of imputation method or sensitivity analysis related to race/ethnicity data and include demographic characteristics in our analysis, as appropriate.

[105] Again, if MassHealth does not use UC, the UCCR report data will not be analyzed.

The thematic analyses of the qualitative data will supplement these findings. The methods for the thematic analyses are described in Chapter 3 (Delivery System Reform) Section 3.4.2 Data Sources and Collection Methods. If feasible, member survey data from the existing ACO survey may be analyzed for members who have received care from SNHs. Descriptive statistics analysis will be conducted to profile member experiences.

Using an embedded mixed methods approach, we will synthesize the quantitative and qualitative data. We will solicit an in-depth nuanced understanding of members' and providers' experiences, examine how those experiences may be related to SNCP, and use these findings to explain pertinent trends and outcomes. For example, we expect better health outcomes identified through quantitative analysis will be associated with better access to care as a result of the SNCP payment. Conversely, preliminary quantitative findings from the analysis of data from early in the Demonstration period can generate questions regarding underlying mechanisms that can then be explored in subsequent qualitative data collection and analysis.

5.4.5. Limitations

The most significant limitation of the evaluation is that the pre-demonstration period (the baseline performance) is still within the Public Health Emergency (PHE). Access and quality of care performance of SNHs may have been impacted during the PHE, resulting from financial, workforce, and technology issues. This may lead to less optimal performance compared to normal circumstances, which sets up a skewed baseline performance and may bias the SNCP policy impact. Similar to other domains, pre-PHE analysis periods will be included to establish the baseline performance. A second limitation is that the current design does not fully account for competing and reinforcing initiatives (e.g., BH Roadmap Initiatives, Hospital Quality and Equity Initiatives (HQEI)) that may impact provider performance during the evaluation period. The results of the evaluation will need to be explained in the context of other initiatives administered by the Commonwealth. Qualitative information from members and providers is expected to reveal more details of the payment impact.

6. Workforce Initiatives

6.1. Overview of Workforce Initiatives (WI) Policy Domain[106]

Similar to national trends, Massachusetts is experiencing a shortage of primary care providers (PCPs) that, without intervention, will continue to grow.[107] Additionally, more than half (56.8 percent) of adults who sought treatment for behavioral health (BH) reported challenges in finding a BH provider.[108] Through the 2022-2027 Demonstration, the Commonwealth is committed to making significant investments to extend and improve primary care and BH services and access to care.[109] In addition to the transition of primary care payment in the Accountable Care Organization (ACO) program to a new sub-capitation payment model and the Commonwealth's implementation of the BH Roadmap, the Commonwealth is investing in three Workforce Initiatives (WI) programs authorized by the Demonstration to address shortages of qualified providers serving MassHealth members. The WIs are categorized into student loan repayment programs and the family nurse practitioner (FNP) residency grant program.

Primary Care Student Loan Repayment Program

This program will offer the following:

1. Up to $100,000 for PCPs who commit to a four-year full-time service obligation in a community-based setting, serving at least 40 percent MassHealth and/or uninsured members.
2. Up to $50,000 for advanced practice registered nurses, pediatric clinical nurse specialists, nurse practitioners (NP), and physician assistants (PA), per practitioner, who commit to a four-year full-time service obligation in a community-based setting serving at least 40 percent MassHealth and/or uninsured members.

Behavioral Health (BH) Student Loan Repayment Program

This program will offer the following:

1. For psychiatrists and NPs with prescribing privileges, up to $300,000 per practitioner who makes a four-year full-time commitment to maintaining a personal practice panel or working at an organization with a panel that includes at least 40 percent MassHealth and/or uninsured members.

[106] Part of Section 6.1 is verbatim from the STC and extension request; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[107] Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. (2013, September). *State-level projections of primary care workforce, 2010-2030.* Graham-Center.org. https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Massachusetts.pdf

[108] Blue Cross Blue Shield Foundation of Massachusetts. (2018). *Access to Care or Mental Health and Substance Use Disorders is a Challenge for Many in Massachusetts.* MHRS_2018_MH SUD Summary_final.pdf (bluecrossmafoundation.org)

[109] Commonwealth of Massachusetts. (2021, December 27). *MA 1115 Extension Request Updated, page 7*. Mass.gov. https://www.mass.gov/doc/1115-waiver-extension-request/download.

2. Up to $50,000 per practitioner for licensed BH 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 BH practitioner licensure within one year of the award and who make a four-year commitment to practice full-time in a community-based setting serving at least 40 percent of MassHealth and/or uninsured members.

Family Nurse Practitioner Residency Grant Program

The Commonwealth will provide up to $105,000 per residency slot to allow Community Health Centers (CHCs), whose patient populations are made up of at least 40 percent MassHealth members, to support up to 10 FNP residency slots annually for four years.

Table 6-1: Workforce Funding by Initiative (In Millions)

Initiative	Demonstration Year (DY) 28 / Performance Year (PY) 1	DY 29 / PY 2	DY 30 / PY 3	DY 31 / PY 4	DY32 / PY 5	Total
BH 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
FNP Residency Grant	$1.21M	$1.21M	$1.21M	$1.21M	$0M	$4.84M
Total	$6.01M	$10.81M	$10.81M	$10.81M	$4.80M	$43.24M

Source: STC Table 12 page 102. https://www.mass.gov/doc/stcs-masshealth-1115-waiver-extension-1/download, https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver.
*Note: If the investment amount changes in the future, this table will be updated accordingly.

The WI programs were informed by lessons learned from the 2017-2022 Demonstration, where the Commonwealth was able to leverage the availability of $115 million of the $1.8 billion in expenditure authority for the Massachusetts Delivery System Reform Incentive Payment (DSRIP) program to fund eight Statewide Investments (SWI) intended to build and strengthen healthcare infrastructure and workforce capacity across Massachusetts to support the success of ACOs, and Community Partners (CPs). The SWIs from the Demonstration fell into three categories and included:

1. Building and Training the Primary Care and BH Workforce: This set of investments supported the recruitment, retention, and training of PCPs, BH providers, and the frontline healthcare workforce in community-based settings.
2. Capacity Building for ACOs, CPs, and Providers: This set of investments provided direct technical assistance and shared learning opportunities for ACOs and CPs, as well as support for providers who were not yet participating in alternative payment methods (APM) to prepare for APM adoption in the future.
3. Initiatives to Address Statewide Gaps in Care Delivery: This set of investments improved the care provided to members with specific BH and accessibility needs through technology solutions and grant funding opportunities.

Under the 2017-2022 Demonstration, DSRIP-funded student loan repayment programs awarded PCPs and BH providers in these community-based primary care and BH settings with student loan repayments of up to $30,000 or $50,000, depending on the provider type, in exchange for a four-year service commitment. The SWIs promoted new opportunities for primary care and BH providers to practice within communities, stimulated novel initiatives to coordinate and integrate care across settings, and pioneered provider strategies to manage performance and population health. These investments addressed gaps in the statewide delivery system and strengthened its capacity to deliver integrated, high-quality care for all members.[110]

Student loan repayment is a promising tool in addressing healthcare workforce challenges, which are particularly acute for diverse and culturally competent clinicians.[111] DSRIP-funded student loan repayment programs have shown efficacy in achieving retention in high-Medicaid community-based settings. Preliminary results show that 94 percent of primary care and BH providers who received these awards in 2018 and 2019, and 98 percent of masters-prepared BH providers who received those awards in 2018, remained employed in community-based settings.[112] In addition, DSRIP funding supported a grant program for CHCs to create or expand FNP residency programs. CHCs that implement FNP residency programs can better recruit and retain FNPs who complete the residencies.[113] Over the first three cycles of funding, nine different CHCs utilized the DSRIP funding to support 30 FNP residency slots, and 91 percent of FNP residents who completed their residencies accepted full-time positions in CHCs.[114]

6.1.1. WI Policy Domain Goals

WI programs aim to support workforce recruitment and retention and promote the increased availability of certain healthcare practitioners to address shortages of qualified providers (both primary care and BH workforce) serving Medicaid beneficiaries. The mounting shortage of PCPs is evident, as mentioned in a report to the Association of American Medical Colleges, where nationally, a shortage of between 17,900 and 48,000 PCPs was projected for 2034.[115] Additionally, as is the case across the country, the Commonwealth is experiencing a dire shortage of BH clinicians, including prescribers, who accept public or private insurance. The need is especially

[110] Commonwealth of Massachusetts. (2021, December 27). *MA 1115 Extension Request Updated.* Mass.gov. https://www.mass.gov/doc/1115-waiver-extension-request/download.

[111] Garcia, A. N., Kuo, T., Arangua, L., & Pérez-Stable, E. J. (2018). Factors associated with medical school graduates' intention to work with underserved populations: policy implications for advancing workforce diversity. *Academic medicine: journal of the Association of American Medical Colleges, 93*(1), 82. Retrieved from: Factors Associated With Medical School Graduates' Intention to Work With Underserved Populations: Policy Implications for Advancing Workforce Diversity - PMC (nih.gov)

[112] Commonwealth of Massachusetts. (2021, December 27). *MA 1115 Extension Request Updated, page 38 Internal MassHealth data.* Mass.gov. https://www.mass.gov/doc/1115-waiver-extension-request/download.

[113] Flinter, M. M., & Bamrick, K. (2017). *Training the next generation: Residency and fellowship programs for nurse practitioners in community health centers.* Community Health Center, Incorporated, and the Weitzman Institute. https://www.weitzmaninstitute.org/sites/default/files/NPResidencyBook/NPResidencyBook.pdf

[114] Commonwealth of Massachusetts. (2021, December 27). *Internal MassHealth Data, MA 1115 Extension Request*, *page 38*. Mass.gov. https://www.mass.gov/doc/1115-waiver-extension-request/download

[115] Markit, I. H. S. (2017). *The complexities of physician supply and demand: Projections from 2015 to 2030.* Association of American Medical Colleges. Retrieved Feb 20, 2023, from The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)

great in the Medicaid space. A robust and diverse workforce is essential for the success of the Commonwealth's BH Roadmap,[116] as addressing BH needs requires skilled, compassionate providers and staff who can provide culturally responsive, evidence-based treatment.

Three programs under the 2022-2027 Demonstration continue from the eight SWI programs under the 2017-2022 Demonstration with either similar or higher financial incentives. Through the WI programs, the Commonwealth will support workforce recruitment and retention and promote the increased availability of certain healthcare practitioners to serve Medicaid members.

6.1.2. WI Policy Components and Desired Outcomes

The 2022-2027 WI consists of three programs described above. The desired outcomes are to increase the primary care and BH workforce, particularly those in community-based clinical settings. Efforts to increase investment in primary care and incentivize enhanced care delivery expectations (e.g., BH integration) while offering providers greater flexibility through the ACO primary care sub-capitation program (see Chapter 3 (Delivery System Reform)) are also expected to advance the desired outcomes of the WI Policy Domain. Ultimately, it is hoped that members' access to care and their outcomes will improve, and utilization of unplanned institutionalized care will drop. In addition, a goal of these initiatives is to further diversify the workforce by prioritizing applicants with cultural and linguistic competence to better reflect and serve the needs of the MassHealth population.

6.1.3. WI Policy Domain Implementation Plans and Timeline

The three programs will continue from the last Demonstration with the same or increased financial incentives. The Commonwealth anticipates launching the FNP residency grant program in CY2023 and the student loan repayment programs in CY2024.

6.2. Logic Model

The WI logic model in Figure ***6-1*** links the Demonstration Goals to inputs, implementation activities, outputs, and outcome(s)/impact. The WI programs are designed to increase the number of primary care and BH providers and improve workforce diversity, which may improve clinician recruitment and reduce provider burdens and turnover. Subsequently, Medicaid members will have a better experience of care (e.g., more choices of providers and more timely access to services). Given existing evidence,[117,118] better access will lead to more preventive care and less inpatient or ED use.

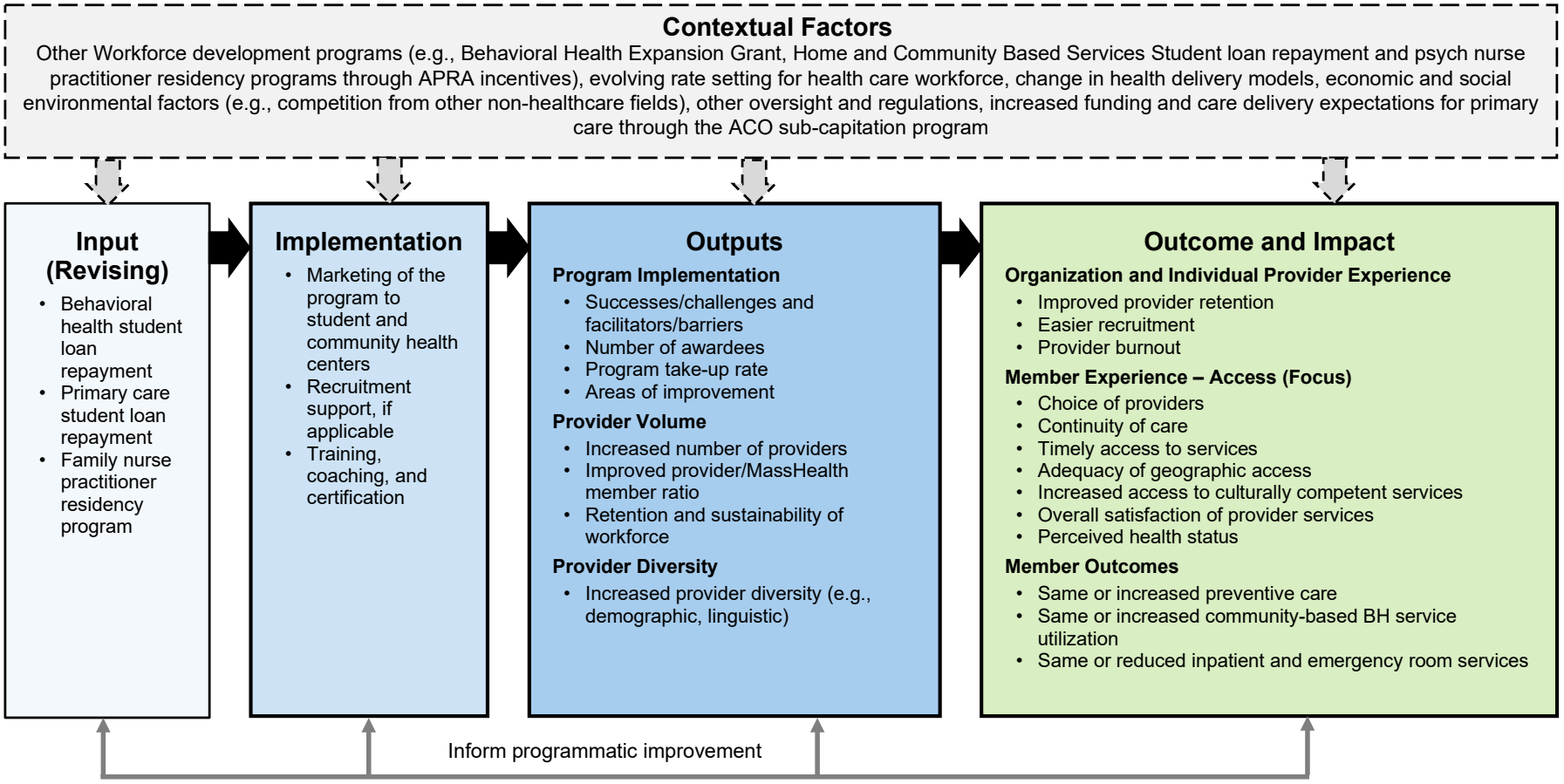
[116] Commonwealth of Massachusetts. (2021). Roadmap for Behavioral Health Reform. Mass.gov. https://www.mass.gov/service-details/roadmap-for-behavioralhealth-reform

[117] Yalamanchi, P., & Blythe, M. et al. (2022). The Evolving Role of Advanced Practice Providers in Otolaryngology: Improving Patient Access and Patient Satisfaction. *Otolaryngology-Head and Neck Surgery.* 166(10), 6-9

[118] Chen, M. & Kiechle, J. et al (2019). Use of Advanced Practice Providers to Improve Patient Access in Urology. *Urology Practice. 6*(3), 151-14

Figure* 6-1*: Logic Model for the WI Component of the Demonstration

Goals: (1) Expand primary care, behavioral health, and family nurse practitioner workforce; and (2) increase access to providers among MassHealth members and the uninsured population



6.3. Research Questions and Hypotheses

Table 6-2 summarizes the WI evaluation RQs and associated hypotheses, study populations, data sources, measures, and analytic methods. Further details on the data sources, measures, and proposed analytic methods are provided in the following sections. The RQs are related to implementation effectiveness, provider experiences, member access and outcomes, and financial sustainability.

Table 6-2: Research Questions and Hypotheses for WI

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ5-1 What actions were taken to implement the three WIs, and what lessons were learned from the implementation ?	H5-1.1 The Commonwealth worked with vendors to implement the program as intended (e.g., market the programs, release clear roles and expectations, develop policies and procedures, make payments promptly, provide operational oversight, and process applications). H5-1.2 Several lessons were learned from implementing these WI programs.	Program documents (ongoing); Qualitative interviews with providers (2024-2025; 2026-2027); WI program administrator interviews and/or open-ended surveys (2024-2025; 2026-2027)	Applicants (both awarded and non-awarded eligible) for WI programs (n ≤ 30); MassHealth WI staff and WI vendors (n=5); Community-based clinical setting administrators (n ≤ 30); Individual PC providers, BH providers, and FNPs (n ≤ 30 combined across different provider types) (Please note that awarded applicants may be individual providers during interviews, so the total number of interviewees is not a direct addition to the number of interviewees for each type of interviewees.)	**H5-1.1** Number of applicants by WI program; Number of accepted applicants; Number (and percentage) of applicants who were accepted and signed a contract; Number (and percentage) of applicants who were accepted and received either a partial or full payment to their loan servicer as outlined in the contract; Number (and percentage) of applicants accepted in the program and completed the 4-year service obligation; Information on whether MassHealth released policy and procedures, made payments, provided operational oversight, and processed applications on time and as planned	Descriptive statistics (provider, administrators, staff); Thematic analysis (applicants, provider, MassHealth program staff, or vendor representative)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				H5-1.2 Information to document the impact of these initiatives on employer organizations' experience and the impact of these initiatives on recruitment, retention, or attrition; Barriers and facilitators/Lessons learned about implementation (e.g., recruitment, education/training catering to serve Medicaid and uninsured population in community clinical settings, transparency of payment such as loan repayment, adequacy of incentives, adequacy of FNP resident grant program slots, the influence of other student loan payments)	
RQ5-2 Did the WI programs increase the volume and diversity of the provider workforce in community-based settings?	H5-2.1 Implementing the WI programs improved providers' willingness to practice in community-based settings. H5-2.2 Offering BH student loan repayment increased the volume and diversity of psychiatrists and NPs with prescribing privileges and licensed BH clinicians or masters-prepared clinicians	Program documents (ongoing); WI program administrator and vendor interviews and/or open-ended surveys (2024-2025; 2026-2027); Provider (Workforce) survey (2025 and 2027); Administrator and provider interviews (2024-2025; 2026-2027)	Applicants (both awarded and non-awarded eligible) for WI programs (n ≤ 30); MassHealth WI staff and WI vendors (n ≤ 5); Community-based clinical setting administrators (n ≤ 30); Individual PC providers, BH providers, and FNPs (n ≤ 30 combined across different provider types); Providers targeted by the WI programs and providers that would	**H5-2.1** Number (and percentage) of accepted applicants who dropped out before completing the four-year commitment (Supplemented by qualitative information on why); Number (and percentage) of accepted applicants who changed organizations during their service commitment period (Supplemented by qualitative information on why);	Descriptive analyses (Provider); Thematic analysis (Individual provider (applicants/staff); Conjoint analysis (Incentive level); Market simulation to explore the best approach to engage more providers to meet the WI objectives (providers)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	practicing in community-based clinical settings. H5-2.3 Offering primary care student loan repayment increased the volume and diversity of PCPs, advanced practice registered nurses, pediatric clinical nurse specialists, NPs, and PAs practicing in a community-based clinical setting. H5-2.4 Offering an FNP residency grant program increased the volume of FNPs in CHCs serving at least 40 percent MassHealth members. H5-2.5 The WI programs improved providers' willingness to practice in community-based settings, as compared to direct intervention, such as direct rate increase.		be eligible for WI program (e.g., medical students) in the future (n ≤ 1,500)	Percentage of accepted applicants who stayed employed at their organization (at one year, two years, three years, and four years, and post-completion of the service obligation, subject to data availability and quality) – Supplemented by qualitative information on why; Qualitative information from students regarding how loan forgiveness could affect their decision to practice in community-based clinical settings; **H5-2.2** Number of psychiatrists and NPs with prescribing privileges in community-based settings serving at least 40 percent of Medicaid members or uninsured individuals, supported by the WI programs by provider demographics, language, region, degree); Number of BH practitioners licensed in a community-based setting serving at least 40 percent of MassHealth and/or uninsured members, supported by the WI programs (and by demographics, language, region, degree, year); The ratio of BH providers (i.e., psychiatrists and NPs with	

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				prescribing privileges, licensed BH clinicians, and master-level clinicians) in community-based settings to MassHealth members with BH needs (and by demographics, language, race/ethnicity, region, provider type, and incentive type by year); **H5-2.3** Number of PCPs, advanced practice registered nurses, pediatric clinical nurse specialists, NPs, and PAs in a community-based setting serving at least 40 percent MassHealth and/or uninsured members, supported by the WI programs (and by demographics, language, region, year); The ratio of PCPs (e.g., PCPs, advanced practice registered nurses, etc.) in community-based clinical settings to MassHealth members (and by demographics, language, region, degree, provider type, and incentive type) by year; **H5-2.4** Number of FNPs in CHCs with at least 40 percent of member populations being MassHealth members, supported by the WI programs (and by demographics, linguistic, region) by year;	

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				The ratio of FNPs in CHCs to MassHealth members (and by demographics, language, region, incentive type) by year; **H5-2.5** Topical areas about interviews with providers; The relative importance/preference of potential incentives to improve providers' participation and engagement in community-based clinical settings; Overall utilities of each scenario; Provider experiences	
RQ5-3 Did WI programs improve MassHealth members' access to and experiences with healthcare?	H5-3.1 WI programs improved MassHealth members' access to covered services.	Member Interviews/focus groups (2024-2025; 2026-2027) MassHealth administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027);	MassHealth members receiving primary care and BH from community-based clinical settings with providers awarded by the WI programs (n ≤ 30); Providers of community-based clinical settings	Access to healthcare providers; Timely access to services (e.g., average wait time for an appointment); Adequacy of geographic access; Increased access to culturally competent service; Adequate length of office visits; Continuity of care; Perceived health status; Members' overall satisfaction with PC, BH, or FNP services; Providers' average number of members per year	Descriptive analyses (member and provider); Thematic analysis (member and provider)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ5-4 Did the WI programs improve provider experiences?	H5-4.1 The WI programs eased the recruitment of providers and improved provider experience and retention in community-based clinical settings.	Program documents (ongoing); WI program administrator interview (2024-2025; 2026-2027) Provider interview (2024-2025; 2026-2027) Provider exit interviews by practice (if feasible) (ongoing)	Community-based clinical setting administrators (n ≤ 30); Individual PC providers, BH providers, and FNPs (n ≤ 30 combined across the three provider types)	Ease of recruiting providers (e.g., time to fill vacancies, quality of applicant pool); Number (and percent) of providers in the WI programs who completed the 4-year service obligation (and by provider type and by program); The average number of years providers serve in community-based clinical settings (by provider type and by program); Qualitative information about provider burnout	Descriptive analyses (administrator/ provider); Thematic analysis (administrator/ provider)
RQ5-5 Did the WI programs affect MassHealth member healthcare utilization?	H5-5.1 The WI programs increased preventive care and community-based outpatient services (including BH services) for MassHealth members served in settings where providers were enrolled in WI programs compared to settings where providers were not enrolled in WI programs. H5-5.2 The WI programs reduced MassHealth members' ED visits and hospitalizations for primary care-sensitive services in settings	Medicaid administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027)	MassHealth members receiving PC, BH, or FNP services from community-based clinical settings in and outside the WI programs (population estimated as N=~400,000)	**H5-5.1** Use of community-based BH care; Adult access to preventive/ambulatory health services **H5-5.2** For MassHealth members receiving PC, BH care, or FNP care: • Rate of inpatient admissions for PC-sensitive services • Rate of all-cause inpatient admission • Rate of ED visits	Quasi-experimental design (QED) (member); Propensity score methods (member); Interrupted time series (ITS) (member); Subgroup analyses (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Period)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	where providers were enrolled in WI programs compared to settings where providers were not enrolled in WI programs.			• Rate of inpatient psych services use	
RQ5-6 Did the WI programs impact the financial sustainability of Medicaid?	H5-6.1 The cost of the WI programs and increased outpatient care costs were offset by decreased inpatient and ED costs for members attributed to community-based settings with providers participating in WI programs. H5-6.2 WI programs reduced the per member per month (PMPM healthcare cost of MassHealth members receiving care at community-based clinical services benefiting from WI programs.	Medicaid administrative data (baseline 2015-2017, pre-2018-2022, post-2023-2027); Program documents (e.g., Program financial report) (ongoing)	MassHealth members receiving PC, BH, or FNP services from community-based clinical settings with providers in the WI programs (population estimated as N=~400,000)	**H5-6.1** Total WI programs cost; Cost of outpatient services; Cost of inpatient and ED services; **H5-6.2** Average PMPM cost for MassHealth members receiving PC, BH care, or FNP care in clinical settings.	Quasi-experimental design (QED) (member); Propensity score methods (member); Interrupted time series (member)

a. Research questions developed in response to STCs sections 13.1-13.8; 1115 MassHealth Demonstration ("Waiver") | Mass.gov
b. Data Sources are described in section 6.4.2, “Data Sources and CollectionMethods,” and section 1.4.1, “Summary of Data Sources.”
c. Analysis methods are described in section 6.4.4, “Analysis Methods.”

6.4. Data and Methods

6.4.1. Study Populations (Including Potential Comparison Groups)

Study population:

The study population for the WI program will include individual providers, practice sites, or individual MassHealth members, depending on the RQ:

1. Providers who were eligible to apply for the three WI programs;
2. Prospective providers potentially eligible for the WI program (e.g., graduating medical students);
3. Community-based practice sites with providers in the WI programs, providing primary care and BH services to MassHealth members; and
4. MassHealth members who received primary care and BH services from community-based practice sites.

Comparison Group:

We encourage MassHealth to randomly select providers among applicants in the WI programs under the 2022-2027 Demonstration; this would allow us to include a random sample of providers and MassHealth members as a comparison group in the evaluation. If that is not possible, the evaluation team will use propensity scores to generate similar comparison groups (described further in Section 6.4.2) of:

1. Eligible providers (practice sites and individual providers) who applied for but were not accepted by these programs or were enrolled but left the program before completion. If such comparison groups are unavailable for a given WI, we will identify comparison group members from other community-based practices and providers eligible for participation in the program.
2. MassHealth members who received primary care and BH services from community-based practice settings.

The IE will use mixed methods to: (1) understand how the WI programs were implemented through qualitative interviews, (2) capture facilitators and barriers to the successful implementation of these programs through qualitative interviews, (3) identify factors that influenced, or would influence, the targeted providers' decision to serve MassHealth members, as stated by the goal of the programs through collection and analyses of survey data, program reports, and qualitative interviews, and (4) determine how the WI programs improved MassHealth members' outcomes and affected MassHealth costs through Medicaid administrative data analyses. The measures, data sources, and analytic approaches that will be used to address each evaluation hypothesis are presented in Table 6-2.

6.4.2. Data Sources and Collection Methods

The key data sources for the WI evaluations are provider (and prospective provider) surveys, provider and stakeholder interviews, member interviews, Medicaid administrative data (enrollment, eligibility, claims, encounters), and program reports (as indicated in Table 6-2).

Qualitative Data

The qualitative data will include the following:

Programs Documents

The documents include Request for Proposals (RFPs), program monitoring, and enrollment reports. Literature will also be reviewed to gather evidence of the effectiveness of similar programs. These data will inform the development of interview guides for program administrators, providers, and members. The collection and review of these documents will be throughout the evaluation period.

WI Program Administrator and Vendor Interviews

These interviews will be conducted with MassHealth staff and MassHealth vendors and will explore the process used in identifying and recruiting providers and the challenges faced, if any, during the program's implementation. The interviews will be conducted in State Fiscal Year (SFY) 24, SFY25, and SFY27. We anticipate using an open-ended questionnaire distributed to MassHealth staff and MassHealth vendors for efficiency when each modality is expected to yield similar information based on the type of respondent and the information being collected.

Provider Interviews

These interviews will include a convenient but diversified sample of practice sites and individual clinicians who applied for the program. Both awardees and non-awardees' perspectives will be explored. The goals are to explore how they learned about the programs, their motivation, and their plans for and experiences complying with the programs' requirements. The interviews will be conducted in SFY24, SFY25, and SFY27.

Providers' Exit Interviews (If Feasible)

These interviews will include a sample of providers who left their work at CHCs for other opportunities. The interviews will inform MassHealth -about reasons for leaving the job, the overall workplace culture, and any processes and systems that contributed to the decision to leave. These interview data will be subject to whether practices can share the exit interview data with the IE. Even if so, this is supplemental data to provider interviews and surveys.

Member Interviews/Focus Groups

These interviews will be with Medicaid members who receive services from CHCs or any other community-based outpatient settings who receive funding or have clinicians who receive funding from the three WI programs. Members' observed changes in

access and experience with receiving primary and BH care will be explored. Up to 50 primary and BH care members will be contacted; the final number of interviews is subject to data saturation. Two waves of interviews will be conducted in SFY25 and SFY27, respectively.[119] A diversified convenience sample of members in terms of age, gender, race, and region will be selected. Focus groups will be arranged if members' schedules match. The interviewing schedule will be coordinated with other policy domains' data collection efforts. To identify and recruit members, we would consider placing flyers in the providers' offices and have them alert members to contact the evaluator to schedule an interview, with a stipend provided to interviewees; or use program encounter data (e.g., mobile crisis intervention encounter of CBHCs; or on-site recruitment of members on a randomly selected day). The selection of interviewees and conduct of interviews will be coordinated with other policy domains, primarily the Delivery System Reform (DSR) policy domain.

Quantitative Data

The quantitative data will include the following:

Medicaid Administrative Data

This data will be used for determining member healthcare utilization and cost, as summarized in Section 1.4.1 Summary of Data Sources. MassHealth members will be attributed to providers of these WI programs in the analyses.

Cross-Sectional Surveys of the Targeted Clinician (or Prospective Clinician) Types (e.g., Residents, Students)

Using a conjoint design,[120] the provider (workforce) survey will construct scenarios of incentives, including financial incentives, that MassHealth might consider increasing providers' motivation to serve MassHealth members in different settings, including community-based clinical settings with a high percentage of Medicaid members. This conjoint survey was chosen because there is no direct rate increase program for the targeted provider population that MassHealth is running, which limits the evaluator's capability to use observational data to assess the relative impact of loan repayment/residency grant programs vs. direct rate increases. Survey respondents' preferences will be solicited using conjoint methods where providers evaluate the complete program, not one part, to allow respondents to incorporate the same trade-off processes they use in the actual decision-making process by reacting to a set of incentive scenarios identified by different levels of attributes. The IE will reference the literature and collaborate with MassHealth and key stakeholders to define each attribute and attribute's levels, such as a range of student loan repayment amounts or percentage increases in direct payment rates. The survey will capture the provider's likelihood of choosing each scenario to meet the WI programs' goal (e.g., residents'

[119] These time points may be adjusted to account for the actual implementation schedule of these award programs.

[120] Mangham, L.J.; Hanson, K.; & McPake, B. (2008). How to do (or not to do) Designing a discrete choice experiment for application in a low-income country. *Health Policy and Planning, 4*(2), 151-158

multi-year services in community-based settings). Additional incentive scenarios (e.g., non-financial attributes) may be explored through open-ended response questions.

Students (who are close to graduation), primary care clinicians (including residents), and BH clinicians (new cohorts) will be asked to participate in an online survey. The survey population will include all providers eligible or who would soon be eligible for the WI programs (e.g., those who applied and were awarded, those who applied but were not awarded, and those who were eligible but did not apply). It will also include providers outside of community-based settings who would be eligible for the WI program if they took a job in a community setting, provided that their contact information is available. MassHealth's WI program managing partner will supply provider contact information. The survey will also include a sample of prospective candidates (those who currently work outside of eligible community-based settings but might be willing to switch to a job in a community setting).

The first wave of the survey will be implemented about a year after each program is implemented (currently estimated to be SFY25), and the second in SFY27. The timeline will be adjusted according to the actual program start date, as needed.

The second wave will include a new cohort of students and clinicians. For those willing to participate in a follow-up in the second wave, the IE will conduct a follow-up survey with them. For the follow-up survey, among a subset of providers benefiting from the WI programs, the IE will include additional questions about their direct experiences with the program and whether their choices would have changed.

6.4.3. Measures

As described in the logic model and Table 6-2, both quantitative and qualitative evaluation measures will be used for different RQs; they cover four categories: organization-level measures (e.g., number of awards, provider demographics), member-reported measures (e.g., access, provider choices), member healthcare utilization (e.g., use of preventive care, acute and emergency service utilization), and cost (e.g., program cost, healthcare cost). Details on the specifications, numerator, and denominator for key measures are given in Appendix B.

6.4.4. Analysis Methods

For qualitative data (interviews/focus groups) and documents, thematic analyses will be conducted. Please refer to Chapter 3 (Delivery System Reform), Section 3.4.5 Analysis Methods for the data analysis approach which would apply here.

For the conjoint cross-sectional survey, the attribute levels will be coded as dummies, and regression models will be performed to estimate the utilities (i.e., level of satisfaction) for each attribute level, i.e., the numerical expression of the value that a respondent would place on each level of each attribute.[121] The unit of analysis is the

[121] Hu, W., Sun, S., Penn, J., & Qing, P. (2022). Dummy and effects coding variables in discrete choice analysis. *American Journal of Agricultural Economics, 104*(5), 1770-1788. https://doi.org/10.1111/ajae.12311

probability of remaining or becoming a MassHealth provider. The analysis will yield utility scores on an interval scale. The utilities associated with each attribute level will be used to compute the relative importance of each attribute. The attributes and their levels will be used to develop a market simulation of potential incentive scenarios the state might consider to encourage more providers to participate in the MassHealth program. A hypothetical example of these scenarios is an option where MassHealth would offer a $2,000 student loan forgiveness program, a 2 percent increase in reimbursement rate, and ask the providers to have a panel of 10 percent MassHealth and/or uninsured members. Using the choice simulation function, the utilities associated with each scenario will be converted into a choice probability to predict which scenario would best meet the objectives of the WI programs. The results will be presented as an aggregate for all respondents and a segmented analysis by respondent eligibility for WI status. A sensitivity analysis will be conducted to convert the predicted utilities into choice probability to allow an estimate of the proportion of providers willing to participate in the program under each market scenario.[122] Individual and segmented analyses will be conducted to show variation in choice probability by gender and provider's years of experience.[123,124] Inverse probability weights will be used to account for non-response bias and examine the various assumptions of missingness. The non-response weights will be computed using covariates included in the sample framework, such as age, gender, and population type.

The IE will use interrupted time series (ITS) with a comparison group for member healthcare utilization analyses using Medicaid administrative data. Please refer to Section 3.4.5 Analysis Methods for the data analysis approach, which would apply here.[125,126] Specifically, the IE plans to compare the outcomes of Medicaid members who receive services from community-based clinical practices (e.g., CHCs, CBHCs) in the WI programs (or intervention group members) with members who receive services from community-based clinical practices that were not part of the WI program over multiple timepoints before and during the Demonstration. A comparative set of providers who have not used the WI programs will be chosen, and the members of these providers will be selected and propensity balanced to reflect the characteristics of those participating in WI programs. The analyses will control the characteristics of providers (e.g., size, region, and proportion of clinicians receiving financial incentives from the WI programs) and members (e.g., demographic and clinical characteristics). The IE will explore the use of imputation methods or sensitivity analysis related to race/ethnicity data and include demographic characteristics in our analysis, as appropriate.

[122] Baier, D., Gaul, W. (2001). Market Simulation Using a Probabilistic Ideal Vector Model for Conjoint Data. In: Gustafsson, A., Herrmann, A., Huber, F. (eds) Conjoint Measurement. Springer, Berlin, Heidelberg. https://doi.org/10.1007/978-3-662-06392-7_4.

[123] Rao, V. R., & Rao, V. R. (2014). Beyond Conjoint Analysis: Advances in Preference Measurement. *Applied Conjoint Analysis,* 1-36; Orme, B.K. (2010) Getting Started with Conjoint Analysis: Strategies for product design and pricing research. Madison, WI: *Research Publishers LLC.*

[124] Pearmain, D., et al. (1991). Stated preference techniques: a guide to practice. *Steer Davis Gleave and Hague Consulting Group, Hague.*

[125] Penfold RB, Zhang F. (2013). Use of interrupted time series analysis in evaluating health care quality improvements. *Academic Pediatrics, 13*(6 Suppl):S38-44.

[126] Cook, T. D., Campbell, D. T., & Shadish, W. (2002). Experimental and quasi-experimental designs for generalized causal inference. *Boston, MA: Houghton Mifflin*. (pp. 103-134).

The analysis timeframe for the quantitative data will be from 2018 to one year after the end date of the Demonstration. The choice of the timeframe beginning in 2018 is to capture outcomes before the Public Health Emergency (PHE). The analysis periods will include the following phases of policies: (1) SWI only (2018-2020), (2) SWI+ PHE (2020-2022), (3) PHE only (2022-2023),[127] and (4) WI programs (2023-2027).

Using an embedded mixed methods approach, we will synthesize the quantitative and qualitative data. We will solicit an in-depth nuanced understanding of providers' experiences, examine how those experiences may be related to policy and practice innovation, and use these findings to explain pertinent trends and outcomes. For example, understanding providers' perspectives on workforce initiatives can help contextualize trends seen in outcomes.[128] Conversely, preliminary quantitative findings from the analysis of data from early in the Demonstration period can generate questions regarding underlying mechanisms that can then be explored in subsequent qualitative data collection and analysis.

6.4.5. Limitations

The evaluation design for the WI domain has a few limitations. First, the WI programs will be implemented when the Commonwealth — and the nation — is facing a severe shortage of healthcare providers. In addition to the three WI programs under the Demonstration, there are other state and federal initiatives related to the workforce and other state policies/programs (e.g., primary care sub-capitation, expansion of community service program, expansion of coverage, etc.) that would impact a member's healthcare access and utilization. All of these programs have the potential to have a confounding effect on the WI initiatives. Using a comparison group will mitigate the problem as much as possible. However, it is possible that our evaluation will not be able to detect significant/measurable changes in utilization and cost due to the relatively large impact of provider shortages relative to smaller effect sizes and benefits distributed over a long-term time horizon expected from the WI programs. Larger investments (e.g., loan amount) may be needed to sufficiently fund a larger percentage of the target provider population. In addition, more pipeline/recruitment programs may be required to incentivize students and workers from other fields to enter the primary care/BH workforce in community settings. For similar reasons, the member interviews may identify no differences of experiences or those hard to be attributable to the WI programs. Therefore, the interpretation of findings from this evaluation will need to be considered in the larger context (e.g., improved access may be a result of multiple policies).

Second, due to a lack of an actual direct rate increase program by MassHealth and the opportunity to experiment with such a program, the conjoint models will be used to fill this gap in data. The conjoint model uses a decomposition model, where a respondent reacts to a set of complete scenarios identified by different levels of attributes. These

[127] Based on the current federal guidelines, the PHE is estimated to end in May 2023,. It is possible that it will extend again and overlap with the WI implementation period.

[128] Creswell, J. W., & Plano Clark, V. L. (2007). Designing and conducting mixed methods research. *Sage Publications*, Thousand Oaks, CA.

preferences are decomposed to determine how much utility is associated with each level of each attribute. However, this approach has several limitations to be addressed:

1. The identified scenarios might not capture all attributes that might affect providers' decision to participate in the program. Therefore, we will involve both MassHealth and key stakeholders in developing these scenarios.
2. Averages can mask important market forces caused by patterns of preferences at the segment or individual level, especially where the utility associated with an attribute level is dominant. To address these limitations, the segmented market simulation will be performed to estimate the impact of different attributes. Moreover, self-reported and perceived preference does not always translate into real choices, which impacts the reliability of the findings. Literature about the impact of the direct rate increase on provider incentives to serve in clinical settings with a high density of Medicaid populations will be reviewed to contextualize our findings. Real choice vs. hypothetical choices could be compared among those benefiting from the WI programs.
3. Because members, especially those in need of BH services (e.g., mobile crisis intervention), can switch to different community-based clinical settings, there is the challenge of attributing members to a specific clinical setting, adding the possibility of misclassifying the source of impact. However, all members must have a MassHealth-attributed PCP, and MassHealth regularly updates primary care practice attributions.
4. It is expected to take at least four years for providers' final commitment to community-based settings to be realized. If some providers join the WI programs towards the end of the Demonstration period, the evaluation timeframe (about two years after the Demonstration is over) cannot fully capture these providers' final choices to stay. Therefore, the IE may miss the final decision data on late adopters of the WI benefits.

7. Hospital Quality and Equity Initiative

7.1. Overview of Hospital Quality and Equity Initiative (HQEI) Policy Domain

In this Demonstration, MassHealth proposes an innovative HQEI to incentivize hospitals to improve healthcare quality and equity. CMS has authorized the expenditure of up to $400 million annually for private acute care hospitals to improve healthcare quality and equity within the Commonwealth and up to $90 million annually for Cambridge Health Alliance (CHA) (the Commonwealth's only non-state-owned public hospital) to improve healthcare quality and equity and to develop interventions for both its Medicaid population and the uninsured individuals it serves. Participating hospitals will demonstrate progress towards improving quality and equity by (1) attaining complete, beneficiary-reported demographic and health-related social needs (HRSN) data; (2) identifying and addressing disparities in access and quality outcomes; and (3) strengthening organizational capacity for health equity including through collaboration with the health system and community partners (CPs). Direct funding is not being provided for implementation or to reimburse provider costs incurred for implementing the HQEI. Participating hospitals will also build organizational and workforce competence to improve quality and health outcomes, reduce disparities, and enhance their ability to provide accessible and culturally appropriate services.[129]

Funding for the HQEI will be at risk for each performance year (PY), with state and hospital accountability. Reductions from statewide accountability will apply to the global amount of funding from which hospital payments may be made for the initiative. The accountability framework is described in the STCs and is further specified in MassHealth's HQEI Implementation Plan (pending CMS approval).

7.1.1. Goals of the Hospital Quality and Equity Initiative (HQEI)

The HQEI component of MassHealth's 2022-2027 Demonstration aims to improve the quality of care and advance health equity, focusing on initiatives addressing HRSNs and health disparities demonstrated by variation in quality performance.[130]

7.1.2. HQEI Policy Sub-Domains and Desired Outcomes

The Commonwealth and participating hospitals will pursue performance improvements in three HQEI sub-domains described further below. Expenditure authority for performance-based payments for private acute care hospitals associated with achievement in each sub-domain is presented in Table 7-1 (i.e., Table 14 of the STCs).[131]

[129] STC 14.1, pages 102-103; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[130] HQEI Performance Year 1 Section 1.A of the Implementation Plan; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[131] STC 14.7, pages 107-108; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

Table 7-1: Expenditure Authority Annual Allocation by Policy Sub-Domains

Row Description	Sub-Domain 1: Demographic and HRSN Data Collection	Sub-Domain 2: Equitable Access and Quality	Sub-Domain 3: Capacity and Collaboration
% of Annual Limit	25 percent	50 percent	25 percent
Annual Amount ($)	$100M	$200M	$100M

Sub-Domain 1- Demographic and Health-Related Social Needs (HRSN) Data

MassHealth and its participating hospitals will be assessed on the completeness of beneficiary-reported demographic and HRSN data submitted in accordance with CMS-approved HQEI Implementation Plan (pending CMS approval). Demographic and HRSN data will include at least the following categories: race, ethnicity, primary language, disability status, sexual orientation, gender identity, and HRSN, and must be submitted in a consistent format across participating entities. Data completeness will be assessed separately for each data element.[132]

Through annual milestones, MassHealth and participating hospitals will be incentivized to meet an interim goal of 80 percent completeness for self-reported race and ethnicity data by the end of PY3. Participating entities will be incentivized through annual milestones to achieve at least 60 percent data completeness for beneficiary-reported disability data (pending approval by CMS), and at least 80 percent data completeness for beneficiary-reported other demographic data (including at least primary language, sexual orientation, and gender identity) by the end of PY5. Participating entities will also be incentivized to meaningfully improve rates of HRSN screenings, as well as the ability to track and report on them, from the baseline period by the end of PY5.[133]

The collection of these demographic and HRSN data is intended to support MassHealth's goals of identifying and monitoring health disparities, increasing screening for HRSNs, and increasing the percentage of members with an identified HRSN referred to appropriate services.[134]

Sub-Domain 2- Equitable Access and Quality

Participating hospitals will be incentivized for performance on metrics 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 (BH); care coordination; and/or patient experience. Subject to CMS approval and informed by needs assessments, the Commonwealth will select a subset of measures, including at least three from CMS's Health Equity Measure Slate for hospital performance and at least seven measures for statewide performance. Measures will be

[132] STC 14.2, page 103; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[133] STC 14.3, page 104; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[134] HQEI Performance Year 1 Implementation Plan, Figure 2; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

selected from the following priority areas: maternal health, care coordination, care for acute and/or chronic conditions, and patient experience of and/or access to care.[135]

Performance expectations are specified further in the HQEI Implementation Plan (pending CMS approval) and include, at a minimum:

1. Reporting on access and quality measure performance, including stratifications by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity), HRSNs, and/or defined by other individual- or community-level markers or indices of social risk;
2. Developing and implementing interventions aimed at improving quality and reducing observed disparities in performance metrics to ensure that all members, regardless of their demographic characteristics, have access to covered services that are delivered in a manner that meets their unique needs; and
3. Improving quality and/or closing disparities as measured through performance on a subset of performance metrics.

For up to the first three years of the Demonstration, performance will be assessed based on reporting on access and quality measure performance and developing and implementing interventions to improve quality and reduce disparities. For at least the last two years of the Demonstration, performance will be assessed based on improving quality and closing "observed disparities on metrics 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."[136]

MassHealth's goals for this policy sub-domain include identifying and monitoring statewide disparities in clinical quality measures, closing gaps in targeted quality measures by PY5, identifying best practices for targeted equity improvement interventions, increasing hospital and accountable care organization (ACO) collaboration on disparities-reduction projects, improving member receipt of linguistically appropriate care, high levels of provider and staff demonstrating disability competency, and closing gaps in the percentage of members reporting their accommodation needs were met.[137]

Sub-Domain 3- Capacity and Collaboration

MassHealth and participating hospitals will be incentivized to improve provider and workforce capacity and collaboration between health system partners to improve quality and reduce healthcare disparities.[138] Participating entities may be assessed on improvements in metrics such as provider cultural competence, achievement of externally validated equity standards, and joint accountability for ACO performance.

[135] STC 14.4, page 105; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[136] STC 14.4, pages 105-106; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[137] HQEI Performance Year 1 Implementation Plan, Figure 3; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[138] STC 14.2, page 104; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

Some assessments, detailed below, will rely on surveys and standards developed by The Joint Commission (TJC). This independent not-for-profit organization offers accreditation, certification, and standard setting for the healthcare industry. For PY1 of the HQEI, participating hospitals will have their performance assessed for the Capacity and Collaboration sub-domain based on timely submission to MassHealth of member survey results pertaining to cultural competency, an attestation that the hospital has completed TJC surveys for health equity accreditation standards, and the health equity performance scores of ACOs with which the hospital is partnered.[139] Achievement of at least 80 percent of hospitals meeting rigorous standards, as established by a national quality or accreditation organization, regarding service capacity, access, and delivery of culturally and linguistically appropriate care is expected by the end of PY3.[140]

MassHealth goals for this policy sub-domain include increasing organizational capacity, structure, and workforce for meaningful health equity work, improving culturally competent care for MassHealth members, and increasing collaboration between health system partners to improve care quality and reduce disparities.[141]

7.1.3. HQEI Policy Domain Implementation Plan and Timeline

The HQEI spans the five-year Demonstration period. Detailed schedules of activities will be included in MassHealth's HQEI Implementation Plan (pending CMS approval). A summary of expenditure authority by performance, Demonstration, and calendar year (CY) is included in Table 7-2 (adapted from Table 13 of the STCs).[142]

Table 7-2: Annual Expenditure Limits (In Millions, Total Computable)

Row Description	Demonstration Year (DY) 27	DY 28	DY 29	DY 30	DY 31	DY 32
Private Acute Hospitals	$80M	$320M	$400M	$400M	$400M	$400M
CHA	$22.5M	$90M	$90M	$90M	$90M	$90M
Performance Years (PY)	PY 1	PY1	PY2	PY3	PY4	PY5
Calendar Years (CY)	10/1/2022 – 12/31/2023	(Through 2023)	2024	2025	2026	2027

[139] HQEI Performance Year 1 Implementation Plan, Table 4; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[140] STC 14.5, page 107; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[141] HQEI Performance Year 1 Implementation Plan, Figure 4; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

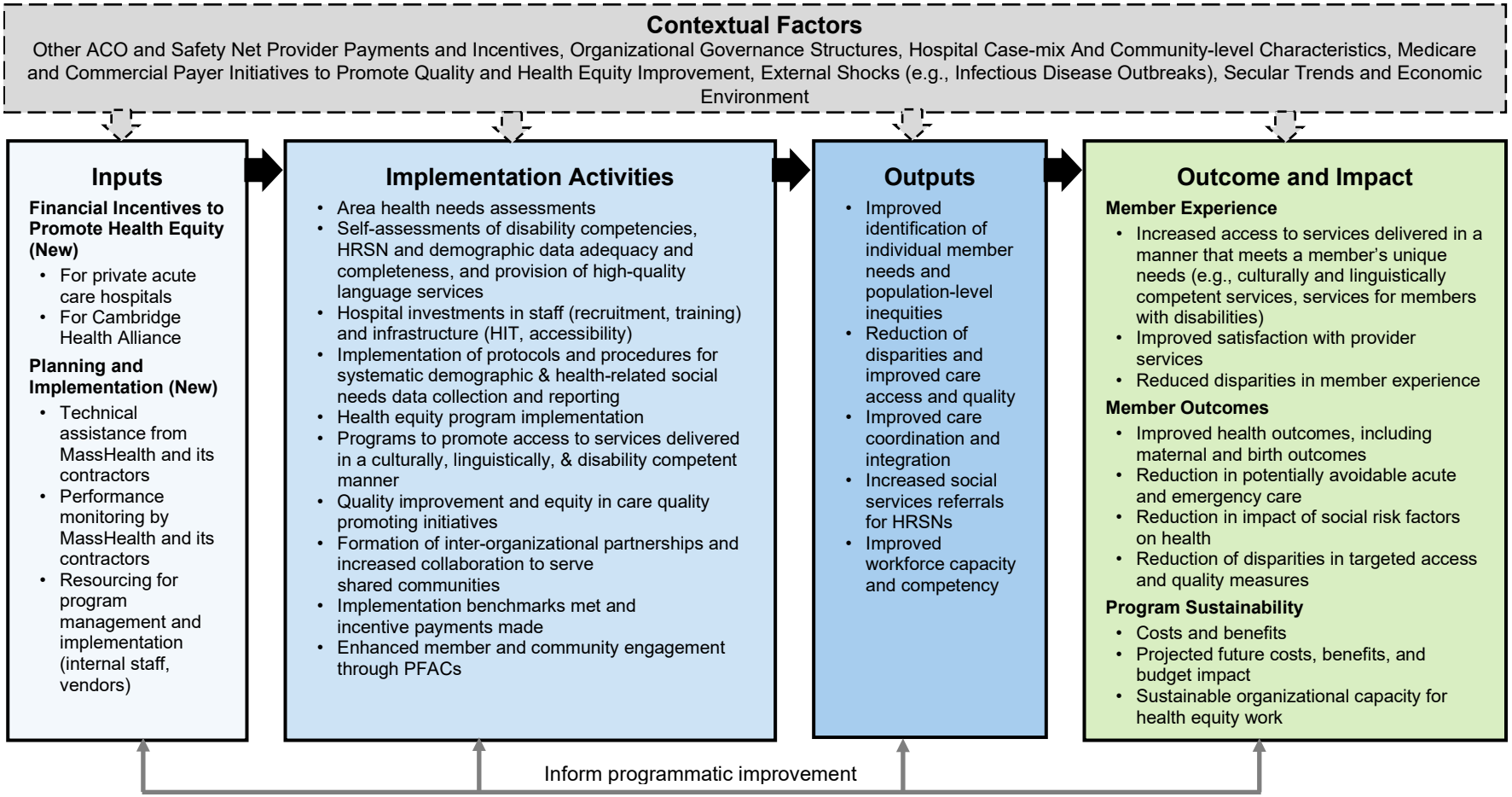
[142] STC 14.1, page 102;

7.2. Logic Model

The HQEI logic model in Figure 7-1 links the Demonstration Goals to the Demonstration Inputs, Implementation Activities, Outputs, and Outcomes and Impact of the Demonstration. The RQs and hypotheses that follow are guided by this logic. The HQEI component of the demonstration is new, as are all its associated programs and policies.

Figure 7-1: Logic Model for the HQEI Component of the Demonstration

Goals: (1) Advance health equity, with a focus on health-related social needs and specific disparities; and (2) Improve healthcare quality



7.3. Research Questions and Hypotheses

Table 7-3 provides an overview of the RQs, hypotheses, data sources, study populations, measures, and analytic methods used to evaluate the HQEI. The elements are described in detail below in Section 7.4 Data and Methods.

Table 7-3: Research Questions and Hypotheses for HQEI

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size-per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ6-1 What actions were taken by the state to support HQEI?	H6-1.1 MassHealth will distribute funding based on reporting and performance for participating hospitals to support HQEI. H6-1.2 MassHealth will develop policies and procedures and provide operational oversight to support implementation. H6-1.3 MassHealth and its contractors will deliver technical assistance (TA) to support HQEI. H6-1.4 MassHealth and its contractors will provide performance monitoring to support HQEI.	Key Informant Interviews (KIIs), focus groups, and/or open-ended surveys (2024-2025; 2026-2027) • MassHealth leadership and staff • Hospital leadership and staff Data and documentation prepared by MassHealth and its contractors (ongoing basis)	MassHealth leadership and staff (Interviewees: n ≤ 5) Hospital leadership and staff (Interviewees: n ≤ 50-70)	Funding distributed; Policies and procedures developed; Types of technical assistance and performance monitoring provided; Perceived effectiveness of procedures and policies to support implementation; Perceived effectiveness of TA; Hospital utilization of TA services; Perceived effectiveness of performance monitoring	Qualitative analysis of data collected through KIIs (MH, hospital); Qualitative analysis of documents; Descriptive analysis
RQ6-2 What actions did participating hospitals take to implement quality	H6-2.1 Participating hospitals will perform competency and needs assessments to target quality and equity initiatives.	KIIs and/or focus groups (2024-2025; 2026-2027) • Hospital leadership and staff • Staff from partnering organizations	Hospital leadership and staff (Interviewees: n ≤ 50-70), staff from partnering organizations (n≤50)	Implementation and reporting of competency and needs assessments; Perceived ability and strategies to recruit, train, and retain providers and staff to implement quality and equity initiatives;	Qualitative analysis of data collected through KIIs (hospital, partner organization);

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size-per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
and equity initiatives?	H6-2.2 Participating hospitals will recruit, train, and retain providers and staff responsible for implementing quality and equity initiatives. H6-2.3 Participating hospitals will modify health information systems to ingest and use self-reported demographic and HRSN screening data. H6-2.4 Participating hospitals will train staff to systematically collect self-reported demographic and HRSN data in a culturally competent manner. H6-2.5 Participating hospitals will establish processes to submit self-reported demographic and HRSN data to the state. H6-2.6. Participating hospitals will implement programs to promote access to services delivered in a culturally, linguistically, and disability-competent manner. H6-2.7 Participating hospitals will implement	Data submitted to MassHealth (2022-2027): • Race, ethnicity, language, disability, social orientation, and gender identity (RELDSOGI) files provided by MassHealth; • Stratified quality data (i.e., performance data including member-level race and ethnicity for clinical measures); • Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey of members results regarding culturally competent care (2023-2027); • Meaningful Access to Health Care Services for Persons with Limited English Proficiency performance data Documentation submitted to MassHealth (2022-2027): • Attestation of completing TJC surveys for health equity accreditation standards and/or documentation showing accreditation; • Attestation of hospital-ACO partnership • Hospital-submitted quarterly Performance Improvement Plan-related documents (e.g., key		Use of health information systems to ingest and use self-reported demographic and HRSN data; Implementation of training for staff to systematically collect self-reported demographic and HRSN data in a culturally competent manner; Established processes to collect and submit self-reported demographic and HRSN data to the state; Number and types of programs implemented; Facilitators and barriers to program implementation; Provider and staff perceptions of HQEI programming; Number and types of new, reciprocal relationships between hospitals and partner organizations formed for the HQEI; Development of organizational policies supporting cooperation between hospitals and partner organizations; Provider and staff perceptions of relationships with partner organizations; Engagement with MassHealth members during the design and implementation of quality and equity initiatives; Timely submission of required documentation; Common themes;	Qualitative analysis of documents; Descriptive analysis (member, hospital)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size-per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	quality improvement initiatives to promote better and more equitable care quality. H6-2.8 Participating hospitals will improve and strengthen relationships with partner organizations. H6-2.9 Participating hospitals will engage MassHealth members and the community in the design and implementation of quality and equity initiatives.	personnel/institutional resources document, mid-year planning report) • Hospitals' completion of competency and needs assessments to target quality and equity initiatives; • Hospital Health Equity Strategic Plan; • Hospital Plan for Screening for Social Drivers of Health; • Hospital-selected HRSN screening tool; • RELDSOGI assessment; • Hospital-submitted interpreter attestation; • Hospital-submitted disability competency self-assessment and plan for improving competency in targeted competency areas; • Accommodation needs report and plan for improvement; • HRSN assessment		Indication of progress toward policy goals	
RQ6-3 Did participating hospitals improve the completeness of member self-reported demographic and HRSN data?	H6-3.1 Participating hospitals will increase the percentage of members screened for HRSN. H6-3.2 Participating hospitals will increase the percentage of members with complete data for	Center for Health Information Analysis (CHIA) Enhanced Demographics Data File sent to MassHealth (2023-2027); MassHealth administrative data (2018-2027); Data submitted to MassHealth (2023-2027)	Participating hospitals (n=61) and members receiving services from participating hospitals (encounter data: members receiving services at CHA n=~6,000;	H6-3.1: % of members screened for HRSN; H6-3.2: % of members with complete data for enhanced demographic data elements; H6-3.3: % of members with unmet needs who are linked with services and supports;	Descriptive analysis (member, hospital)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size-per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	enhanced demographic data elements. H6-3.3 Participating hospitals will increase the percentage of members with unmet needs who are linked with services and supports. H6-3.4 Participating hospitals will report performance data stratified by demographics and HRSN.		members receiving services at acute private hospitals n=~470,000)	H6-3.3: % of members (overall and among those with HRSNs) enrolled in social services and programs to address HRSNs (e.g., SNAP if data are available from MassHealth, Flexible Services, specialized CSP programs); H6-3.4: % of hospitals reporting stratified performance data by demographics and HRSN	
RQ6-4 Did participating hospitals reduce disparities and improve care access and quality?	H6-4.1 Healthcare quality will improve. H6-4.2 Disparities in healthcare quality will decrease. H6-4.3 Members will report increased access to services delivered in a manner that meets their needs.	CHIA Enhanced Demographics Data File sent to MassHealth (2022-2027); MassHealth administrative data (2018-2027); Member Experience Surveys (HCAHPS) (2023-2027); KIIs and/or focus groups (2024-2025; 2026-2027) with MassHealth members	Members receiving services from participating hospitals (Interviewees: n ≤ 30; Encounter data: members receiving services at CHA n=~6,000; members receiving services at private hospitals n=~470,000)	Perceived access to services delivered in a manner that meets their needs; HCAHPS items related to access and cultural competency; Quality measures from the CMS Health Equity slate, including: • Childhood Immunization Status (CIS-CH); • Timeliness of Prenatal Care (PPC-CH); • Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD and FUA-CH); • Follow-up after Hospitalization for Mental Illness (FUH-AD)	Descriptive analysis (member, hospital); Observed vs. expected (member); Quasi-experimental methods (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size-per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ6-5 Did participating hospitals improve member experience and outcomes?	H6-5.1 Member experience will improve. H6-5.2 Disparities in member experience will decrease. H6-5.3 Member health outcomes (e.g., maternal and birth outcomes) will improve. H6-5.4 Members will experience a reduction in the impact of social risk factors on their health. H6-5.5 Disparities in member outcomes will decrease.	CHIA Enhanced Demographics Data File (2023-2027); MassHealth administrative data (2018-2027); Member Experience Surveys (HCAHPS) (2023-2027); KIIs and/or focus groups (2024-2025; 2026-2027) MassHealth members	Members receiving services from participating hospitals (Interviewees: n ≤ 30; Encounter data: members receiving services at CHA n=~6,000; members receiving services at private hospitals n=~470,000)	HCAHPS measures; Perception of quality and equity initiatives; Experience of care; Access to care; Service delivery met needs; Perceived impact of social risk factors on health; Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD); Controlling High Blood Pressure (CBP-AD); Unnecessary C-Section (TJC PC02); Emergency Department (ED) Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions; ED Visits (adult, pediatric); 30-day readmission; Maternal morbidity	Qualitative analysis of data collected through KIIs (member); Descriptive analysis (member); Observed vs. expected (member); Quasi-experimental methods (member);
RQ6-6 How did costs and benefits of HQEI affect plans for sustainability?	H6-6.1 The costs and benefits of hospital quality and equity initiatives will vary by hospital and program type. H6-6.2 Participating hospitals and the state will identify health equity initiatives where projected	KIIs, focus groups, and/or open-ended surveys (2024-2025; 2026-2027) • Hospital leadership and staff, staff from partnering organizations • MassHealth staff CHIA Enhanced Demographics Data File (2023-2027);	MassHealth leadership and staff (Interviewees: n ≤ 5); Hospital leadership and staff (Interviewees: n ≤ 50-70); Members receiving services from	HQEI costs overall and by hospital and program type; Stratified analyses of quality, experience, and outcomes by hospital and program type; Perceptions of costs and benefits; Barriers/facilitators to continuing HQEI programs;	Qualitative analysis of data collected through key informant interviews (MH, hospitals, members); Descriptive analysis (MH,

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size-per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	benefits from continuing the program merit projected costs. H6-6.3 Participating hospitals will make investments in staff recruitment, training, and retention to sustain the organizational capacity needed to continue health equity work.	MassHealth encounter and MassHealth Medicaid Management Information System (MMIS) claims data (2018-2027); Data submitted to MassHealth (2023-2027); Documentation submitted to MassHealth (2023-2027)	participating hospitals (Interviewees: n ≤ 30; Encounter data: members receiving services at CHA n=~6,000; members receiving services at private hospitals n=~470,000)	Plans to recruit/train/retain staff and providers to continue HQEI work; Identification of successful initiatives Barriers/facilitators to continuing HQEI; Perceptions of costs and benefits of HQEI programs	hospitals, members; Expected vs. observed (member)

a. Research Questions developed based on the following STC sections 14.1, 14.3, 14.4, 14.5, 14.6, 14.7, 14.9, 14.10, 14.16, and 14.17; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

b. Data sources are described in section 7.4.2 “Data Sources and Collection Methods” and in section 1.4.1 “Summary of Data Sources”

c. Analytic methods are described below in section 7.4.5 “Analysis Methods”

7.4. Data and Methods

7.4.1. Study Populations

MassHealth Staff and Contractors

The IE team will rely on MassHealth staff and contractors at both the programmatic and leadership levels to inform the evaluation of this initiative. We will collect data from individuals involved in the planning, implementation, and support of the HQEI via key informant interviews (KIIs).

Participating Hospital Staff

The IE team will study participating hospitals' providers, leadership, and staff. The target providers will be any individuals delivering healthcare services to members and those who are involved in designing or implementing HQEI programming. Leaders include executives and program leadership engaged in the design and implementation of the HQEI at their particular institution. Staff includes individuals responsible for the ingestion, transformation, and transmission of HRSN and demographic data from hospital systems to MassHealth and those who support the initiatives in an administrative role. The IE team will collect information from hospital personnel via key informant interviews. Interviewees may also include staff from partnering organizations (e.g., community-based organizations) when such organizations are working with hospitals to implement HQEI programming.

MassHealth Members

The HQEI has the potential to benefit Massachusetts residents in the communities served by participating hospitals, regardless of whether or not they have been hospitalized or their insurance status. The plausibility of measurable spillover effects of the HQEI for populations receiving hospital services, other than the specified targets of MassHealth members (applicable to all participating hospitals, including CHA) and served uninsured residents of the Commonwealth (applicable to CHA), will be considered as additional information on MassHealth and participating hospital implementation and strategic plans become available. However, our primary population of interest will be the MassHealth members and uninsured residents of the Commonwealth who are the direct targets of the HQEI programming — i.e., those who receive inpatient or emergency department (ED) services from a participating hospital. While we will study all individuals in this primary study population where appropriate (e.g., for measures of data reporting), we anticipate defining multiple study subpopulations corresponding to the target populations of HQEI programs (e.g., members whose primary language is not English), the denominators of quality and access measures (e.g., those with diabetes), and based on other characteristics of members (e.g., HRSN), their communities (e.g., area-level socioeconomic stress), or of participating hospitals (e.g., ACO affiliation). Attribution to a study population will be time-varying and determined consistent with measure technical specifications (e.g., an individual may be hospitalized and in the study population in 2023 but not in 2024). Furthermore, although participating hospitals are not expected to be targeting HQEI programming differentially based on the category of MassHealth enrollment, differences

in data availability and quality between MassHealth managed care eligible members (for whom MassHealth is the primary payer) and other MassHealth members will likely necessitate stratified analyses and reporting by enrollment category for specific measures.

Comparison Groups

We will use several comparison groups, following the general principle of selecting comparator populations that most closely resemble the populations exposed to specific Demonstration policies and programs. Due to systematic differences between Medicaid members and commercial enrollees and between interstate policy environments, we plan to primarily draw comparison groups from within the MassHealth program while also exploring opportunities to obtain and leverage data from other Medicaid programs. Accessing individual-level member data from other states is challenging due to privacy and security rules, capacity constraints, and requirements that sharing such data produces information that is deemed of value to the other state sharing data. We expect to use publicly available data from the Hospital Cost and Utilization Project (HCUP) to make comparisons to other state Medicaid program members for measures that can be calculated and compared using individual-level data from HCUP data (namely the hospital readmissions measure) and for measures that can only be compared using aggregated data because individual level denominator data is not available (e.g., ED visits, maternal mortality, C-sections). We will explore the feasibility of creating synthetic controls from other states with the most similar policy environments for these measures that will be calculated using aggregated data. However, the appropriateness of this approach is uncertain because Massachusetts has a unique policy environment and a healthcare system that falls in the tails of the distribution for coverage, delivery system reform efforts, cost, and quality, which raises concerns that a pool of other states cannot satisfy assumptions of the method needed to represent a true counterfactual and may introduce interpolation bias.[143]

If available, we will draw comparison groups from private acute care hospitals in Massachusetts that are not participating in the HQEI or that are delayed in implementation. We will seek to leverage situations conducive to quasi-experimental methods that support stronger levels of inference, such as phased implementation, when possible. However, to our knowledge, implementation has not been delayed for any existing hospital, and participation in the HQEI is ubiquitous. When data are available, we will use historical comparison groups, but we recognize that HRSN and sociodemographic data elements will often not be available or will be incomplete for periods before the HQEI implementation. Since the HQEI grants hospitals autonomy to design their own programs tailored to the needs and priorities of their patient populations, local communities, and organizations, we anticipate that variation in the types of programs and targeted populations implemented will facilitate the use of contemporary comparison groups of members who closely resemble those exposed to specific HQEI programs but who were not exposed because they visited a hospital with

[143] Abadie, Diamond, and Hainmueller: Synthetic Control Methods for Comparative Case Studies. Journal of the American Statistical Association June 2010, Vol. 105, No. 490 McClelland R, Gault S. The Synthetic Control Method a Tool to Understand State Policy. *Urban Institute*. March, 2017.

a sufficiently distinct set of HQEI programs. Such comparisons will be conservative, as all hospitals will implement some overlapping HQEI elements (e.g., data collection and reporting, strategic planning). Another potential secondary comparison group may include individuals who were not hospitalized but who had a similar probability of being hospitalized to members who were hospitalized.

7.4.2. Data Sources and Collection Methods

The IE team will rely on several types of data sources described in Section 1.4.1 Summary of Data Sources to evaluate the effectiveness and implementation of the HQEI program. The specific utility of each source and its relation to the HQEI RQs and evaluation plan is detailed below.

KIIs

KIIs will be conducted with MassHealth staff and contractors, as well as hospital leadership and staff and MassHealth members. They may be in an individual or group format and will be conducted virtually via Zoom or a similar platform in two waves, as described below. Open-ended surveys will also be used for some participants where the information content is expected to be similar between modalities based on the type of respondent and information being collected. The decision regarding individual versus group interview procedures will be made based on the focus or topic of the interview, the number and types of relevant HQEI programs to be covered in the interview, and to minimize the burden to organizations and members. Consideration will be given to individuals' communication preferences, particularly members receiving Long-Term Services and Supports (LTSS), who may prefer to be interviewed individually or use the video chat function rather than communicate verbally. Participants will submit a background survey to provide demographic data and additional information about their roles, responsibilities, and training as applicable and appropriate. KIIs will provide insight into how MassHealth supports HQEIs (RQ6-1), how participating hospitals implement them (RQ6-2), and the implications for member experience (RQ6-4, RQ6-5). They will also allow the IE team to explore MassHealth and hospital leadership perspectives on the costs and benefits of implementing HQEI programs, the facilitators and barriers to continuing them, and to identify sustainable programs (RQ6-6).

In the second year of the evaluation (2024), we will conduct interviews with individuals in staff and leadership positions involved in the HQEI implementation at participating hospitals. We anticipate all 61 acute care hospitals will participate but presently lack information on their governance structures, HQEI staffing plans, and their Health Equity Strategic Plans. However, we are estimating 50-70 interviews (one to two per hospital or group of affiliated hospitals) per wave, which may be adjusted as more information becomes available. The focus of the first wave of interviews will be experiences with and perspectives on developing their strategic plans, conducting needs assessments, engaging MassHealth and community members, and infrastructure development necessary to provide more equitable and culturally appropriate care, including the implementation of HRSN and demographic data collection systems and staff and provider training. The second wave, to be conducted between 2026-2027, will examine how these new programs have enabled participating hospitals to provide accessible,

culturally appropriate care and to reduce disparities. The interviews will address HQEI program implementation progress, barriers and facilitators, perceived costs and benefits of implementing HQEI programs, and perspectives on sustainability.

Thirty interviews will be held with MassHealth members between 2024-2025 and again in 2026-2027. We will purposefully sample a diverse set of participants across hospitals and program types to better understand the breadth of perceptions of care and access. These interviews will complement and help with the interpretation of findings from administrative and clinical data and allow for a more nuanced understanding of how members perceive the initiative, their hospital care, and the impacts it has on their health and social risk factors.

The IE team will also schedule two waves of about five interviews each with MassHealth staff and leadership, which are expected to be completed in 2025 and 2027. These interviews will provide an opportunity for key personnel involved in the design and implementation of the HQEI policies to share their experiences, assess barriers and facilitators, and reflect on the program's sustainability and potential future directions.

Interview protocols for all three key informant categories will be developed with input from MassHealth and representatives from each group. Interview and focus group guides will be informed by the Consolidated Framework for Implementation Research (CFIR) and by the Comprehensive Theory of Integration (CTI) conceptual model.[144,145] The CTI defines integration as “a set of organizational and social features and course of action or activities requiring unification that may exist both within and between organizations,” and it is described further in Chapter 3 (Delivery System Reform). CFIR integrates dissemination and integration theories into five implementation domains (Innovation, Outer Setting, Inner Setting, Individuals, and Implementation Process). Both frameworks are relevant for the HQEI, which will be newly implemented and seeks to promote inter and intra-organizational coordination. We will work with MassHealth and participating hospitals to identify, recruit, and schedule participants for the interviews, with an eye towards diversity and a representation of differing viewpoints in the sample selection.

KII interview transcripts will be analyzed using a qualitative data analysis software program for analyzing qualitative and mixed methods data. The IE team will code the interviews to identify common themes that answer the research questions and provide insight into the various domains of the initiative. Analysts will work together in pairs to establish coding methodology, and once an agreement is reached and is reliability maintained, they will be able to work independently.

[144] Singer, S. J., Kerrissey, M., Friedberg, M., & Phillips, R. (2020). A comprehensive theory of integration. *Medical Care Research and Review, 77*(2), 196-207.doi: 10.1177/1077558718767000. Epub 2018 Apr 2. PMID: 29606036..

[145] Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation Science, 17*(1), 1-16.

Document Review

The evaluation team expects to review various existing documents throughout the Demonstration to obtain data on participating entities' plans and progress in implementing HQEI programs and the state's progress in implementing supports for the HQEI.

Participating hospitals must submit several documents to MassHealth. A summary of HQEI Performance Expectations for Performance Year 1 is detailed in the PY1 HQEI Implementation Plan (pending CMS approval).[146] Relevant documents for HQEI evaluation include:

- Participation and Collaboration Attestations
- Qualified Interpreters Attestation
- Race, ethnicity, language, disability, sexual orientation, and gender identity (RELDSOGI) Assessment
- HRSN Assessment
- Disability Competency Deliverables
- Health Equity Strategic Plan
- Plan for Screening for Social Drivers of Health and Selection of a screening tool
- Quarterly reports on the ACO-partnered performance improvement plan
- Accommodation needs report and plan for improvement
- Attestation of TJC surveys for health equity accreditation standards

The IE team will evaluate documents on an ongoing basis as they are made known and available from MassHealth. It is anticipated that similar documents will be required in future performance years, and the evaluation team will review them in the manner described below in Section 7.4.5 Analysis Methods.

Administrative and Other Data Files

Administrative data files include eligibility, enrollment, and claims and encounter data, along with clinical or other data submitted by hospitals to support the calculation of quality metrics. CHIA-enhanced demographic data files will indicate if hospitals meet targets in capturing self-reported demographics and screening members for HRSNs (RQ6-3). MassHealth encounter and MassHealth Medicaid Management Information System (MMIS) claims data will support analyses of patterns in quality and access to care (RQ6-4), including the identification of gaps or disparities and their eventual improvement or closure through the implementation of this program (RQ6-2, RQ6-4). When individual-level data are substantially incomplete for certain sociodemographic data elements (e.g., race/ethnicity), imputed data (e.g., from area-level data sources such as the Census) will also be used when such missingness is extensive. Sensitivity

[146] HQEI Performance Year 1 Implementation Plan; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

analyses will be performed to examine the robustness of findings to alternative assumptions regarding missingness mechanisms and analytic approaches to accounting for missingness.

Survey Data

Aggregate results of required Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys of MassHealth members receiving services from participating hospitals will be used to better understand their hospital care experience during HQEI implementation. These surveys cover domains including communication with nurses and doctors, the experience of care, care transition, hospital rating, and recommendations. MassHealth may also add questions to these surveys related to health equity.

7.4.3. Measures

The measures used to evaluate the HQEI policy domain are listed in Table 7-3 according to the research question. Additional measures may be specified — informed by details of MassHealth's HQEI PY1-5 Implementation Plan (pending CMS approval) and hospital strategic plans as they become available.

Qualitative measures will capture information on actions taken by participating hospitals to implement HQEI policies and procedures provided by MassHealth to improve the quality of care and advance health equity. Participating entities are expected to take actions to upgrade or create health information systems to ingest self-reported demographic and HRSN data, to establish culturally competent processes for members to report demographic and HRSN data, for providers and staff to access and use recorded data, to update staff workflows, to recruit and retain staff and providers to implement HQEI initiatives, and to develop and implement staff training and other HQEI programming. Qualitative analyses will also produce information on changes in the approach to delivering services and support and improving health equity from the perspective of members, providers, staff, and organizational leaders. For participating entities, we will examine the facilitators and barriers to designing, implementing, and sustaining HQEI programs and perspectives regarding modifications needed to successfully deliver equitable, person-centered care.

Quantitative measures hypothesized to be affected by the HQEI policy domain initiatives that can be operationalized using data collected from primary sources (e.g., HCAHPS surveys) or made available for the evaluation will be studied. Quality measures will be drawn from the following sources:

- MassHealth HQEI Slate
- CMS Health Equity Slate (once available)
- National quality measure stewards (e.g., AHRQ, NCQA)

Quantitative data will also be examined to better understand changes in data collection rates, disparity reductions, healthcare utilization rates, and costs.

7.4.4. Covariates

For analyses conducted at the individual (member) level using administrative data, we will draw from a consistent set of characteristics including — age, race, ethnicity, language, sex, sexual orientation, gender identity, disability status (either client of the Massachusetts DMH or the DDS, or eligible for Medicaid due to disability), housing problems (either more than three addresses in the year or homelessness by ICD-10 code), the Neighborhood Stress Score, the DxCG medical morbidity summary score, and the RxCG drug-based medical morbidity summary score. A narrower set of characteristics may be used for specific analyses as applicable (e.g., subgroup analyses among women would not use sex as a covariate).

Analyses conducted at the ACO level (or that incorporate clustering at the ACO level) will include covariates such as ACO type (academic hospital-anchored, community hospital anchored, physician-anchored), ACO size (number of MassHealth members, number of total enrollees across all payers), region, and experience with risk-based contracts with Medicare and commercial payers. Analysis conducted at the hospital level will include covariates such as type (academic medical center, teaching hospital, community hospital, and specialty hospital), payer mix, level of acuity (acute, acute critical access, acute sole community, non-acute), trauma center designation (Level 1, 2, 3), profit or non-profit status, hospital size (number of MassHealth members, number of total enrollees across all payers), acuity of patients (case mix), region, and profit margin.

7.4.5. Analysis Methods

Mixed qualitative and quantitative methods will be used to answer the RQs in the HQEI policy domain. Quantitative analyses will examine the impact of HQEI program implementation on changes in quality and outcomes. Qualitative approaches, including semi-structured interviews and/or focus groups with key stakeholders, will support an understanding of stakeholder perspectives related to policy implementation activities, context, and outcomes. Interviews will also provide a contextual understanding of factors that help explain quantitative metrics changes.

Quantitative Analyses

Descriptive

Demographic, clinical, and social characteristics will first be described by data source and calendar year for each study population and subpopulation of interest, including measure-specific populations (e.g., A1c and members with diabetes). Where feasible, process and outcome measures will then be calculated for each population in each CY during the baseline and Demonstration period. Certain survey and clinical quality measures will only have data available for the 2023-2027 periods.

Observed versus Expected

The first comparison will be between observed and multivariable-adjusted estimates of the expected values of each measure for each calendar year of the Demonstration period. Expected values will be estimated from multivariable models developed using

pre-period data and applied to Demonstration period data to predict an individual's value for each measure based on a member's demographic and clinical characteristics (e.g., members with SMI are expected to have a higher probability of ED utilization). These expected values will serve as a historical benchmark against which performance during the Demonstration will be compared. For dichotomous (i.e., yes or no) measures, the probability of success on a given measure will be predicted using logistic models. Rates (e.g., hospitalizations per 100 person-years) will be predicted using Poisson, negative binomial, or zero-inflated models, as appropriate. Continuous outcomes (e.g., expenditures) will be predicted using linear models. For each measure and year of the Demonstration period, the observed value for a measure will be divided by the expected value predicted by the model. When higher values of a measure are desired (e.g., a higher proportion of the population screened), a ratio of observed to predicted greater than one will suggest improved quality. When lower values of a measure are desired (e.g., readmission rates), a ratio of observed to predicted of less than one will suggest improved quality.

Quasi-experimental Methods

To estimate the counterfactual outcomes that would have occurred absent the Demonstration and which can support stronger inferences regarding program effects, analyses must address potential sources of bias, including: 1) population and hospital characteristics that differ between exposed and unexposed groups and 2) unrelated secular trends occurring between the baseline (2018-2022), and the Demonstration (2022-2027) periods. Modern epidemiologic and quasi-experimental design and analysis methods will be applied for this purpose, including propensity score methods to balance population characteristics,[147,148] including overlap weighting, which addresses the limitations of traditional inverse probability weighting.[149] Difference-in-difference comparisons will address secular trends,[150,151] and weighting will address any violations of parallel trends assumptions. Generalized mixed effects linear models will be used for modeling each type of outcome (e.g., dichotomous, continuous, rate) as appropriate and based on observed distributions, with random effects to account for clustering within healthcare organizations, geographic units, and repeated measurements within individuals over time.[152] Bootstrap methods that reflect clustering adjustments will be used to calculate confidence intervals.

[147] Rosenbaum, P. R., & Rubin, D. B. (1983). The central role of the propensity score in observational studies for causal effects. *Biometrika, 70*(1), 41-55.

[148] D'Agostino Jr, R. B. (1998). Propensity score methods for bias reduction in the comparison of a treatment to a non-randomized control group. *Statistics in medicine, 17*(19), 2265-2281.

[149] Li, F., Morgan, K. L., & Zaslavsky, A. M. (2018). Balancing covariates via propensity score weighting. *Journal of the American Statistical Association, 113*(521), 390-400.

[150] Vats, S., Ash, A. S., & Ellis, R. P. (2013). Bending the cost curve? Results from a comprehensive primary care payment pilot. *Medical Care, 51*(11).

[151] Lechner, M. (2011). The estimation of causal effects by difference-in-difference methods. *Foundations and Trends in Econometrics, 4*(3), 165-224. Retrieved from: https://EconPapers.repec.org/RePEc:now:fnteco:0800000014.

[152] McWilliams, J. M., Hatfield, L. A., Landon, B. E., Hamed, P., & Chernew, M. E. (2018). Medicare spending after 3 years of the Medicare Shared Savings Program. *New England Journal of Medicine, 379*(12), 1139-1149.

Continuous Enrollee Analysis

The stable population of continuous MassHealth members, who may have disabilities or other criteria for eligibility for MassHealth that are likely to be permanent or semi-permanent, has been identified as a subpopulation of interest. The stability of this population also affords the opportunity to perform a self-controlled comparison, which contrasts member outcomes during the Demonstration period with their own outcomes during the pre-Demonstration period. A strength of this self-controlled design is that by comparing within individuals, it accounts for time-invariant member characteristics (i.e., those that do not change over time). We will again use difference-in-difference analyses to remove secular effects and mixed effects generalized linear models to account for clustering and repeated measurements while adjusting for demographic (e.g., aging) and disease trends. For each year of the Demonstration, we will conduct a continuous enrollee subgroup analysis where members present in the population of interest during the Demonstration year will be evaluated if they were continuously enrolled in the MassHealth managed care eligible population beginning in 2021 or 2022.

Using an embedded mixed methods approach, we will integrate the quantitative and qualitative data. We will solicit an in-depth and nuanced understanding of various stakeholder experiences, examine how those experiences may be related to hospital policy and clinical innovation, and use these findings to explain pertinent trends and outcomes. For example, understanding stakeholder perspectives on program implementation can help contextualize trends seen in targeted access and quality measures.[153] Conversely, preliminary quantitative findings from the analysis of data from early in the Demonstration period can generate questions regarding underlying mechanisms that can then be explored in subsequent qualitative data collection and analysis.

Qualitative Analyses

Our use of document and KII data, qualitatively analyzed and informed by the CFIR and CTI models, reflects our commitment to an embedded design, integrating quantitative and qualitative data reflecting diverse perspectives to explore the implementation process and to contribute to the explanation of outcomes.[154] KII transcripts and document review data will be analyzed using qualitative data analysis methods described in Chapter 3 (Delivery System Reform), Section 3.4.5 Analysis Methods. The following is a summary of these methods:

KIIs

The IE team will code the interviews to identify common themes that address the research questions and provide insight into the various domains of the initiative. Analysts will work together in pairs to establish coding methodology, and once an agreement is reached and is reliability maintained, they will be able to work

[153] Creswell, J. W., & Clark, V. L. P. (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: *Sage Publications.*

[154] Creswell, J. W., & Clark, V. L. P. (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: *Sage Publications.*

independently. Interrater reliability will be monitored at regular intervals during the coding processes. The Dedoose platform will be used to calculate kappa coefficients.

Once the coding process is complete, researchers will extract reports of coded text from Dedoose, review the reports for patterns among themes, and summarize findings in memos drafted for review by the entire team. Finally, the team will discuss the summary memos to ensure that themes are accurately conveyed and to add additional information as relevant. Where applicable, the team will compile analytic matrices with coded data to facilitate further analysis.

Document Review

Data systematically extracted from documents and recorded in standardized templates will be stored in secure files for qualitative analyses.

Documents will be analyzed for thoroughness and timely submission. They will be used to evaluate corresponding hypotheses for all research questions to ascertain hospitals' progress toward improving data collection, improving access to culturally appropriate care, decreasing disparities, providing staff training, and increasing inter- and intra-organizational collaborations. A template will be developed and used for each set of documents, allowing the team to evaluate them as individual documents as they relate to documents submitted by other hospitals and as they change and develop over time (if applicable). The document review process will be ongoing. Analysts will work together as partner teams to review documents and develop a shared understanding of the template frameworks and the data in question. The team will review document data templates as they are relevant to specific RQs and hypotheses being addressed. As inter-rater reliability is established, analysts will work individually, coming together periodically to review their progress, share common themes, and discuss unexpected results or findings.

Team members will draft memos summarizing template data for routine review by the larger team. Document review data will be integrated with findings from other sources to address RQs and hypotheses.

7.4.6. Limitations

Quantitative Analyses

Our quantitative data sources and analytic approaches utilizing these data have several limitations. We will cautiously interpret results from multiple analytic methods together with qualitative findings to arrive at robust conclusions.

Surveys

The member experience surveys have several limitations, including the potential for recall bias, low response rates, and, most notably, we only anticipate receiving aggregate results, limiting our ability to perform weighting adjustments for non-response bias and repeated measurements. Some new items may require further refinement and validation. Finally, the member surveys are conducted by a third party for a purpose

distinct from evaluation, and the evaluation team is unlikely to have input into survey design and implementation.

Administrative Data Analyses

Analyses of administrative data are subject to limitations associated with the nature of such data being created for billing purposes, which may not reflect the actual presence of clinical conditions (e.g., if a member doesn't seek care or obtain a diagnosis) or use of a medication (e.g., if a drug is filled and not taken). Administrative data lack important clinical details such as laboratory values and non-billable services (e.g., certain forms of care coordination and management). For select quality measures and associated measurements, clinical data will be available. However, such data are expected only to be available for subsets of the populations and comparison groups of interest. Although rigorous quasi-experimental designs and statistical methods are planned, comparative analyses remain subject to unmeasured confounding. Another potential limitation will be missing data. In situations with substantial sociodemographic data missingness (e.g., of self-reported race and ethnicity), we will explore options for conducting analyses using imputed data. Furthermore, we will perform extensive sensitivity analyses to examine the plausibility of alternative explanations for our findings.

Qualitative Analyses

Our qualitative data sources and analytic approaches utilizing these data have several limitations.

Document Review

Relevant documents for review will be provided by MassHealth as they become available and from other sources (e.g., relevant state-wide groups) as they are identified. The volume of available documents poses a potential limitation. We will work with MassHealth to prioritize documents for the review process to ensure we review the most relevant and potentially significant documents. Another limitation is that the scope and content of the documents have been developed to support program implementation and determine eligibility for performance-based payments. The evaluation team has not provided input into the content of such documents.

KIIs

We may confront several limitations during the primary data collection process. As with any self-reported data, information collected in KIIs may be subject to recall bias. KIIs may be conducted by video conference, which represents a strength in terms of consistency of interview format and data collected across sites. Another strength is increased efficiency, which we anticipate will enable us to successfully schedule and collect information from a larger pool of respondents. However, video conference limits our ability to view organizational contexts firsthand. We will solicit responses from a range of staff and probe for specifics about processes and workflows to achieve a nuanced understanding of each organization's activities. For member interviews, videoconferencing may pose difficulties related to technology availability. Furthermore, some members may initially express interest when first recruited but may no longer be interested or may not participate in an interview due to various clinical or social factors.

Our interview procedures have been reviewed by a consultant with experience receiving and expertise in studying LTSS, who provided recommendations regarding the use of plain language and the presentation of materials. Historically, we have had a sufficiently representative pool of potential interviewees to draw from for interviews; therefore, we anticipate we will be able to complete the planned number of interviews, notwithstanding the limitations described here.

8. Health-Related Social Needs

8.1. Overview of Health-Related Social Needs (HRSN) Policy Domain

8.1.1. HRSN Policy Domain Goals

Under prior Demonstration periods, the Commonwealth has taken steps to offer programs and services (e.g., the Flexible Services Program (FSP) and the specialized Community Support Programs (CSP)) that address Health-Related Social Needs (HRSNs).[155] With this Demonstration, the pre-existing FSP and certain specialized CSP services are continued, modified, and expanded with the goals of continuing to improve access to and the quality and equity of care, and to continue the path of restructuring and reaffirming accountable, value-based care.[156]

8.1.2. HRSN Policy Domain Components and Desired Outcomes

The programs to address HRSNs include the FSP and three specialized CSPs. To be eligible for the respective programs, members must have a documented medical need for the services as defined by the specific program, and the services must be medically appropriate.[157] Specialized CSP is available in all delivery systems, while FSP is available only to ACO members. The programs are as follows:

Flexible Services Program

FSP targets MassHealth ACO-enrolled members 0 to 64 years of age who meet at least one of the health needs-based criteria (i.e., a behavioral health (BH) need, complex physical health need, activities of daily living or instrumental activities of daily living need, repeated emergency department (ED) utilization, high-risk pregnancy) and at least one risk factor (either experiencing homelessness/at risk of homelessness or at risk for a nutritional deficiency/nutritional imbalance due to food insecurity) defined by the Commonwealth. The FSP addresses the health-related social needs (HRSN) of eligible individuals in the areas of housing and nutrition by providing access to the following tenancy preservation and nutrition-sustaining supports:[158]

Tenancy Preservation Supports

Allowable housing supports consist of pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention; housing transition navigation services; one-time transition and moving costs; housing deposits to secure housing, including application and inspection fees and fees to secure needed identification; medically necessary air conditioners, humidifiers, air filtration devices, and asthma remediation, and refrigeration units as needed for medical treatment; medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest

[155] STC 15, page 115, verbatim; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[156] STC 2, page 3, from Commonwealth's goals; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[157] STC 15.5, page 119, verbatim; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[158] STC 15.5.a, page 119, nearly verbatim, minor modifications; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

remediation; case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance and application fees; and transportation to HRSN services for tenancy supports as described above.[159]

Nutrition Supports

Allowable nutrition supports include:

- nutrition counseling and education, including on healthy meal preparation;
- up to three meals a day delivered in the home, or private residence, for up to six months;
- additional nutrition support provided to the household of a child or pregnant individual identified as high risk, as defined in the risk and needs-based criteria and in accordance with program requirements;
- medically-tailored or nutritionally-appropriate food prescriptions delivered in various forms such as nutrition vouchers and food boxes, for up to six months cooking supplies that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs;
- case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance and application fees; and
- transportation to HRSN services for nutrition supports.[160]

Specialized Community Support Programs (Specialized CSPs)

MassHealth members, except MassHealth Limited members, who meet certain criteria related to BH needs are eligible to receive specialized CSP services. Specialized CSP services are outreach and support services that 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 members' 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 vary with respect to hours, type, and intensity of services depending on the changing needs of the beneficiary. The following specialized CSPs target populations in need of specialized supports.[161]

Community Support Program for Homeless Individuals (CSP-HI)

CSP-HI is a specialized CSP service to address the HRSNs of members who are experiencing homelessness and are frequent users of acute health MassHealth

[159] STC 15.3.a, b, d, page 118, nearly verbatim, minor modifications. For a more detailed list of Tenancy Preservation Supports, see Attachment P, Protocol for Assessment of Beneficiary Eligibility and Needs and Provider. Qualifications for HRSN Services ; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[160] STC 15.3.b, c & d, page 118, nearly verbatim, minor modifications; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[161] STC 15.5.b, page 119, verbatim; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

services, as defined by EOHHS, or are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development.[162]

CSP-HI includes assistance from specialized professionals who can engage and support individuals experiencing homelessness in searching for permanent supportive housing, preparing for and transitioning to an available housing unit, and, once housed, coordinating access to physical health, BH, and other needed services geared towards helping them sustain tenancy and meet their health needs. In addition to the core CSP services,[163] CSP-HI services also include the following:

- Pre-tenancy supports, including engaging the member and assisting in the search for an appropriate and affordable housing unit
- Support in transition into housing, including assistance arranging for and helping the member move into housing
- Tenancy sustaining supports, including assistance focused on helping the member remain in housing and connect with other community benefits and resources[164]

CSP for Individuals with Justice Involvement (CSP-JI)

CSP-JI is a specialized CSP service to address the HRSNs of members with justice involvement and who have a barrier to accessing or consistently utilizing medical and BH services, as defined by EOHHS. CSP-JI includes BH and community tenure sustainment supports.

CSP-JI targets members 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 MassHealth-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.[165]

In addition to the core CSP Services,[166] CSP-JI includes the following:

- If the referral source is a correctional institution, coordinating with the Behavioral Health for Justice-Involved Individuals (BH-JI) provider conducting in-reach services
- Ensuring that the CSP-JI service plan does not conflict with the member's probation and parole supervision plan, as applicable
- Addressing the member's criminogenic needs in the service plan goals, including interventions and strategies for developing alternative behaviors.[167]

[162] 103 CMR 461.402 Proposed

[163] 130 CMR 461.410.B.4 Proposed

[164] 103 CMR 461.410.C.1 Proposed, nearly verbatim, minor modification to reference core CSP services

[165] STC 15.5.b.ii, page 119, verbatim; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

[166] 130 CMR 461.410.B.4 Proposed

[167] 103 CMR 461.410.C.3 Proposed, nearly verbatim, minor modification to reference core CSP services

CSP Tenancy Preservation Program (CSP-TPP)

CSP-TPP is a specialized CSP service to address the HRSNs of members who are at risk of homelessness and facing eviction as a result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation.[168]

CSP-TPP provides tenancy-sustaining services, including tenant rights education and eviction prevention. In addition to the core CSP services,[169] CSP-TPP services also include:

- Assessing the underlying causes of the member's eviction and identifying services to address both the lease violation and the underlying causes
- Developing a service plan to maintain the tenancy
- Providing clinical consultation services as well as short term, intensive case management and stabilization services to members
- Making regular reports to all parties involved in the eviction until the member's housing situation is stabilized[170]

8.1.3. HRSN Policy Domain Implementation Plans and Timeline[171]

Flexible Services

During the period of the glide path for Flexible Services (i.e., until January 1, 2025), MassHealth will continue to administer the FSP as it did under the prior Demonstration, providing HRSN goods and services allowable in the Special Terms and Conditions (STCs) and in accordance with the HRSN Protocol. During this time, MassHealth will undertake activities to move Flexible Services into the ACO managed care structure. Information regarding that implementation has been incorporated into the HRSN Implementation Plan, the draft of which was submitted to CMS on June 30, 2023.

Specialized CSP

Fee-for-Service (FFS) Implementation

The state has developed programmatic and rate regulations that govern the implementation of specialized CSP services through its FFS delivery system. The state published the proposed regulations (programmatic and rates) for public comment in January 2023, and a public hearing was held on January 31, 2023. Final regulations went into effect in April 2023.

[168] 103 CMR 461.402 Proposed, verbatim

[169] 130 CMR 461.410.B.4 Proposed

[170] 103 CMR 461.410.C.2, nearly verbatim, minor modification to reference core CSP services

[171] Attachment T: HRSN Partial Implementation Plan, verbatim; 1115 MassHealth Demonstration ("Waiver") | Mass.gov

The state also finalized its clinical criteria guidelines for specialized CSP services and developed and finalized specialized CSP provider applications and related materials to enroll FFS providers of specialized CSP services.

Managed Care Implementation

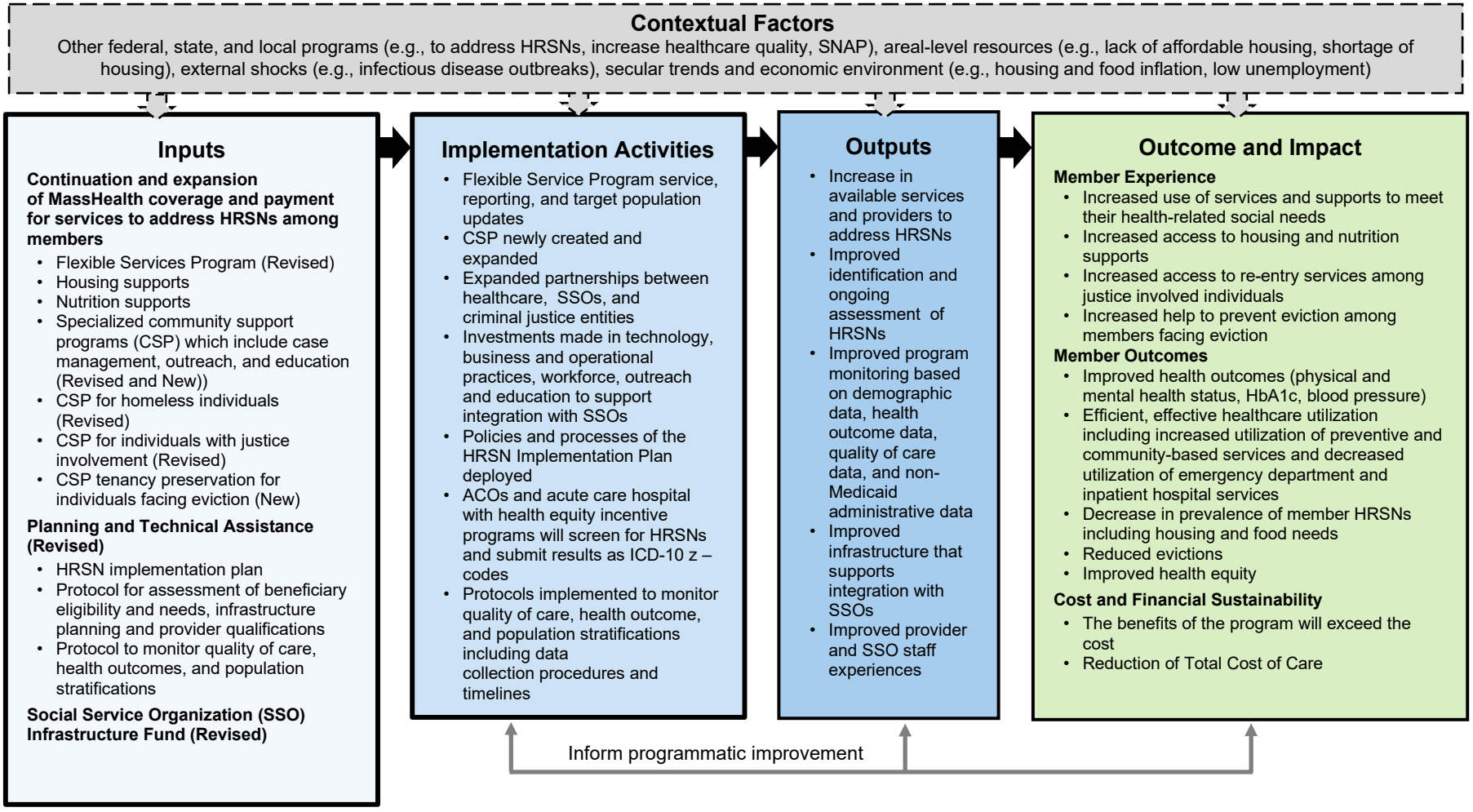
The state developed guidance for managed care plans related to contracting, service delivery, and payment for specialized CSP services. The Commonwealth worked with the managed care plans to develop performance specifications based on this guidance, which aligned to FFS regulations, for implementation in April 2023. The state directed plans to pay at least the rate established for specialized CSP services delivered through FFS. Specialized CSP services were incorporated in managed care contracts and rates, effective in April 2023.

8.2. Logic Model

The HRSN logic model in Figure 8-1 links the Demonstration Goals to the Demonstration Inputs, Implementation Activities, Outputs, and Outcomes and Impact of the Demonstration. The draft RQs and hypotheses that follow are guided by this logic.

Figure 8-1: Logic Model for the HRSN Component of the Demonstration

Goals: (1) Advance health equity, with a focus on health-related social needs and specific disparities; and (2) Continue the path of restructuring and reaffirming accountable, value-based care



8.3. Research Questions and Hypotheses

The RQs and hypotheses focus on assessing the effectiveness of the HRSN services in mitigating the identified needs of MassHealth members.[172] The evaluation will use data on the prevalence of members' HRSNs (RQ7-2, 7-9, 7-12) and the provision of and member utilization of FSP and specialized CSP services (RQ7-7, RQ7-9 - RQ7-12). The RQs assess how the initiatives affect the utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity healthcare, and member physical and mental health outcomes (RQ7-9 - RQ7-12). The evaluation will also assess the effects of the FSP and Specialized CSP in reducing disparities in healthcare (RQ7-16).

The evaluation also assesses the effectiveness of the Social Service Organization (SSO) infrastructure investments to support the development and implementation of FSP (RQ7-13). In addition, the evaluation assesses whether and how FSP and Specialized CSP spending facilitates the development of additional clinical/community linkages for housing and nutrition SSOs (RQ7-14). A cost analysis will provide cost estimates of providing FSP and Specialized CSP services (RQ7-15). The evaluation also includes an 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 (RQ7-10, 7-11).

Table 8-1 provides an overview of the RQs, hypotheses, data sources, study populations, measures, and analytic methods that will be used to evaluate HRSN policies. The elements are described in detail in Section 8.3 Data and Methods.

Table 8-1: Research Questions and Hypotheses for HRSN

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ7-1 What was the prevalence of HRSN screening among ACO/ Managed Care Organizations (MCO) enrolled members and members seen in a hospital over the course of the Demonstration?	**H7-1.1** There was variation in the prevalence of HRSN screening associated with observable member characteristics (e.g., race, ethnicity, language, disability,	Administrative data: Demographics (2018-2027); Eligibility/Enrollment (2018-2027); Screened HRSNs (2018-2027)	ACO/MCO enrolled members (ACO n=~1.3 million; MCO n=~73,000); and members seen in a hospital (Encounter data: members receiving services at CHA n=~6,000; members receiving services at acute private hospitals n=~470,000)	HRSN screening rates (crude and adjusted prevalence ratios) by HRSN type, year, member demographics, ACO/MCO, and hospital	Descriptive Statistics (member); Generalized linear modeling to test for trends and identify factors associated with receiving HRSN screening (member)

[172] STC 17.6 and STC is the basis for narrative of this section;

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	social orientation, and gender identity; RELDSOGI), ACO/MCO, and hospital. **H7-1.2** The prevalence of HRSN screening among ACO/MCO members and members seen in a hospital increased over time.				
RQ7-2 What was the prevalence of HRSN needs among MassHealth members over the course of the Demonstration?	**H7-2.1** MassHealth members had varying levels of HRSN needs by type (housing insecurity, food insecurity, issues with transportation, and issues obtaining utilities) and RELDSOGI demographic group. **H7-2.2** The prevalence of HRSN needs decreased over time.	Administrative data Demographics (2018-2027); Eligibility/Enrollment (2018-2027); Screened HRSNs (2018-2027)	ACO/MCO enrolled members (ACO n=~1.3 million; MCO n=~73,000); and members seen in a hospital (Encounter data: members receiving services at CHA n=~6,000; members receiving services at private hospitals n=~470,000)	Prevalence of HRSN by type, year, and member demographics, ACO/MCO, and hospital	Descriptive Statistics (member); Generalized linear modeling to test for trends and identify RELDSOGI factors associated with HRSN needs (member)
RQ7-3 What were the experiences of members receiving FSP/specialized CSP services, and what was	**H7-3.1** Recipients of FSP/specialized CSP services perceived their HRSN needs as	Interviews or Focus Groups (2024-2025; 2026-2027)	Recipients of FSP and specialized CSP services, member interviewees (n ≤ 30)	Qualitative Interview/Focus Groups (QI)/(FG): Member experience of HRSN screening,	Qualitative (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
their understanding of the programs?	having been effectively identified. **H7-3.2** Members receiving FSP/specialized CSP services were satisfied with their service plans. **H7-3.3** Members receiving FSP/specialized CSP services understood the programs. **H7-3.4** Members receiving FSP/specialized CSP services described how the services they received decreased their HRSN needs. **H7-3.5** Members receiving FSP/specialized CSP services described how services they received improved their physical and/or mental health.			needs assessment, and service plan development Perceived changes in HRSNs and health by members and relationship to FSP/CSP programming; Member experiences of facilitators and barriers to program engagement; Perspective of program utility for members Variation in member experience between sociodemographic groups	

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
RQ7-4 What actions did MassHealth and Key Stakeholders take to implement, operate, integrate, and coordinate HRSN initiatives?	**H7-4.1** MassHealth implemented HRSN services; released policy and procedures and provided operational oversight (monitoring protocols). **H7-4.2** FSP and specialized CSP providers provided services, and in some cases, identified eligible members. **H7-4.3** ACOs/MCOs coordinated (identified, referred, provided care coordination) member services with FSP and specialized CSP providers.	Survey (open-ended questions) (2024, 2026); Interviews or Focus Groups (2024-2025; 2026-2027) Document Review (Ongoing)	MassHealth staff interviewees (H7-4.1) (n ≤ 5-10); FSP and specialized CSP staff interviewees (H7-4.2) (n ≤ 15-20); ACO (FSP+CSP) and MCO (CSP) providers staff and other stakeholder interviewees (staff of housing, justice, and other agencies) (H7-4.3) (n≤60);	QI/FG: Types and perceptions of policies, procedures, and operational oversight provided by MassHealth; Staff reported the type and frequency of information sharing between SSOs and healthcare organizations Staff reported changes to clinical practice associated with HRSN initiatives Variation in implementation workflows and processes for HRSN service delivery; Facilitators and barriers to service delivery; Number of new and continuing reciprocal relationships between SSOs and partner organizations for FSP; Perceptions of partnership formation and coordination	Qualitative (MH member, FSP/CSP staff, ACO staff, MCO staff, provider staff, stakeholders)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				between key stakeholders to deliver programming to members	
RQ7-5 How were members identified for referral to FSP and specialized CSP Providers?	**H7-5.1** Standardized processes and objective criteria were used by ACOs, MCOs, and partnering organizations (e.g., justice entities and housing agencies) for identifying needs, assessing eligibility, and providing referrals for each respective service.	Survey (open-ended questions) (2024, 2026); Interviews or Focus Groups (2024-2025; 2026-2027); Document Review (Ongoing)	ACO/MCO and specialized CSP providers and staff and/or staff of partnering organization interviewees (e.g., justice entities and housing agencies) (n≤60)	QI/FG: Barriers and facilitators to member needs identification, eligibility determination, and referral; Variability in needs identification, eligibility determination, and referral processes	Qualitative (staff)
RQ7-6 What were the FSP/specialized CSP service utilization and cost trends?	**H7-6.1** The service utilization and cost trends vary by HRSN program type and member demographics, comorbidity, and past utilization/cost.	Administrative data: Demographics (2020-2027 for FSP and CSP-HI, 2023-2027 for other specialized CSP); Eligibility/Enrollment (2020-2027 for FSP and CSP-HI, 2023-2027 for other specialized CSP); Claims/Encounters (2020-2027);	Recipients of FSP and specialized CSP services (Housing support n=~3,000 nutrition support n=~11,000; CSP-HI n=~2,000, CSP-JI n=~2,000, CSP-TPP n=500)	FSP and specialized CSP service utilization; FSP and specialized CSP service costs; **Note: All statistics by program type and year*	Descriptive Statistics (member); Generalized linear modeling to identify factors associated with identification/ screening, service utilization, and cost trends (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
		FSP/specialized CSP (2020-2027 for FSP and CPS-HI, 2023-2027 for other specialized CSP)			
RQ7-7 What was the effect of the FSP and specialized CSP services on HRSNs?	**H7-7.1** FSP nutrition supports increase food security. **H7-7.2** FSP TPS increases housing security. **H7-7.3** CSP-HI and CSP-TPP increases housing security. **H7-7.4** CSP-JI increases housing security.	Administrative data: Demographics (2023-2027); Eligibility/Enrollment (2023-2027); HRSNs (2023-2027); FSP/Specialized CSP (2023-2027)	FSP nutrition services recipients (n=~11,000). Comparison groups of referred but not served (n=~1,000) and propensity-balanced non-recipients of services. (H7-7.1) (n= ~11,000); FSP housing services recipients (n=~3,000). Comparison groups of referred but not served (n=~300) and propensity-balanced non-recipients of services (n=~3,000). (H7-7.2) (n~400); Members receiving CSP-HI and CSP-TPP services that are ACO/MCO enrolled or seen in a hospital (H7-7.3) (n=~500-1,000); other members will be studied if data are available; Members receiving CSP-JI services that are ACO/MCO enrolled or seen in a hospital (n=~500-1,000); comparison group of referred but not served (H7-7.4); other	Statuses of respective HRSN needs among FSP and Specialized CSP services recipients	Descriptive statistics (member); Pre/Post comparison (CSP-HI, CSP-TPP) (member); Difference-in-difference model (FSP, CSP-JI) (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
			members will be studied if data are available		
RQ7-8 What was the effect of FSP and specialized CSP on healthcare utilization and cost?	**H7-8.1** FSP and specialized CSP increased efficient, effective healthcare utilization, including (but not limited to) increased utilization of preventive and community-based services and decreased utilization of emergency department (ED) and inpatient hospital service. **H7-8.2** FSP and specialized CSP decreased the total cost of care (TCOC).	Administrative data: Demographics (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP); Eligibility/Enrollment (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP); Claims/Encounters (2020-2027); FSP/Specialized CSP (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP)	Members receiving FSP (Housing support n=~3,000; nutrition support n=~11,000) and specialized CSP services. (specialized CSP: referred and served n=~2,000 per program). Comparison groups of referred but not served (FSP housing n=~300 and nutrition n=~1000; and n=~750 CSP-JI members from select providers who may report these data) and propensity balanced non-recipients of services ((Housing support n=~3,000; nutrition support n=~11,000; specialized CSP n=~2,000 per program)	Utilization PMPM, Cost PMPM by program type and eligibility criteria categories	Descriptive statistics (member); Pre/Post Comparison (CSP-HI, CSP-TPP) (member); Difference-in-Difference Model (FSP, CSP-JI) (member)
RQ7-9 What were the effects of FSP on physical and mental health outcomes?	**H7-9.1**. FSP services improved self-reported physical health. **H7-9.2**. FSP services improved self-reported mental health. **H7-9.3.** FSP nutrition support lowered	Administrative data: Demographics (2023-2027); Eligibility/ Enrollment (2023-2027); FSP (2023-2027)	FSP services recipients (Housing support n=~3,000; nutrition support n=~11,000) (H7-9.1 and H7-9.2). FSP nutrition supports participants with diabetes (n=~3,500). Comparison group of referred but not served members with	Physical health status; Mental health status; HbA1c level; Blood pressure; Self-reported physical health status;	Descriptive statistics (member); Pre/Post Comparison (H7-9.1, H7-9.2, H7-9.6) (member); Difference-in-Difference Model (H7-9.3, H7-9.4 - H7-9.6) (member)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	HbA1c levels among members with diabetes. **H7-9.4**. FSP lowered blood pressure levels among members with hypertension. **H7-9.5** The magnitude of FSP nutrition support services' effects on HbA1c levels among members with diabetes were dependent on the duration of services and, for nutrition support vouchers, the amount of the voucher. **H7-9.6**. Whether the effects of FSP on health outcomes will be sustained beyond the end of services will vary by service type.		diabetes (n=280) (H7-9.3 and H7-9.5); FSP services recipients with hypertension (Housing support n=~2,000; nutrition support n=~5,000). Comparison group of referred but not served members with hypertension (Housing support n=~150; nutrition support n=~ 420); Comparison group of propensity-balanced non-recipients (housing n=~2,000; nutrition n=~5,000)(H7-9.4); See study populations for H7-9.1-4 (H7-9.6)	Self-reported mental health status; HbA1c; Blood pressure See H7-9.1-4	
RQ7-10 Do nutritional FSP services for MassHealth members at risk for nutritional deficiencies achieve better outcomes when	**H7-10.1** Allowing nutritional supports to be delivered to MassHealth members and their households will lead	Administrative data: Demographics (2020-2027); Eligibility/Enrollment (2020-2027);	FSP members receiving nutrition support services for their household (TBD) Comparisons will be made to programs that operated in the	Number of individuals receiving nutritional supports; The total volume of services delivered;	Descriptive statistics (member); Pre/post comparison (member); Difference-in-difference model (member);

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
supports are delivered to MassHealth members and those in their household versus when supports are delivered to members only?	to more nutritional supports being delivered to those in food-insecure households. **H7-10.2** Among members with diabetes who share meals with those in their household, nutritional supports will improve A1c more when delivered to a member and their household versus when delivered to the member only. **H7-10.3** Nutritional supports will reduce food insecurity more when delivered to a member and their household compared with when only delivered to the member.	Claims Encounters (2020-2027); FSP (2020-2027); Member interviews (2024-2025; 2026-2027)	first FSP iteration in which household members did not receive FSP services. As diabetes is rare in children, we will first assess sample size and statistical power to assess feasibility prior to this research aim	A1c; Food insecurity; Member or proxy respondent experiences with and perceptions of nutrition support services delivered to the household	Qualitative: focus groups or interviews (member)
RQ7-11 Were the Social Service Organizations (SSO) infrastructure investments effective in supporting the development and	**H7-11.1**. The infrastructure investments supported the development and implementation of HRSN services.	Qualitative: Survey (2024-2025,2026-2027); Interviews or Focus Groups (2024-2025; 2026-2027); Document Review (Ongoing)	SSOs participating in Flexible Services and specialized CSP providers allocated SSO Integration Funding (n=~25-40)	QI/FG: Number and types of programs implemented by SSOs receiving	Qualitative (SSOs); Descriptive analysis

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
implementation of Flexible Services?				infrastructure investments; Facilitators and barriers to program implementation; Provider and staff perceptions of the value of SSO infrastructure investments to support development and implementation of FSP programming	
RQ7-12 What were the impacts of FSP/specialized CSP Medicaid spending on local investments on comparable services, for example, housing and nutrition?	**H7-12.1.** FSP and specialized CSP Medicaid spending strengthened clinical-to-community linkages and non-Medicaid funding to address HRSNs among FSP and specialized CSP providers. **H7-12.2.** FSP and specialized CSP providers partnered with local and state entities to identify and fill service gaps in HRSN services.	Qualitative Interviews or Focus Groups (2024-2025; 2026-2027); Document Review (Ongoing)	FSP and specialized CSP providers interviewees (n ≤ 35-50) FSP providers survey (n=~40)	QI/FG: Perceived changes in investments in comparable services locally over time; FSP and specialized CSP perspectives of facilitators and barriers to developing clinical-to-community linkages and obtaining non-Medicaid funding to address HRSNs; FSP and specialized CSP perspectives of facilitators and barriers to coordinating with local and state entities to	Descriptive statistics (providers); Qualitative (providers)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
				identify and fill service gaps; Perspectives on changes to the landscape of domain of service delivery (e.g., housing services) as relates to FSP programming initiation and CSP programming changes	
RQ7-13. What were the costs of providing HRSN services?	**H7-13.1.** The costs of providing HRSN services were partially offset by the benefits of these programs in terms of lower costs for healthcare services, for example, decreased costs for emergency room visits and inpatient hospitalizations. H7-13.2 FSP programs were cost-effective when compared to the costs of medications or other healthcare services with known impacts on	Administrative data: Demographics (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP); Eligibility/Enrollment (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP); Claims/Encounters (2020-2027); FSP/specialized CSP (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP)	FSP (Housing support n=~3,000 and nutrition support n=~11,000) and specialized CSP services recipients (n=~2,000 per program)	TCOC; Total costs of FSP services; Blood pressure, HbA1c	Descriptive analysis of program and healthcare costs (program, member); Difference-in-difference model to compare healthcare costs (program, member); Return on investment analysis (H7-13.1); Cost-effectiveness analyses (H7-13.2)

Research Questions[a]	Hypotheses	Data Sources (Evaluation Periods)[b]	Study Populations (Estimated Sample or Population Size- per Wave for Primary Data and per Year for Secondary Data)	Measures	Analytic Methods (Unit of Analysis)[c]
	cardiometabolic biomarkers.				
RQ7-14 To what extent did FSP and specialized CSP reduce health disparities by improving outcomes among demographic groups with a high prevalence of HRSNs?	**H7-14.1** FSP and specialized CSP improved outcomes among demographic groups with a high prevalence of HRSNs (H7-7.1-4).	Administrative data: Demographics (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP); Eligibility/ Enrollment (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP); Claims/Encounters (2020-2027); FSP/specialized CSP (2020-2027 for FSP and CSP-HI, 2022-2027 for other specialized CSP) See RQ7-7 See RQ7-8 See RQ7-9	FSP (Housing support n=~3,000 and nutrition support n=~11,000) and specialized CSP services recipients (n=~2,000 per CSP program): See RQ7 H.1-4 (H14.1); See RQ8 (H14.2); See RQ9 H.1-4 (H14.3)	See RQ7, 10, 11 with outcomes for RELDSOGI categories: See RQ7 (H14.1); See RQ8 (H14.2); See RQ9 H.1-4 (H14.3)	See RQ7-7, 7-8, 7-9: Descriptive analysis (member, demographic groups); Stratified analyses (member, demographic groups); Difference-in-difference model (member, demographic groups)

a. Research Questions developed based on the following STC sections 15.1 – 15.18; 1115 MassHealth Demonstration ("Waiver") | Mass.gov
b. Data sources are described in section 8.4.2 “Data Sources and Collection Methods” and in section 1.4.1 “Summary of Data Sources”
c. Analytic methods are described below in section 8.4.5 “Analysis Methods”

8.4. Data and Methods

8.4.1. Study Populations (Including Comparison Groups)

The study populations vary across research questions (See Table 8-1)

For the RQs that address HRSN screening, prevalence, or referral to HRSN programs (RQ7-1, 7-2, 7-6), the study population will be comprised of MassHealth ACO/MCO enrolled members and members seen in a hospital where these data will be available.

For RQs that address member-level FSP and specialized CSP program outcomes (RQ7-3, RQ7-6 to RQ7-10, 7-14), the study populations will be the members receiving FSP and specialized CSP services. Comparison groups and propensity score-based statistical approaches (e.g., matching, weighting) will be used to estimate the effects of the FSP, CSP-JI, and CSP-HI programs (RQ7-7 to RQ7-10, 7-14). For these RQs, we anticipate using the following comparison groups:

1. MassHealth members screened as eligible, but who never received or were delayed in receiving (e.g., on wait lists) services in the respective HRSN program (FSP and CSP-JI); where possible, we will leverage variation in program implementation to draw comparison groups of individuals who likely would have received services if they had been in a different delivery system
2. MassHealth members who were not screened and did not receive services in the respective HRSN but who closely resemble the individuals who did receive services (FSP)
3. MassHealth members who received FSP at the individual-level and not at the household-level as a comparison group (RQ7-10)
4. To the extent possible, MassHealth members who are homeless and not participating in CSP-HI

For RQs that address process or implementation questions, the study populations will be comprised of providers and staff of the applicable agency or group: MassHealth, FSP and specialized CSP service providers, ACOs, MCOs, justice entities, and/or local and state HRSN service providers (RQ7-4, 7-5, 7-11, and 7-12).

For the cost analysis (RQ7-13), the study population will be comprised of members receiving FSP and specialized CSP services and the staff of the applicable agency: MassHealth, FSP and Specialized CSP service providers, and ACOs/MCOs.

8.4.2. Data Sources and Collection Methods

The evaluation data sources and data collection for the Demonstration are described in Chapter 1 (Executive Summary), Section 1.4. This section also provides additional information on the data sources specific to FSP and specialized CSPs.

MassHealth administrative data will be the source for member HRSNs. We anticipate that HRSN data will be available for the subpopulations of MassHealth members that include ACO/MCO enrolled members and any member that presents to a hospital that contracts and participates in the HQEI (Chapter 7 (Hospital Quality and Equity)) with MassHealth. MassHealth will align its HRSN screening specifications with the CMS Social Drivers of Health screening tool when the final specifications are available. At this time, the MassHealth ACO/MCO contracts specify that the ACOs and MCOs must screen for housing insecurity, food insecurity, issues with transportation, the risk for violence, and issues obtaining utilities, including heating and internet. Identified needs will be submitted to MassHealth in the form of ICD-10 Z-codes on encounters and claims. MassHealth will begin utilizing Z-codes as part of the required HRSN screening in CY2024.

MassHealth administrative data and the Center for Health Information Analysis (CHIA) Enhanced Demographics Data File will be the source for member demographic data, including member race, ethnicity, language, disability, sexual orientation, and gender identity (RELDSOGI). MassHealth administrative RELDSOGI data is currently limited; however, MassHealth has plans to increase the collection of RELDSOGI data to include all members. Data will be collected by ACOs/MCOs and hospitals and it will also be collected as part of the MassHealth eligibility determination process. We expect that the data completeness will increase over time, with race and ethnicity data completeness occurring before data completeness is achieved for language, disability, and SOGI data. MassHealth plans to implement the new data collection activities throughout 2023.

MassHealth administrative data will be used to identify members referred for and who receive FSP services. Through at least the end of CY2024, ACOs will report data to MassHealth including lists of members receiving FSP services by type of service, risk factor (RF) and health needs-based criteria qualifying the individual for services, household level data (if receiving allowable nutritional supports for the household), and baseline plus follow-up data on self-reported mental and physical health, financial stress, food insecurity (if receiving nutritional supports), and their housing situation (if receiving housing supports).

MassHealth administrative data will be used to identify members receiving specialized CSP services. MassHealth will collect per diem services in the form of claims and encounters. A subgroup of CSP-JI providers that are also BH-JI vendors, per their BH-JI Contracts, will submit lists of members who were referred and who received CSP-JI to MassHealth. The list will include data that is not redundant to other MassHealth data collection efforts: demographics, referral source, service start date, service end date, the reason for stopping services, and housing and employment status at the end of services.

Access to administrative data from sources besides MassHealth will be explored, such as from the Department of Transitional Assistance (DTA) and DPH (e.g., for SNAP and WIC enrollment) and the Department of Correction (e.g., for incarceration dates). If available, such data will be useful for describing the characteristics of members,

adjusting for confounding, tracking potential program outcomes, and examining the heterogeneity of program effects.

Qualitative and survey data will be collected via staff surveys, member interviews or focus groups (which may include embedded survey items), staff interviews or focus groups, and document reviews. See Chapter 3 (Delivery System Reform) Section 3.4 Data and Methods for additional details on qualitative data collection methods.

8.4.3. Measures

The measures and methods that will be used to evaluate the FSP and specialized CSPs are listed in Table 8-1 by RQ.

The measures include population or subpopulation level descriptive statistics, for example, frequencies of member demographic characteristics and chronic conditions, HRSN screening rates (RQ7-1), the prevalence of HRSNs (RQ7-2, 7-9), counts of FSP and specialized CSP identification/screening, referrals, service utilization, and program costs (RQ7-7), per-member-per-month (PMPM) healthcare costs (RQ7-8, 7-13), PMPM healthcare utilization (RQ7-8), self-reported physical and mental health status (RQ7-9), biomarkers (RQ7-9, 7-10), and FSP and specialized CSP provider organization descriptive statistics on revenue, programs, and clients served (RQ7-12)

8.4.4. Covariates

For analyses conducted at the individual (member) level using administrative data, we will draw from a consistent set of characteristics, including age, sex, race, ethnicity, language, sexual orientation, gender identity, disability status (either client of the Massachusetts DMH or the DDS, or eligible for Medicaid due to disability), housing problems (e.g., three or more addresses in the year, homelessness by ICD-10 code, identified as homeless or housing unstable from other state data sources), the Neighborhood Stress Score, justice-involvement, the DxCG medical morbidity summary score, and the RxCG drug-based medical morbidity summary score. A narrower set of characteristics may be used for specific analyses as applicable (e.g., subgroup analyses among women would not use sex as a covariate).

Analyses conducted at the ACO level (or that incorporate clustering at the ACO level) will include covariates such as ACO type (academic hospital-anchored, community hospital anchored, physician-anchored), ACO size (number of MassHealth members, number of total enrollees across all payers), region, and experience with risk-based contracts with Medicare and commercial payers. Analyses conducted at the SSO, CSP, and/or FSP level (or that incorporate clustering at those levels) will include number of MassHealth members served, location, and number of years providing flexible services or specialized CSP services for MH members.

8.4.5. Analysis Methods

Mixed qualitative and quantitative methods will be used to answer the RQs of the HRSN policy domain and to evaluate the extent to which Demonstration initiatives and implementation activities advanced health equity and improved outcomes. For

quantitative analyses, we will begin with descriptive statistics by CY to characterize populations with specific HRSNs and the subsets who were screened, referred, and who ultimately received HRSN services. We will conduct multivariable modeling to examine adjusted trends over time and to identify characteristics (e.g., age, RELDSOGI, region, area-level socioeconomic stress) associated with process measures (e.g., screening, referral, starting services, stopping services). Outcome and cost measures will next be described by calendar year among recipients of HRSN services overall and within subpopulations of interest (e.g., with certain conditions or receiving specific HRSN services). As described in Chapter 3 (Delivery System Reform), we will proceed to apply quasi-experimental difference-in-difference methods with propensity-balanced comparisons to examine program effects on outcomes and costs while seeking to address observed sources of bias. Generalized mixed effects linear models will be used for modeling each type of outcome (e.g., dichotomous, continuous, rate) as appropriate and based on observed distributions, with random effects to account for clustering within healthcare organizations, geographic units, and repeated measurements within individuals over time. For the CSP-TPP and some FSP, CSP-HI, and CSP-JI outcomes, we will use a pre/post method to estimate program effects when adequate data are not available to implement comparative analyses.

For RQ7-13, a return on investment and cost-effectiveness analysis will be conducted for the FSP program consistent with the approach described for each in our evaluation design for the 2017-2022 Demonstration.[173]

RQ7-14 will assess the effects of FSP and specialized CSP on health disparities by conducting stratified descriptive and pre-post analyses by RELDSOGI categories and, where feasible, adding interaction terms between program effects and RELDSOGI categories to previously described difference-in-difference models and then calculating effect estimates for each category.

Qualitative methods will be used to assess FSP and specialized CSP members' experiences and understanding of programs (RQ7-3), the actions that MassHealth and key stakeholders took to implement, operate, and coordinate HRSN initiatives (RQ7-4), how members were identified for referral to programs (RQ7-5), whether SSO infrastructure investments were effective in supporting the development and implementation of FSP (RQ7-11), experiences of household level nutrition supports (RQ7-10), and the impacts of FSP and specialized CSP Medicaid spending on local investments in comparable services (RQ7-12). See Chapter 3 (Disability Systems Reform), Section 3.4 Data and Methods, for a description of qualitative analysis methods.

Using an embedded mixed methods approach, we will synthesize the quantitative and qualitative data. We will solicit an in-depth nuanced understanding of various members' experiences, examine how those experiences may be related to HRSN policy and

[173] Commonwealth of Massachusetts. (2022, September 29). *Revised Draft Independent Evaluation Interim Report. Massachusetts Medicaid 1115 Demonstration Extension 2017-2022.* Mass.gov. https://www.mass.gov/doc/cms-approved-interim-evaluation-report/download

practice innovation, and use these findings to explain pertinent trends and outcomes. For example, understanding members' perspectives on HRSN screening and utilization of FSP and specialized CSP services can help contextualize trends seen in utilization and outcomes.[174] Conversely, preliminary quantitative findings from the analysis of data from early in the Demonstration period can generate questions regarding underlying mechanisms that can then be explored in subsequent qualitative data collection and analysis.

8.4.6. Limitations

With the exception of qualitative data from key informant interviews (KII) and document review, which are subject to their own limitations as described in Chapter 3 (Delivery System Reform) Section 3.4, the evaluation of FSP and specialized CSP will rely on MassHealth administrative data (defined broadly to include member-level data reported by HRSN providers and ACOs/MCOs). The traditional MassHealth administrative data (member eligibility/enrollment and claim/encounters) is complete and available for the full Demonstration period; however, RELDSOGI, HRSN, and FSP and specialized CSP program administrative data are not as complete as the traditional MassHealth administrative data. We anticipate that the completeness will improve throughout the Demonstration period and that the MassHealth administrative data will be sufficient to implement the proposed research methods.

At this time, the ACO/MCO contracts specify that the ACOs and MCOs must screen for housing insecurity, food insecurity, issues with transportation, the experience of violence, and issues obtaining utilities, including heating and internet. Hospitals participating in the HQEI are also required to screen for HRSNs. However, we will not have HRSN data available for specialized CSP members in FFS delivery systems and who are not hospitalized. Members are also able to decline to answer any part of the screening. Due to the sensitive nature of screening for experience of violence, these questions are sometimes not asked in the same tool or setting as other questions, and results may be recorded elsewhere. This is important, for example, for ensuring a member is not put in a position of disclosing an experience of violence in front of the perpetrator.

For analyses affected by substantial missing data, we will use one or more missing data methods (e.g., last-observation carry forward, multiple imputation, inverse probability weighting), and if missingness is highly dependent on calendar time, we will perform stratified analyses by time period. We will conduct sensitivity analyses to examine the robustness of findings to alternative assumptions regarding missingness mechanisms and approaches to accounting for missingness. Some analyses may not be sufficiently powered to detect a program impact. For example, for H7-10.2, there may be very few referrals for services delivered at the household level for members with diabetes, and

[174] Creswell, J. W., & Clark, V. L. P. (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: *Sage Publications.*

the feasibility of pursuing this research aim will need to be assessed after examining referral volume.

For members receiving FSP services, ACOs will report baseline and follow-up data on self-reported health, food insecurity (if receiving nutritional supports), and housing insecurity (if receiving housing supports). These data will augment the HRSN data and be used to assess the effects of FSP on food and housing needs. Unlike members receiving FSP services, these data will not be collected specifically for comparison groups or for those receiving specialized CSP services. Blood pressure and HbA1c levels will also be required submissions for ACOs as part of quality measure reporting. We expect that the completeness of member-reported and clinical outcome data will vary across FSP and specialized CSP programs and that the health outcome data will be the most complete for members receiving FSP services. These data will provide outcome data for the FSP comparison group and support the estimation of the effects of FSP on these clinical outcomes. We expect that MassHealth may increase the collection of outcome data for comparison groups and members receiving specialized CSP services during the Demonstration period.

After the end of CY2024, MassHealth may discontinue the baseline and follow-up data collection on self-reported health, food insecurity (if receiving nutritional supports), and housing insecurity (if receiving housing supports) and may discontinue the data collection to identify the comparison group of individuals that are referred to FSP but never participate. If the data collection is discontinued, we will change the data sources used to assess the effects of FSP based on what is available. We will use HRSN screening data before and after FSP participation to assess outcomes, and we will identify comparison groups from the population of MassHealth members with housing and/or food needs who never participated in FSP.

MassHealth administrative RELDSOGI data is currently limited; however, MassHealth plans to increase the collection of RELDSOGI data to include all members. ACOs, MCOs, and hospitals will collect data, and it will also be collected as part of the MassHealth eligibility determination process. We expect that the data completeness will increase over time, with race and ethnicity data completeness occurring before achieving data completeness for language, disability, sexual orientation, and gender identity. MassHealth plans to implement the new data collection activities throughout 2023.

Some program effect estimates (e.g., FSP and CSP-JI effects on HRSNs, healthcare cost, and utilization) will be based on a differences-in-differences model with one or more comparison groups of individuals that were referred to the respective program but did not receive services, and of individuals who were not screened or referred and did not receive HRSN services. Each comparison group is susceptible to potential unobserved sources of selection bias and confounding associated with their status as either screened but did not receive services (e.g., no longer needed the services) or not screened (less access or engagement with the healthcare system). Therefore, we are using propensity score balancing techniques to address confounding and multiple

comparison groups to interrogate the robustness of our findings regarding program effects.

We will also rely on qualitative findings to inform our quantitative analysis protocols and understand how programs are working from the perspectives of members, providers, and program administrators. To the extent that system-level conditions arise whereby members of certain ACOs/MCOs (or residents of certain parts of the state) have differential access to one or another category of HRSN service, we will seek to leverage this natural variation to produce less biased estimates of program effects.

Program effect estimates for CSP-TPP will be based on a pre/post model. This approach is vulnerable to bias if there are unobserved effects of time (e.g., secular trends, other time-varying interventions or confounders) that occur concurrently with the pre/post periods. To address this limitation, we will work with MassHealth to determine if administrative data can be used to define a suitable comparison group.

Appendices

Appendix A: Independent Evaluator Selection, Assurance of Independence, and Qualifications

A.1 Selection of Independent Evaluator and Assurance of Independence

Based on previous performance and familiarity with MassHealth programs, policies, and data systems, Massachusetts (MA) has selected the UMass Chan Medical School (UMass Chan) as the Independent Evaluator (IE) for the 2022-2027 Demonstration. The Independent Evaluation will also be informed by review and guidance from a Scientific Advisory Committee (SAC) and external reviewers comprised of nationally recognized experts in Medicaid systems transformation, program evaluation, and health services research.

As a state agency of the Commonwealth of Massachusetts, UMass Chan is subject to, participates in mandatory training regarding, and complies with, applicable state conflict of interest laws, including Mass. Gen. Laws, Ch. 268A and Ch. 268B. Under those laws and UMass Chan's Conflict of Interest Policy, employees must disclose potential financial conflicts of interest. In an Interdepartmental Service Agreement (ISA) between UMass Chan and MA, UMass Chan employees and agents are prohibited from having financial, personal, or professional interests in conflict with the state; UMass Chan is required to comply with all applicable state and federal requirements governing conflicts of interest; and UMass Chan must report potential conflicts of interest to MA. Further, the ISA for the 2017-2022 Evaluation specifically guaranteed UMass Chan's editorial control over the evaluation and reporting process. An ISA with similar language will be developed for the 2022-2027 Independent Evaluation and will include a statement of "no conflict of interest" that will be signed by the IE.

UMass Chan certifies that, to the best of its knowledge, there are presently no conflicts of interest in performing this work. Any conflicts that arise during the evaluation will be reported to the UMass Chan Conflict of Interest Committee to determine the appropriate course of action to manage or remove the conflict, including reporting the conflict to MA pursuant to the ISA.

UMass Chan will conduct a fair and impartial evaluation and develop independent reports on findings from the Independent Evaluation.

A.2 UMass Chan Resources and Leadership for the Independent Evaluation

Faculty members and staff participating in the Independent Evaluation are drawn from the UMass Chan Department of Population and Quantitative Health Sciences (PQHS), the Research & Evaluation unit of ForHealth Consulting at UMass Chan, and the Department of Family Medicine and Community Health (FMCH) at UMass Chan.

The mission of PQHS is to advance science and improve population health. Formed in 2009, PQHS is located on the UMass Chan campus and includes a broad array of research and evaluation expertise. Several PQHS faculty will play key roles in the

Independent Evaluation: Matthew Alcusky, PharmD, PhD, will serve as Principal Investigator for the IE and will serve as lead researcher for several policy Domains. Elaine Wang, PhD, will serve as PI with Dr. Alcusky and lead several policy Domains. Yara Halasa-Rappel, DMD, PhD, will serve as a Co-PI and Co-evaluation lead for the Behavioral Health and Workforce Initiatives Domains. Jay Himmelstein, MD, MPH, will serve as Senior Policy Advisor for the evaluation and coordinate input from the scientific advisory committee and external reviewers. Arlene Ash, PhD, will serve as the Senior Scientist and advise on advanced analytic methods for the evaluation. PQHS also houses the UMass Chan Quantitative Methods Core (QMC), which provides biostatistical, epidemiological, and other methodological consultation and technical support for research across the campus. Eric Mick, PhD, PQHS faculty and former Assistant Director of the QMC, will lead the statistical team for the Demonstration evaluation.

ForHealth Consulting, formerly known as Commonwealth Medicine, is the public sector consulting arm of UMass Chan. The Research & Evaluation unit of ForHealth Consulting, led by Elaine Wang, PhD, includes UMass Chan faculty and staff with deep experience in evaluating Medicaid and public health programs and routinely partners with health and human services agencies, nonprofits, and other organizations to evaluate program outcomes and support evidence-based policymaking. Yara Halasa-Rappel, DMD, PhD, will serve as a Co-PI and Co-evaluation lead for the Behavioral Health and Workforce Initiatives Domains. Susan Pfefferle, PhD, will serve as Co-PI and lead for the Behavioral Health domain. Jack Gettens, PhD, will serve as Co-Investigator with a focus on the Health-Related Social Needs Domain. The multi-disciplinary researchers in the unit focus on applied research and data analytics using qualitative and quantitative methods. Staff from multiple disciplines leverage education and training in areas such as health policy, social policy, epidemiology, health economics, public health, and sociology. They use a community-participatory approach to collect, generate, analyze, and summarize information that advances policies, programs, and services to a higher level of impact and performance.

The Department of FMCH emphasizes the relationship between clinical practice and community health with a particular focus on serving vulnerable populations by providing clinical care, medical education, and research in health policy. Being one of UMass Chan's founding departments, FMCH works to advance the fitness of populations and communities and advance the needs of the Commonwealth's underserved populations. FMCH faculty will play key roles in the Independent Evaluation as Drs. Susan Pfefferle and Jack Gettens are also faculty of the department.

The Draft Evaluation Design has been informed by review and feedback from the 1115 Demonstration Scientific Advisory Committee (SAC), and additional external reviewers, including nationally recognized experts in Medicaid program evaluation and health services research, convened to ensure scientific rigor and feasibility of the evaluation design. It is anticipated that SAC members and external reviewers will be involved on an ongoing basis to help address evaluation implementation challenges and review evaluation deliverables as appropriate.

A.3 Faculty Leadership and Subject Matter Experts

Matthew Alcusky, PharmD, PhD
Assistant Professor, Department of Population and Quantitative Health Sciences (PQHS)
Principal Investigator and Lead Researcher for Delivery System Reform, Health Related Social Needs, and Hospital Quality and Equity Initiative Domains

Dr. Matthew Alcusky will serve as a Principal Investigator with Dr. Wang and will be responsible for integrating and supporting evaluation efforts across all Demonstration goals. Dr. Alcusky and Dr. Wang will oversee the core research team and faculty investigators and function as the day-to-day scientific liaisons with MassHealth and CMS as needed. Dr. Alcusky and Dr. Wang will regularly meet with MassHealth leadership to oversee workstreams and data access essential for the Independent Evaluation.

Dr. Alcusky is a pharmacoepidemiologist and health services researcher focused on generating evidence from mixed methods data sources to inform clinical practice and guide health policy. His pharmacoepidemiologic research has focused on the study of prescribing patterns, comparative safety and effectiveness, and medication-related healthcare utilization, often in vulnerable segments of the Medicaid and Medicare populations. Dr. Alcusky has a history of working with MassHealth and deep knowledge of their programs. Together with Dr. Ash and Dr. Mick, he develops and refines predictive models for risk adjustment of ACO quality measures and to adjust payments to managed care entities, including the MassHealth ACOs and their primary care providers. He is also developing and implementing methods to set value-based prices for pharmaceuticals to support MassHealth's value-based pricing initiative. He currently serves as a Principal Investigator for the Independent Evaluation of MassHealth's 2017-2022 1115 Demonstration with responsibility for leading the evaluation of the state's Delivery System Reform Incentive Payment (DSRIP) Program.

Ying (Elaine) Wang, PhD
Associate Professor, PQHS and Executive Director, Research & Evaluation, ForHealth Consulting
Principal Investigator and Lead Researcher for the Coverage and Eligibility, Workforce Initiatives, and Safety Net Care Pool Domains

Dr. Elaine Wang will serve as a Principal Investigator with Dr. Alcusky and will be responsible for integrating and supporting evaluation efforts across all Demonstration goals. Dr. Alcusky and Dr. Wang will oversee the core research team and faculty investigators and function as the day-to-day scientific liaisons with MassHealth and CMS as needed. Dr. Alcusky and Dr. Wang will regularly meet with MassHealth leadership to oversee workstreams and data access essential for the Independent Evaluation. She also leads the Coverage and Eligibility and Safety Net Care Pool domains and co-leads the Workforce Initiatives with Dr. Halasa-Rappel.

Dr. Wang is a mixed methods health services and health policy researcher with more than 20 years of policy research experience. She currently serves as the

executive director of Research & Evaluation at ForHealth Consulting. She has deep experience in 1115 Medicaid Waiver evaluation, value-based purchasing programs, and children with special health needs (e.g., those with life-limiting conditions and autism), amongst her other fields of interest. She has led various projects for the Centers for Medicare & Medicaid Services, including leading a Medicare Part D star rating project, developing performance measures for monitoring Medicare Parts C and D plans, and helping create a Qualified Health Plan Quality Rating system. Before joining UMass Chan, Dr. Wang held leadership roles at policy consulting firms, including the American Institutes for Research and IMPAQ International (now merged). She received her doctoral degree from the School of Public Policy at the University of Maryland Baltimore County.

Yara Halasa-Rappel, DMD, PhD
Assistant Professor, PQHS and Senior Project Director, Research & Evaluation, ForHealth Consulting
Co-PI and Co-lead for the Behavioral Health and Workforce Initiatives Domains

Dr. Yara Halasa-Rappel will serve as the Co-PI and Co-evaluation lead for the Behavioral Health and Workforce Initiatives Domains. Dr. Halasa-Rappel has over 18 years of experience conducting health-related research in the United States and internationally. Her research focuses on evaluating healthcare programs and technologies, health financing, and economic evaluation of health and health-related projects. She has experience analyzing the cost-effectiveness of randomized control trials in the U.S. and Africa, in addition to Real-World Data such as enrollment and claims data, electronic medical, and national surveys to inform policy change. As the senior project director of the Massachusetts 1115 DSRIP Demonstration, she estimated the ROI, analyzed data from primary and secondary sources, and coordinated and synthesized findings from the qualitative and quantitative components. Dr. Halasa-Rappel authored over 50 articles and book chapters, including key publications on dengue, oral health, and health financing. She earned her PhD in Social Policy from the Heller School at Brandeis University in Waltham, Massachusetts, her Master of Science in Health Care Policy, Management, and Economics from Bocconi University in Milan, Italy, and her DMD from Aleppo, Syria.

Susan Pfefferle, PhD
Assistant Professor, Department of Family Medicine and Community Health (DFMCH) and Senior Research Scientist, Research & Evaluation, ForHealth Consulting
Co-PI and Lead for Behavioral Health Domain

Dr. Susan Pfefferle will serve as co-PI and lead for the Behavioral Health domain. Dr. Pfefferle has over 20 years of expertise in BH services research, program evaluation, qualitative and mixed methods research, and BH policy. Her studies focus on BH and health services for underserved populations. She has conducted numerous evaluations of programs providing services to Medicaid beneficiaries with SMI and OUD and jail diversion programs with people with BH diagnoses for federal agencies and states. She currently leads the evaluation of the Massachusetts

Behavioral Health Helpline and is a subject matter expert for the evaluation of the BH Roadmap evaluation.

Dr. Pfefferle received a PhD in Social Policy from the Heller School at Brandeis University, where she was a NIMH trainee, and a MEd in Counseling Psychology from the University of Massachusetts. She was a NIMH post-doctoral fellow at Washington University in St. Louis, where she studied the integration of BH services in community health programs.

Joanne Nicholson, PhD
Professor, Institute for Behavioral Health/Schneider Institutes for Health Policy, the Heller School at Brandeis University, and Adjunct Professor of Psychiatry, UMass Chan Medical School
Co-PI and Senior Scientist for Qualitative Studies

Dr. Joanne Nicholson will serve as the lead investigator, providing oversight on all qualitative interviewing, data collection, and analysis efforts, and will contribute to mixed methods approaches to address relevant research questions in the Demonstration evaluation. She serves in a similar role as Co-PI for the 2017-2022 1115 independent evaluation.

Dr. Nicholson is a clinical and rehabilitation psychologist and health services researcher with over 30 years of experience focusing on individuals and families living with BH conditions and disabilities. She is an internationally recognized expert and consultant on adapting treatments and services to meet the needs of families in which parents have mental illness and/or substance use disorders. As an implementation scientist, Dr. Nicholson has led numerous studies of interventions adapted to new target populations or service settings. She currently chairs the Scientific Advisory Group for an EU-funded study to replicate a model intervention for parents with mental illness and their families in eight European countries. She is particularly interested in demonstrating the effectiveness of strategies for changing provider practice and in community engagement in research. She has been the PI/PL on studies funded by NIDILRR, NIH, PCORI, SAMHSA, NSF, private foundations, and industry sources. She consults on PCORI-funded studies currently underway on perinatal health and BH services for Black women, women in rural communities, and perinatal psychiatric consultation. Dr. Nicholson is an invited member of the SAMHSA National Advisory Committee on Women's Services.

A.4 UMass Chan Subject Matter Experts:

Arlene Ash, PhD
Professor and Division Chief, Biostatistics and Health Services Research, Department of Quantitative Health Sciences
Co-Investigator and Consulting Methodologist

Dr. Arlene Ash will serve as a consulting methodologist, providing advice on advanced analytic methods for the evaluation process and outcome measures.

Dr. Ash is professor and division chief for Biostatistics and Health Services Research in QHS at UMass Chan and an internationally recognized methods expert in health services research. She pioneered tools for using administrative data to monitor and manage healthcare delivery systems, including those now used by the Medicare program. Dr. Ash was one of six appointees to the COPSS-CMS white paper project: “Statistical Issues in Assessing Hospital Performance.” Her UMass Chan team has helped MassHealth incorporate social determinants of health into Medicaid/CHIP global payments.

Jack Gettens, PhD
Senior Research Scientist, Research and Evaluation, ForHealth Consulting
Assistant Professor, Family Medicine and Community Health
Co-investigator with a focus on Health-Related Social Needs Domain and Senior Biostatistician

Dr. Jack Gettens will serve as Co-Investigator with a focus on the Health-Related Social Needs Domain. Dr. Gettens has over 15 years of expertise in health services research, program evaluation, and qualitative and quantitative research methods. His studies focus on the healthcare and well-being of people with disabilities, public health, and supports for justice-involved individuals. He currently leads the evaluation of the MassHealth Behavioral Health Supports for Justice-Involved Individuals (BH-JI) program. Dr. Gettens’ recent work includes a mixed method study (focus group, population survey, and claims analysis) of the employment-related health insurance needs of working-age persons with disabilities and a qualitative study assessing how low-income Social Security Disability Insurance participants “make ends meet.” Dr. Gettens received a PhD in Social Policy from the Heller School at Brandeis University.

Kurt Hager, PhD, MS
Instructor, PQHS
Co-Investigator with a focus on Health-Related Social Needs Domain

Dr. Kurt Hager will serve as a co-investigator and content expert in the HRSN domain. His research focuses on the effectiveness of nutritional interventions and policies on chronic disease in the U.S. This includes evaluations of produce prescriptions and medically tailored meals integrated into clinical care that leverage quasi-experimental methods similar to the analyses proposed in the EDD. He has been involved in policy initiatives at the Center for Health Law and Policy Innovation at Harvard Law School and as a steering committee member of the National Produce Prescription Collaborative to advance HRSNs coverage in Medicare and Medicaid. Dr. Hager’s training and research also include policy modeling and implementation science using mixed methods.

Jay Himmelstein, MD, MPH
Professor, PQHS and Family Medicine and Community Health
Co-Investigator and Senior Health Policy Advisor

Jay Himmelstein, MD, MPH, will serve as a senior policy advisor to the 2022-2027 IE and coordinate input from the Scientific Advisory Committee and external

reviewers and will be responsible for communicating and incorporating reviewer feedback into the evaluation design and related deliverables.

Dr. Himmelstein is a professor in the departments of PQHS and FMCH. His professional career in research, policy development, and service has been dedicated to improving healthcare and health outcomes for those served by the public sector. He has placed special emphasis on Medicaid programs and health services for people with disabilities and is a nationally recognized physician, educator, and researcher. Dr. Himmelstein was the PI and executive sponsor for the 2017-2022 IE and has been involved with developing and evaluating Medicaid programs and policies for more than 25 years. He has authored over 100 peer-reviewed articles, chapters, and technical reports. He is an elected member of the National Academy of Social Insurance and has served on review committees for the National Academy of Science and several editorial review boards.

Eric Mick, ScD
Associate Professor of Epidemiology, Department of Population and Quantitative Health Sciences
Co-Investigator and Senior Statistician

Dr. Eric Mick will serve as Co-Investigator and Senior Statistician. Dr. Mick will be responsible for supervising study biostatisticians and for developing, managing, and analyzing the administrative data that will be used to track implementation efforts and outcomes. Dr. Mick will be responsible for translating the research design into clearly documented working code. He will be a member of the overall evaluation leadership team, participating in leadership meetings and coordinating meetings with MassHealth, as appropriate.

Dr. Mick was trained as a psychiatric and genetic epidemiologist, and his methodological areas of interest are epidemiology (descriptive and clinical), analysis of “big-data” (genomic research and administrative databases), and multivariate methods for longitudinal data. His current focus is on informing healthcare delivery reform through risk adjustment modeling of total cost of care (TCOC) and measures of quality.

A.5 Independent Evaluation Scientific Advisory Committee (SAC) and External Reviewers

The MA 1115 Demonstration Scientific Advisory Committee (SAC) and additional external reviewers have provided feedback on the evaluation design and analytic approaches in this Draft Demonstration Evaluation Design Document. SAC members and external reviewers were selected based on their expertise in health services research expertise and methodological experience in evaluating the impact of policy changes on healthcare systems and populations of interest. Reviewers have provided feedback and guidance on the proposed evaluation methods and data sources to ensure that the proposed approaches in the EDD are feasible and meet prevailing standards of scientific and academic rigor.

The SAC will be consulted over the life of this evaluation as scientific advisors and will be asked to review CMS deliverables. The SAC will be available as needed to consult with IE faculty to address potential obstacles to the evaluation and provide guidance relating to specific analyses, interpretation of findings, and may collaborate on reports in the scientific literature.

SAC Members:

K. John McConnell, PhD
Director, Center for Health Systems Effectiveness, Oregon Health & Sciences University

Dr. McConnell has several areas of expertise relevant to this evaluation. He is the principal investigator for the Oregon 1115 Demonstration evaluation team. His health economics research has addressed total costs of care (in the context of provider accountability), displaced cost estimates, and Medicaid quality of care. He has studied the impact of CCO (ACO-type) implementation on coordination, access, quality, outcomes, costs, avoidable care (linked database evaluation), and behavioral and physical healthcare integration in Medicaid populations. Dr. McConnell has also conducted research on costs and outcomes in alternate substance abuse care pathways and developed comparison populations for Waiver evaluation, including interstate data. His current work focuses on understanding the effectiveness of reform of the Medicaid payment and delivery system, with Oregon serving as a leading example.

Dr. McConnell is a health economist and Director of the Center for Health Systems Effectiveness at OHSU. His research has also addressed emergency and trauma care, organizational management, BH, and state health policy.

Deborah Peikes, MPA, PhD
Vice President, Measurement and Evaluation, Blue Cross Blue Shield of Massachusetts

Dr. Peikes's areas of expertise relevant to this evaluation include the impact of alternative primary care models on health outcomes and qualitative studies of healthcare systems. Her expertise includes program evaluation, evaluation of patient-centered medical homes, primary care effectiveness, and integration of care for persons with multiple comorbidities.

Dr. Peikes is a leader in research on value-based care, how to improve the delivery of primary care through the patient-centered medical home and related models of care, care coordination and disease management for people with chronic illnesses, and the health, employment, and social integration of beneficiaries with severe disabilities. Dr. Peikes spent over two decades leading evaluations of some of CMS's leading care delivery and payment reform initiatives as a Senior Fellow at Mathematica Policy Research and was formerly the Vice President of Healthcare Research at Humana. She currently serves on the Board of Governors of the Patient-Centered Outcomes Research Institute.

Rebecca Wells, PhD
Professor, Management, Policy and Community Health, University of Texas School of Public Health

Dr. Wells' experience relevant to this evaluation includes being the principal investigator for the first Texas 1115 Demonstration and DSRIP evaluation. Her expertise includes program and infrastructure change, implementation and performance measures for DSRIP-funded initiatives, BH, substance abuse disorder program effectiveness, and evaluating the impacts of community support services programs.

Dr. Wells is based at the University of Texas Health Science Center (UTHealth) School of Public Health, where she is currently involved in a team-based intervention to improve ambulatory care and a study of intersectoral cooperation. She also serves on the University of North Carolina-based National Maternal and Child Health Workforce Development Center, where she trains public health leaders in facilitating both internal transformation and intersectoral adaptive change.

External Reviewers:

The subject matter experts listed below provided focused reviews on early drafts of specific domain chapters.

Katherine Howitt, MA; Coverage and Eligibility Domain
Director, Massachusetts Medicaid Policy Institute, Blue Cross Blue Shield of Massachusetts Foundation

Ms. Howitt develops and leads the strategic policy and research agenda on MassHealth for the Foundation. She has expert knowledge of Medicaid and MassHealth, healthcare system change, and economics. Previously, she was the associate director of policy at Community Catalyst, responsible for the Medicaid policy agenda. Ms. Howitt contributed her expertise to a review of the Coverage and Eligibility domain.

Michaela Kerrissey, PhD; Delivery System Reform Domain
Assistant Professor of Management, Health, and Policy Management, Harvard T.H. Chan School of Public Health

Dr. Kerrissey researches the work of teams that address problems crossing organizational boundaries in healthcare. She is interested in the innovation and integration of services in organizations. In addition to teaching at the School of Public Health, Dr. Kerrissey offers courses at Harvard University's business and medical schools. Prior to her career in academia, she was a consultant with The Bridgespan Group. Dr. Kerrissey brought her expertise in measuring the integration of healthcare services and survey methods to a review of the Delivery System Reform Domain.

Chris Sheldrick, PhD; Behavioral Health Domain
Research Associate Professor Health Law, Policy & Management, Boston University School of Public Health

Dr. Sheldrick researches screening and clinical decision-making. He has experience developing, implementing, and evaluating screening protocols. He was part of the team that created the Survey of Wellbeing of Young Children and is interested in identifying and helping children with developmental and behavioral needs. Dr. Sheldrick teaches at Boston University and is a recipient of a KM1 fellowship.

Joan Kaijala, MPP; Workforce Initiative Domain
Consultant

Ms. Kaijala is an expert in the health professions workforce, health equity, organizational development, and program management. She has conducted public health leadership trainings, researched and developed a survey of public health professionals, and is working on the development of the New England Rural Health Leadership Training Center. Ms. Kaijala was also involved with the creation of the Massachusetts Health Care Workforce Center and its loan repayment programs. Ms. Kaijala drew on these experiences while reviewing the Workforce Initiative domain.

Additional external reviewers will be added as needed.

Appendix B: Specifications of Quantitative Measures Derived from Existing Sources

B.1 Overview

The table below lists process and outcome measures derived from existing data sources to be used in the quantitative evaluation of Demonstration Chapters 2 through 8. These measures were selected to quantify the Demonstration's effects on healthcare access, program enrollment, care processes, needs identification, integration, healthcare utilization, member outcomes, and healthcare costs.

B.2 Measure Selection

Accountability measures comprising the Massachusetts Executive Office of Health and Human Services (EOHHS) Accountable Care Organization (ACO) Quality and Health Equity and the Community Partner measure slates were selected by MassHealth after iterative feedback from stakeholders in Massachusetts and from CMS. Measures that were not selected by MassHealth for accountability purposes but that were deemed important for evaluating Demonstration policies will also be studied. Additional quality measures were selected from established measure stewards, giving preference to measures that were endorsed by the National Quality Forum (NQF) to study Demonstration effects on processes and outcomes across other important conceptual areas, particularly those included in the evaluation Logic Models. Standard epidemiologic measures (e.g., rates, proportions) will also be calculated to track changes in utilization and costs over the study period. Similar to other state evaluations, measure selection accounts for outcomes specific to this Demonstration.

The measure information in the tables below is organized into seven sections, each corresponding to one policy domain. We have summarized important information for the measures listed in the table, including the steward, NQF measure number (if applicable), NQF endorsement, and national benchmarks from the Centers for Medicare and Medicaid Services (CMS), National Council for Quality Assurance (NCQA), and Agency for Healthcare Research and Quality (ARHQ), if available. Measures operationalized by MassHealth and UMass Chan do not have national benchmarks.

Note: Some measures are repeated across chapters for different populations. The titles of these measures will be included in each chapter where they are being calculated, with a reference to the chapter where the measure details were provided.

Measure Stewards

Measure stewards are recognized as expert organizations involved in developing measure definitions. The stewards used in this evaluation include:

- National Council for Quality Assurance (NCQA): A national nonprofit organization that monitors healthcare quality and accredits health plans. The Healthcare Effectiveness Data and Information Set (HEDIS) developed and maintained by NCQA is a tool used by many American health plans to measure performance on various aspects of healthcare and services provided

- Agency for Healthcare Research and Quality (AHRQ): A federal agency that strives to improve the quality and safety of American healthcare systems
- Choosing Wisely: A national initiative that works with patients and clinicians to avoid wasteful and/or unnecessary healthcare services
- MassHealth: The program that administers Medicaid and the Children's Health Insurance Program in Massachusetts
- Dental Quality Alliance: An alliance established by the American Dental Association to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.

Measure Data

Measure information in this Appendix includes national or state benchmarks where available. CMS benchmarks are presented here at the 50th and 90th percentile. The other benchmarks appear as rates (ARHQ measures) or percentiles. Most measures will be calculated from the following data sources:

- Massachusetts Medicaid Administrative Data: This member-level database is comprised of eligibility, enrollment, and billing records for healthcare services for the MassHealth member population.
- Health Insurance Exchange/Integrated Eligibility Information System (HIX/IES) data: The HIX/IES data set contains Medicaid ID, demographic information, date of enrollment/renewal, whether the individual lost coverage or had their aid category changed after 90 days, and reason for loss of coverage.
- Clinical Information Reported by ACOs: These extracts will include data for hybrid quality measures that require clinical information
- Other: A few evaluation measures utilize data from other sources, such as the Massachusetts Uncompensated Care Cost reports, Safety Net Hospital reports, and program data from MassHealth, as detailed below.

Measure Information by Policy Domain

Chapter 2: Coverage and Eligibility

Measure:	Adult Access to Preventive/Ambulatory Health Services (AAP)
Steward	National Committee on Quality Assurance
NQF Endorsed	No
Description	This measure is used to assess the percentage of members 20 years and older who had an ambulatory or preventive care visit. Medicaid members who had an ambulatory or preventive care visit during the measurement year.
Numerator	One or more ambulatory or preventive care visits during the measurement year
Denominator	Members 20 years of age and older as of December 31 of the measurement year
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Annual Primary Care Visit
Steward	MassHealth
NQF Endorsed	No
Description	Percentage of enrollees 18 to 64 years of age who had an annual primary care visit in the measurement year.
Numerator	Number of enrollees who had at least one primary care visit during the measurement year.
Denominator	Eligible population
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Immunizations for Adolescents (IMA)
Steward:	National Committee on Quality Assurance (#1407)
NQF Endorsed:	Yes
Description	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Numerator	Adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Denominator	Adolescents who turn 13 years of age during the measurement year
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 79.3%

	Source: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/

Measure:	**Primary Care Provider Visit (Children)**
Steward:	Steward: National Committee on Quality Assurance
NQF Endorsed:	No
Description	Percentage of children and adolescents 12 months of age to 19 years of age who had a visit with a primary care practitioner (PCP). Four separate percentages are reported: • Children ages 12 to 24 months of age and 25 months to 6 years of age who had a visit with a PCP during the measurement year. • Children 7 to 11 years of age and adolescents 12 to 19 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Numerator	• For 12 to 24 months of age and 25 months of age to 6 years of age: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year. • For 7 to 11 years of age and 12 to 19 years of age: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year or the year prior to the measurement year. Count all children/ adolescents who had an ambulatory or preventive care visit to any PCP.
Denominator	The eligible population
Data Sources	Medicaid claims/encounters data
National Benchmark	2019 Medicaid HMO = 95.1% https://www.ncqa.org/hedis/measures/children-and-adolescents-access-to-primary-care-practitioners-cap/

Measure:	**Child and Adolescent Well-Care Visits (WCV)** ***MassHealth ACO Monitoring Measure**
Steward:	National Committee for Quality Assurance
NQF Endorsed:	No
Description	The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Numerator	At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the adolescent.
Denominator	The eligible population
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 49.5% Source: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/

Measure:	All Cause Inpatient Admissions
Steward:	MassHealth
NQF Endorsed:	No
Description	Rate of all-cause acute hospital admissions (or observation stays).
Numerator	The number of acute inpatient admissions from any cause.
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	All Cause ED Visits
Steward:	MassHealth
NQF Endorsed:	No
Description	Rate of all-cause ED visits for enrollees 3 to 64 years of age.
Numerator	All ED visits by enrollees 3 to 64 years of age on or between January 1 and December 1 of the measurement year.
Denominator	Enrollees 3 to 64 years of age
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Primary Care Sensitive ED Visits
Steward:	None
NQF Endorsed:	No
Description	Rate of primary care sensitive ED visits for enrollees 3 to 64 years of age.
Numerator	All primary care sensitive ED visits by enrollees 3 to 64 years of age on or between January 1 and December 1 of the measurement year.
Denominator	Person-time contributed by enrollees 3 to 64 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Pediatric ED Visits (All-cause)
Steward	None
NQF Endorsed:	No
Description	Rate of all-cause pediatric ED visits for members under 18 years of age.
Numerator	The observed number of all-cause pediatric ED visits for members under 18 years of age.
Denominator	The person-time contributed by members in the population of interest during the measurement period.

Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Pediatric Hospitalizations (All-cause)**
Steward:	None
NQF Endorsed:	No
Description	Rate of all-cause hospital admissions (and observation stays) for members under age 18.
Numerator	The observed number of all-cause pediatric hospitalizations for members under 18.
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Chapter 3: Delivery System Reform

Measure:	**Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)** ***MassHealth BH CP Quality Measure**
Steward:	National Committee on Quality Assurance (#1932)
NQF Endorsed:	Yes
Description	The percentage of patients 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Numerator	Among patients 18 to 64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.
Denominator	Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 79.2% Source: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

Measure:	**Physician Visit within 30 Days of Hospital Discharge**
Steward:	None
NQF Endorsed:	No
Description	Percentage of hospitalizations for enrollees 18 to 64 years of age where the member received follow-up within 30 days of hospital discharge.

Numerator	Enrollees 18 to 64 years of age who had a follow-up visit within 30 days of hospital discharge.
Denominator	Enrollees 18 to 64 years of age who were hospitalized.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD and FUA-CH)**
Steward:	National Committee for Quality Assurance (#3488)
NQF Endorsed:	Yes
Description	The percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and who had a follow-up visit for AOD. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).
Numerator	The numerator consists of two rates: • 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD, within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. • 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD, within seven days after the ED visit (eight total days). Include visits that occur on the date of the ED visit. These rates are stratified by age (13 to 17, 18 and older, total).
Denominator	ED visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO for follow-up within seven days of ED visit= 11% 2021 Medicaid HMO for follow-up within 30 days of ED visit= 15.9% Source: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/

Measure:	**Follow-Up After Hospitalization for Mental Illness (FUH)** *** MassHealth ACO Quality Measure**
Steward:	National Committee for Quality Assurance (#0576)
NQF Endorsed:	Yes
Description	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

	• The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within seven days after discharge.
Numerator	• 30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. • 7-Day Follow-Up: A follow-up visit with a mental health provider within seven days after discharge
Denominator	Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e., January 1 to December 1) for members 6 years and older.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO for follow-up within seven days post-discharge= 38.4% 2021 Medicaid HMO for follow-up within 30 days post-discharge = 58.7% Source: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Measure:	**Follow-up with CP after Acute or Post-Acute Stay *MassHealth LTSS CP and BH CP Quality Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	The percentage of discharges from acute or post-acute stays for Long Term Services and Supports Community Partner (LTSS CP) enrollees 3 to 64 years of age or Behavioral Health Community partners (BH CP) enrollees 18 to 64 years of age that were succeeded by a follow-up with the LTSS CP or BH CP within (# to be specified) business days of discharge.
Numerator	Discharges for LTSS CP enrollees 3 to 64 years of age or BH CP enrollees 18 to 64 years of age that were succeeded by a follow-up with the LTSS CP or BH CP within 3 business days of discharge.
Denominator	Discharges for LTSS CP enrollees 3 to 64 years of age or BH CP enrollees 18 to 64 years of age during the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Follow-up with BH-CP or Provider after ED Visit *MassHealth BH CP Quality Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of ED visits for enrollees 18 to 64 years of age where the member received follow-up within seven days of ED discharge.
Numerator	Enrollees 18 to 64 years of age who received follow-up care from a BH CP or provider after an ED visit.

Denominator	Enrollees 18 to 64 years of age who had an ED visit in the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Developmental Screening in the First 3 Years of Life *MassHealth ACO quality measure**
Steward:	National Committee for Quality Assurance (#1448)
NQF Endorsed:	No
Description	The percentage of children 1, 2, and 3 years of age who had a developmental screening performed. Three Rates – • Rate 1: Developmental Screening by Child's First Birthday • Rate 2: Developmental Screening by Child's Second Birthday • Rate 3: Developmental Screening by Child's Third Birthday
Numerator	Children who had documentation of a developmental screening (screening for risk of developmental, behavioral, and social delays) using a standardized tool by their first, second, and third birthdays.
Denominator	Children with a visit who turned 1, 2, and 3 years of age.
Data Sources	Hybrid/Medicaid claims/encounters data
National Benchmark	None

Measure:	**Immunizations for Adolescents (IMA)**
Steward:	National Committee on Quality Assurance (#1407)
NQF Endorsed:	Yes
Description	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Numerator	Adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Denominator	Adolescents who turn 13 years of age during the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 79.3% Source: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/

Measure:	**Childhood Immunization Status (CIS) *MassHealth ACO quality measure (pediatric ACOs)**
Steward:	National Committee on Quality Assurance (#0038)

NQF Endorsed:	Yes
Description	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine.
Numerator	Children who received the recommended vaccines by their second birthday.
Denominator	Children who turn 2 years of age during the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO for Influenza: 47.6% 2021 Medicaid HMO for Combination 10: 35.9% 2021 Medicaid HMO for Combination 2: 70.4% 2021 Medicaid HMO for Combination 2: 63% 2021 Medicaid HMO for Diphtheria, Tetanus, Acellular Pertussis (DTaP/DT): 69.7% 2021 Medicaid HMO for Hepatitis B (HEP B): 84.9% 2021 Medicaid HMO for Haemophilis Influenza Type B (HIB B): 82.6% 2021 Medicaid HMO for Inactivated Polio Virus (IPV): 84.7% 2021 Medicaid HMO for Measles, Mumps, Rubella (MMR): 83.1% 2021 Medicaid HMO for Pneumococcal Conjugate (PCV): 70.7% 2021 Medicaid HMO for Varicella (VZV): 82.9% 2021 Medicaid HMO for Hepatitis A (Hep A): 79.9% 2021 Medicaid HMO for Rotavirus (RV): 68.4% Sources: https://www.ncqa.org/hedis/measures/childhood-immunization-status/; NQF.

Measure:	**Prenatal & Postpartum Care (PPC)/ Timeliness of Prenatal Care * MassHealth ACO Quality Measure**
Steward:	National Committee on Quality Assurance (#1517)
NQF Endorsed:	Measure Retired and Endorsement Removed
Description	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Numerator	This measure assesses whether pregnant women had timely prenatal and postpartum care visits. It has two rates, one assessing the timeliness of prenatal visits, and one assessing the timeliness of postpartum visits.

Denominator	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO: 83.5% Source: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/

Measure:	**Topical Fluoride for Children at Elevated Caries Risk** *** MassHealth ACO quality measure**
Steward:	American Dental Association on behalf of the Dental Quality Alliance (#2528)
NQF Endorsed:	Yes
Description	The percentage of Medicaid beneficiaries, between 6 to 14 years of age, who are at elevated risk of caries who received a topical fluoride application and/or sealants at a dental or oral health service within the measurement year.
Numerator	Medicaid beneficiaries 6 to 14 years of age as of the last day of the measurement year, meeting the above eligibility criteria, meets the above criteria for elevated caries risk, and meets the following criteria: - Received a topical fluoride or a sealant as a dental or oral health service (as defined by the NUCC maintained Provider Taxonomy Codes Value Set) during the measurement year.
Denominator	Medicaid beneficiaries aged 6-14 years old as of the last day of the measurement year, meeting the above eligibility criteria, and meets the following criteria for elevated caries risk: • Has a CDT code identifying elevated caries risk in the measurement year OR • Has a CDT code identifying elevated caries risk in any of the three years prior to the measurement year OR • Has a visit with a CDT code ‘D0602’ or ‘D0603’ in the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Asthma Medication Ratio** *** MassHealth ACO quality measure**
Steward:	National Committee for Quality Assurance (#1800)
NQF Endorsed:	Yes
Description	The percentage of patients 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 during the measurement year.

Numerator	The number of patients who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Denominator	All patients 5 to 64 years of age as of December 31 of the measurement year who have persistent asthma by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year: • At least one ED visit with asthma as the principal diagnosis. • At least one acute inpatient encounter with asthma as the principal diagnosis. • At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events. The visit type need not be the same for the four visits. • At least four asthma medication dispensing events for any controller medication or reliever medication.
Data Sources	Medicaid claims/encounters
National Benchmark	2021 Medicaid HMO=64.9% Source: https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/

Measure:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)** *** MassHealth ACO and BH CP Quality Measure**
Steward:	National Committee for Quality Assurance (#0004)
NQF Endorsed:	Yes
Description	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment: The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment: The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Numerator	Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date. Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).
Denominator	Patients 13 years of age and older who were diagnosed with a new episode of AOD dependency during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).
Data Sources	MMIS claims/encounter data
National Benchmark	Initiation: 2021 Medicaid HMO = 43.1%

	Engagement: 2016 Medicaid HMO = 28.4% Source: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/

Measure:	**Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** *** MassHealth ACO Quality Measure (Pediatric ACOs)**
Steward:	National Committee on Quality Assurance (#2800)
NQF Endorsed:	Yes
Description	The percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Numerator	Children and adolescents who received glucose and cholesterol tests during the measurement year.
Denominator	Children and adolescents who had ongoing use of antipsychotic medication (at least two prescriptions).
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 36.6% Source: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/

Measure:	**Antidepressant Medication Management (AMM)** *** MassHealth BH CP Quality Measure**
Steward:	National Committee on Quality Assurance (#0105)
NQF Endorsed:	Yes
Description	The percentage of patients 18 years of age and older with a diagnosis of major depression who were treated with antidepressant medication and who remained on an antidepressant medication treatment. Two rates are reported. • Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). • Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (six months).
Numerator	Adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment.
Denominator	Patients 18 years of age and older with a diagnosis of major depression and who were newly treated with antidepressant medication.
Data Sources	Medicaid claims/encounters data
National Benchmark	Effective Acute Phase Treatment Rate: 2021 Medicaid HMO = 60.8% Effective Continuation Phase Treatment Rate: 2021 Medicaid HMO: 44.1% Source: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/

Measure:	Oral Health Evaluation
Steward:	American Dental Association on behalf of the Dental Quality Alliance (#2517)
NQF Endorsed:	Yes
Description	Percentage of enrolled children under 21 years of age who received a comprehensive or periodic oral evaluation within the reporting year.
Numerator	Unduplicated number of enrolled children under 21 years of age who received a comprehensive or periodic oral evaluation as a dental service.
Denominator	Unduplicated number of enrolled children under 21 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Preventive Care and Screening: Screening for Depression and Follow-Up Plan * MassHealth ACO quality measure
Steward:	Centers for Medicare & Medicaid Services (#0418)
NQF Endorsed:	Endorsement Removed
Description	Percentage of patients 12 years of age and older screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter.
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter.
Denominator	All patients 12 years of age and older at the beginning of the measurement period with at least one eligible encounter during the measurement period
Data Sources	Hybrid
National Benchmark	None

Measure	Enrollment in ACO Care Management Programs
Steward:	None
NQF Endorsed:	No
Description	The percentage of ACO enrollees in care management programs.
Numerator	The number of ACO enrollees who are receiving ACO care management program services.
Denominator	The number of ACO enrollees.
Data Sources	Claims and encounters
National Benchmark	None

Measure	Prevalence of ACO Primary Care Practices by Clinical Tier
Steward:	None
NQF Endorsed:	No
Description	The percentage of ACO primary care practice sites in clinical Tiers 1, 2, and 3 of the primary care sub-capitation program.
Numerator	The number of ACO primary care practice sites in clinical Tiers 1, 2, and 3 of the primary care sub-capitation program.
Denominator	The number of primary care practice sites in the sub-capitation program.
Data Sources	ACO program data
National Benchmark	None

Measure:	Continuity of Primary Care
Steward:	None
NQF Endorsed:	No
Description	A ratio of the number of visits with a member's attributed primary care practice site to the total number of visits with primary care providers.
Numerator	Number of visits with a member's attributed primary care practice site.
Denominator	The eligible population.
Data Sources	Claims and encounters
National Benchmark	None

Measure:	Health Related Social Needs Screening * MassHealth ACO Monitoring Measure
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of members who were screened for health-related social needs in the measurement year.
Numerator	Specification pending
Denominator	Specification pending
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Annual Primary Care Visit * MassHealth CP Quality Measure
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of enrollees 18 to 64 years of age who had an annual primary care visit in the measurement year.

Numerator	Number of enrollees who had at least one primary care visit during the measurement year.
Denominator	Eligible population.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Treatment Plan Completion (BH CP)** *** MassHealth BH CP Quality Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of BH CP enrollees 18 to 64 years of age who completed a treatment plan within the measurement year.
Numerator	Enrollees 18 to 64 years of age who completed a treatment plan.
Denominator	Enrollees 18 to 64 years of age.
Data Sources	Medicaid claims/encounters, analytics vendor extract
National Benchmark	None

Measure:	**Care Plan Completion (LTSS CP)** *** MassHealth LTSS CP Quality Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of LTSS CP enrollees 3 to 64 years of age who completed a care plan within the measurement year.
Numerator	Enrollees 3 to 64 years of age who completed a care plan.
Denominator	Enrollees 3 to 64 years of age.
Data Sources	Medicaid claims/encounters, analytics vendor extract
National Benchmark	None

Measure:	**Oral Health Evaluation (LTSS CP)** *** MassHealth LTSS CP Quality Measure**
Steward:	American Dental Association on behalf of the Dental Quality Alliance (#2517)
NQF Endorsed:	Yes
Description	Percentage of LTSS CP enrollees 3 to 64 years of age who received a comprehensive or periodic oral evaluation within the reporting year.
Numerator	Unduplicated number of LTSS CP enrollees 3 to 64 years of age who received a comprehensive or periodic oral evaluation as a dental service.
Denominator	LTSS CP enrollees 3 to 64 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Post-acute Care Utilization (Adult and Pediatric)
Steward:	None
NQF Endorsed:	No
Description	Rate of post-acute care utilization overall and by type for members in MCEs, ACOs, and MCOs.
Numerator	• Number of discharges where the person used any post-acute care service (inpatient rehab, nursing facility, or home care) in the 14 days after the discharge date. Include utilization on the discharge date and count it as day 0 (so 15 total days from 0-14). • Number of discharges where the person used any institutional post-acute care service (inpatient rehab or nursing facility) in the 14 days after the discharge date. Include utilization on the discharge date and count it as day 0 (so 15 total days from 0-14). • Number of discharges where the person used any home health service in the 14 days after the discharge date. Include utilization on the discharge date and count it as day 0 (so 15 total days from 0-14).
Denominator	The number of eligible index hospital stays (discharges) during the study period (between January 1 and December 17).
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Primary Care Utilization
Steward:	None
NQF Endorsed:	No
Description	Rate of members 0 to 64 years of age who utilized primary care services.
Numerator	Total number of 0 to 64 years of age who utilized primary care services.
Denominator	Person-time contributed among members 0 to 64 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Ambulatory Care Utilization
Steward:	None
NQF Endorsed:	No
Description	Rate of ambulatory care visits among members 0 to 64 years of age.
Numerator	Total number of ambulatory care visits among members 0 to 64 years of age.
Denominator	Person-time contributed among members 0 to 64 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Pharmacy Utilization
Steward:	None
NQF Endorsed:	No
Description	Number of medications used among members 0 to 64 years of age.
Numerator	Number of unique medications used among members 0 to 64 years of age.
Denominator	Members 0 to 64 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Imaging for Low Back Pain (LBP)
Steward:	National Committee on Quality Assurance
NQF Endorsed:	No
Description	Adults 18 to 50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, or CT scan) within 28 days of the diagnosis.
Numerator	The number of patients without an order for or report on an imaging study during the 28 days after pain onset.
Denominator	Adults 18 to 50 years of age with a primary diagnosis of low back pain.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 74.5% Source: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/

Measure:	Inpatient Utilization—General Hospital/Acute Care (IPU)
Steward:	None
NQF Endorsed:	No
Description	Rate of inpatient stays among members 0 to 64 years of age.
Numerator	Total number of inpatient stays.
Denominator	Person-time contributed by members 0 to 64 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Unnecessary C-Section
Steward:	Joint Commission National Quality Measures (#PC-02)
NQF Endorsed:	No
Description	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.
Numerator	Patients with cesarean births.

Denominator	Nulliparous patients delivered of a live-term singleton newborn in vertex presentation.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Plan All-Cause Readmissions (PCR)**
Steward:	National Committee for Quality Assurance (#1768)
NQF Endorsed:	Endorsement Removed
Description	The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.
Numerator	At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.
Denominator	Patients 18 years of age and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 10% Source: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

Measure:	**Acute Unplanned Hospital Admissions**
Steward:	Adapted from Risk-Standardized Acute Admission Rates for Patients with Diabetes (NQF#2887)
NQF Endorsed:	Endorsement removed
Description	The rate of acute unplanned admissions. Calculated separately for adult and pediatric populations.
Numerator	The number of acute unplanned hospital admissions.
Denominator	Person-time contributed by the eligible population.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Hospital Admissions for Ambulatory Care Sensitive Conditions (Chronic ACSCs)**
Steward:	AHRQ
NQF Endorsed:	No
Description	Rate of admissions for members with chronic ACSCs.
Numerator	The number of acute unplanned hospital admissions for adults with chronic ACSCs (or observation stays).

Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Hospital Admissions for Ambulatory Care Sensitive Conditions (Acute ACSCs)**
Steward:	AHRQ
NQF Endorsed:	No
Description	Rate of admissions for members with acute ACSCs.
Numerator	The outcome measure is the observed number of acute unplanned hospital admissions for adults with acute ACSCs (or observation stays) per 1,000-member months at risk for admissions.
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Neonatal Intensive Care Unit Utilization**
Steward:	None
NQF Endorsed:	No
Description	Rate of NICU hospitalizations among live births.
Numerator	The observed number of NICU hospitalizations.
Denominator	The number of live births.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**ED Boarding of Members with BH Conditions**
Steward:	None
NQF Endorsed:	No
Description	The rate of ED visits resulting in boarding among members with BH conditions.
Numerator	The number of ED visits for members with a BH condition with an arrival date and discharge date separated by one or more days (a minimum duration in the ED of 24 hours).
Denominator	The person-time contributed by members of the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions * MassHealth ACO Quality Measure
Steward:	MassHealth
NQF Endorsed:	No
Description	Rate of ED visits for members 18 to 64 years of age identified with a diagnosis of SMI and/or substance addiction.
Numerator	Number of emergency department visits
Denominator	Enrollees 18 to 64 years of age as of December 31 of the measurement year with a diagnosis of serious mental illness and/or substance use disorder
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Maternal Morbidity
Steward:	MassHealth
NQF Endorsed:	No
Description	Specification pending.

Measure:	Controlling High Blood Pressure (CBP-AD) * MassHealth monitoring measure
Steward:	National Committee for Quality Assurance (#0018)
NQF Endorsed:	Yes
Description	The percentage of adults 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
Numerator	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.
Denominator	Patients 18 to 85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 58.6% Source: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/

Measure:	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) * MassHealth ACO Quality Measure
Steward:	National Committee for Quality Assurance (#0059)
NQF Endorsed:	Endorsement Removed

Description	The percentage of patients 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is >9.0% during the measurement year.
Numerator	Patients whose most recent HbA1c level is greater than 9.0%, is missing a result, or for whom an HbA1c test was not done during the measurement year.
Denominator	Patients 18 to 75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 42.3% Source: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/ * Lower rates signify better performance

Measure:	**Total Cost of Care (All Covered Services)**
Steward:	None
NQF Endorsed:	No
Description	Costs of all MassHealth covered services.
Numerator	Costs of all MassHealth covered services (excludes cosmetic surgery, treatment for infertility, experimental treatment, personal comfort items, non-covered laboratory services, and other services specified as not covered by MassHealth).
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Expenditures by Service Category**
Steward:	None
NQF Endorsed:	No
Description	Costs for specific categories (e.g., services included in ACO medical risk corridors) and sub-categories of services including inpatient (e.g., non-maternity physical health, maternity, BH), ED visits, outpatient non-BH (lab and radiology, non-BH outpatient hospital), outpatient BH (e.g., Emergency Services Program, diversionary services), professional services, pharmacy, home health, durable medical equipment, emergency transportation, long-term care, other medical services, and services excluded from the TCOC (e.g., applied behavioral analysis, Children's Behavioral Health Initiative, LTSS).
Numerator	Costs for specific categories and sub-categories of services (calculated separately for each category of service).
Denominator	The person-time contributed by members in the population of interest during the measurement period.

Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Shared Savings and Shared Losses**
Steward:	None
NQF Endorsed:	No
Description	The separate and combined sum of shared savings and losses accrued by: 1. MassHealth 2. ACOs 3. both MassHealth and the ACOs
Numerator	Not applicable
Denominator	Not applicable
Data Sources	Financial reconciliation reports
National Benchmark	None

Chapter 4: Behavioral Health

Measure:	**Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions Stratified by Age (6-17, 18-64) * MassHealth ACO Quality Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	Rate of ED visits for members 18 to 64 years of age identified with a diagnosis of SMI and/or substance addiction.
Numerator	Number of emergency department visits
Denominator	Enrollees 18 to 64 years of age as of December 31 of the measurement year with a diagnosis of serious mental illness and/or substance use disorder
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**ED Boarding (ED LOS >24 hours) for Members with BH Conditions**
Steward:	None
NQF Endorsed:	No
Description	The percentage of ED visits resulting in boarding among members with BH conditions.
Numerator	The number of ED visits for members with a BH condition with an arrival date and discharge date separated by one or more days (a minimum duration in the ED of 24 hours).
Denominator	The person-time contributed by members of the population of interest during the measurement period.

Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Follow-Up After Emergency Department Visit for Mental Illness**
Steward:	National Committee for Quality Assurance (#3489)
NQF Endorsed:	Yes
Description	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).
Numerator	The numerator consists of two rates: • 30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • 7-day follow-up: The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).
Denominator	ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO Follow-up within seven days = 40.1% 2021 Medicaid HMO Follow-up within 30 days = 53.4% Source: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/

Measure:	**Total Cost of Care (All Covered Services) Broken Down by Individuals with Any SUD-related, OUD, or SMI/SED Diagnoses**
Steward:	None
NQF Endorsed:	No
Description	Costs of all MassHealth covered services.
Numerator	Costs of all MassHealth covered services (excludes cosmetic surgery, treatment for infertility, experimental treatment, personal comfort items, non-covered laboratory services, and other services specified as not covered by MassHealth).
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) * MassHealth ACO and BH CP Quality Measure
Steward:	National Committee for Quality Assurance (#0004)
NQF Endorsed:	Yes
Description	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment: The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment: The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Numerator	• Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date. • Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).
Denominator	Patients aged 13 years of age and older who were diagnosed with a new episode of AOD dependency during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).
Data Sources	MMIS claims/encounter data
National Benchmark	Initiation: 2021 Medicaid HMO = 43.1% Engagement: 2016 Medicaid HMO = 28.4% Source: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/

Measure:	Continuity of Pharmacotherapy for Opioid Use Disorder
Steward:	University of Southern California (#3175)
NQF Endorsed:	Yes
Description	Percentage of adults of at least 18 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.
Numerator	Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.
Denominator	Individuals at least 18 years of age who had a diagnosis of OUD and at least one claim for an OUD medication.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
Steward:	National Committee for Quality Assurance (#2605)
NQF Endorsed:	Endorsement Removed
Description	The percentage of discharges for patients 18 years of age and older who had a visit to the ED with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: • The percentage of ED visits for mental health for which the patient received follow-up within seven days of discharge. • The percentage of ED visits for mental health for which the patient received follow-up within 30 days of discharge. • The percentage of ED visits for alcohol or other drug dependence for which the patient received follow-up within seven days of discharge. • The percentage of ED visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge
Numerator	The numerator for each denominator population consists of two rates: Mental Health • Rate 1: An outpatient visit, intensive outpatient encounter, or partial hospitalization with any provider with a primary diagnosis of mental health within seven days after ED discharge. • Rate 2: An outpatient visit, intensive outpatient encounter, or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after ED discharge. Alcohol or Other Drug Dependence • Rate 1: An outpatient visit, intensive outpatient encounter, or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within seven days after ED discharge. • Rate 2: An outpatient visit, intensive outpatient encounter, or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after ED discharge.
Denominator	Patients who were treated and discharged from an ED with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Emergency Department Use for any SUD-related Diagnosis and OUD Diagnosis
Steward:	
NQF Endorsed:	No

Description	ED visits for SUD-related diagnoses and for OUD/1,000 member months for SUD-related and OUD diagnoses.
Numerator	Total number of ED visits for SUD-related and OUD diagnoses.
Denominator	1,000-member months among members with SUD/OUD diagnosis.
Data Sources	MMIS claims/encounter data
National Benchmark	None

Measure:	**Outpatient SUD Services Usage per Month**
Steward:	
NQF Endorsed:	No
Description	Percentage of members with any SUD/OUD diagnosis who used the following per month: • Outpatient SUD services • Intensive outpatient services • Medication-assisted treatment for SUD • Residential treatment (ASAM Level 3.1), including average length of stay • ASAM level 3.3 • Clinical stabilization services (ASAM Level 3.5) • Acute Treatment Services (ASAM Level 3.7) • Inpatient Withdrawal Management • Outpatient detox • Recovery Coach • Recovery Support Navigator
Numerator	Total number of members with any SUD/OUD diagnosis who used any of the listed services per month.
Denominator	Total number of members with SUD/OUD diagnosis.
Data Sources	MMIS claims/encounter data, BSAS program data (if available)
National Benchmark	None

Measure:	**Use of Opioids at High Dosage in Persons Without Cancer**
Steward:	Pharmacy Quality Alliance (#2940)
NQF Endorsed:	Yes
Description	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four or more prescribers AND four or more pharmacies.
Numerator	Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer AND who received opioid prescriptions from four or more prescribers AND four or more pharmacies.

Denominator	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days' supply is greater than or equal to 15.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Inpatient Admissions for any SUD-related Diagnosis and OUD Diagnosis**
Steward:	None
NQF Endorsed:	No
Description	Inpatient admissions for SUD and OUD/1,000-member months for SUD-related and OUD diagnoses.
Numerator	Total number of inpatient admissions for SUD-related and OUD diagnoses.
Denominator	1,000-member months among members with SUD/OUD diagnosis.
Data Sources	MMIS claims/encounter data
National Benchmark	None

Measure:	**Plan All-Cause Readmissions (PCR) for Members with a SUD/SMI/SED Diagnosis**
Steward:	National Committee for Quality Assurance (#1768)
NQF Endorsed:	Endorsement Removed
Description	The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.
Numerator	At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.
Denominator	Patients 18 years of age and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 10% Source: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

Measure:	**Healthcare Utilization**
Steward:	None
NQF Endorsed:	No
Description	Healthcare service utilization among members with SUD diagnosis.
Numerator	Total number of members with SUD and OUD diagnoses who used healthcare services used among members with SUD and OUD diagnoses:

	• Outpatient SUD Professional visits • Inpatient visits • Ambulatory care visits • Other
Denominator	1,000 member months among members with SUD/OUD diagnosis.
Data Sources	MMIS claims/encounter data
National Benchmark	None

Measure:	**Medication for Addiction Treatment (MAT) Prescribers**
Steward:	None
NQF Endorsed:	No
Description	Rate of MAT prescribers per # of members with OUD.
Numerator	Providers who prescribe MAT.
Denominator	N/A
Data Sources	MMIS claims/encounter data
National Benchmark	None

Measure:	**Nonfatal Overdoses, Overall and Opioid-Related**
Steward:	
NQF Endorsed:	No
Description	Percentage of members who had a non-fatal overdose.
Numerator	Total number of all-cause and opioid-related nonfatal overdoses in MassHealth members.
Denominator	Total number of MassHealth members.
Data Sources	MMIS claims/encounter data, Ch. 55 Public Health Dataset
National Benchmark	None

Measure:	**Overdose Deaths, Overall and Opioid-Related**
Steward:	
NQF Endorsed:	No
Description	Percentage of members who had a fatal overdose.
Numerator	Total number of all-cause and opioid-related fatal overdoses in MassHealth members.
Denominator	Total number of MassHealth members.
Data Sources	MMIS claims/encounter data, MA death records
National Benchmark	None

Measure:	Follow-Up After Hospitalization for Mental Illness (FUH) broken down by age (6-17, 18-64) * MassHealth ACO Quality Measure
Steward:	National Committee for Quality Assurance (#0576)
NQF Endorsed:	Yes
Description	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within seven days after discharge.
Numerator	• 30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. • 7-Day Follow-Up: A follow-up visit with a mental health provider within seven days after discharge
Denominator	Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e., January 1 to December 1) for members 6 years and older.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO for follow-up within seven days post-discharge= 38.4% 2021 Medicaid HMO for follow-up within 30 days post-discharge = 58.7% Source: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Chapter 5: Safety Net Care Pool

Measure:	Developmental Screening in the First 3 Years of Life *MassHealth ACO Quality Measure
Steward:	National Committee for Quality Assurance (#1448)
NQF Endorsed:	No
Description	The percentage of children 1, 2, and 3 years of age who had a developmental screening performed. Three Rates – • Rate 1: Developmental Screening by Child's First Birthday • Rate 2: Developmental Screening by Child's Second Birthday • Rate 3: Developmental Screening by Child's Third Birthday
Numerator	Children who had documentation of a developmental screening (screening for risk of developmental, behavioral, and social delays) using a standardized tool by their first, second, and third birthdays.
Denominator	Children with a visit who turned 1, 2, and 3 years of age.

Data Sources	Hybrid/Medicaid claims/encounters data
National Benchmark	None

Measure:	**Immunizations for Adolescents (IMA)**
Steward:	National Committee on Quality Assurance (#1407)
NQF Endorsed:	Yes
Description	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Numerator	Adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Denominator	Adolescents who turn 13 years of age during the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 79.3% Source: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/

Measure:	**Prenatal & Postpartum Care (PPC)/ Timeliness of Prenatal Care *MassHealth ACO Quality Measure**
Steward:	National Committee on Quality Assurance (#1517)
NQF Endorsed:	Measure Retired and Endorsement Removed
Description	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Numerator	This measure assesses whether pregnant women had timely prenatal and postpartum care visits. It has two rates, one assessing the timeliness of prenatal visits, and one assessing the timeliness of postpartum visits.
Denominator	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO: 83.5% Source: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/

Measure:	Preventive Care and Screening: Screening for Depression and Follow-Up Plan *MassHealth ACO Quality Measure
Steward:	Centers for Medicare & Medicaid Services (#0418)
NQF Endorsed:	Endorsement Removed
Description	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter.
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter.
Denominator	All patients 12 years of age and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.
Data Sources	Hybrid
National Benchmark	None

Measure:	Health-Related Social Needs Screening *MassHealth ACO Quality Measure
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of members who were screened for health-related social needs in the measurement year.
Numerator	Specification pending
Denominator	Specification pending
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions *MassHealth ACO Quality Measure
Steward:	MassHealth
NQF Endorsed:	No
Description	Rate of ED visits for members 18 to 64 years of age identified with a diagnosis of SMI and/or substance addiction.
Numerator	Number of emergency department visits
Denominator	Enrollees 18 to 64 years of age as of December 31 of the measurement year with a diagnosis of serious mental illness and/or substance use disorder
Data Sources	Medicaid claims/encounters data

National Benchmark	None

Measure:	**Follow-Up After Hospitalization for Mental Illness (FUH)** ***MassHealth ACO Quality Measure**
Steward:	National Committee for Quality Assurance (#0576)
NQF Endorsed:	Yes
Description	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • Rate 1: The percentage of discharges for which the member received follow-up within 30 days after discharge. • Rate 2: The percentage of discharges for which the member received follow-up within seven days after discharge.
Numerator	30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. 7-Day Follow-Up: A follow-up visit with a mental health provider within seven days after discharge.
Denominator	Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e., January 1 to December 1) for members 6 years and older.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO for follow-up within seven days post-discharge= 38.4% 2021 Medicaid HMO for follow-up within 30 days post-discharge = 58.7% Source: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Measure:	**Controlling High Blood Pressure (CBP-AD)** ***MassHealth Monitoring Measure**
Steward:	National Committee for Quality Assurance (#0018)
NQF Endorsed:	Yes
Description	The percentage of adults 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
Numerator	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.
Denominator	Patients 18 to 85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 58.6%

	Source: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/

Measure:	**Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** *** MassHealth ACO Quality Measure**
Steward:	National Committee for Quality Assurance (#0059)
NQF Endorsed:	Endorsement Removed
Description	The percentage of patients 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is >9.0% during the measurement year
Numerator	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year.
Denominator	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 42.3% Source: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/ * Lower rates signify better performance

Measure:	**Asthma Medication Ratio** ***MassHealth ACO Quality Measure**
Steward:	National Committee for Quality Assurance (#1800)
NQF Endorsed:	Yes
Description	The percentage of patients 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 during the measurement year.
Numerator	The number of patients who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Denominator	All patients 5 to 64 years of age as of December 31 of the measurement year who have persistent asthma by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year: • At least one ED visit with asthma as the principal diagnosis. • At least one acute inpatient encounter with asthma as the principal diagnosis. • At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events. The visit type need not be the same for the four visits. • At least four asthma medication dispensing events for any controller medication or reliever medication.

Data Sources	Medicaid claims/encounters
National Benchmark	2021 Medicaid HMO=64.9% Source: https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/

Measure:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET * MassHealth ACO and BH CP Quality Measure**
Steward:	National Committee for Quality Assurance (#0004)
NQF Endorsed:	Yes
Description	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment: The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment: The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Numerator	• Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date. • Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive).
Denominator	Patients 13 years of age and older who were diagnosed with a new episode of AOD dependency during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).
Data Sources	MMIS claims/encounter data
National Benchmark	Initiation: 2021 Medicaid HMO = 43.1% Engagement: 2016 Medicaid HMO = 28.4% Source: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/

Measure:	**Childhood Immunization Status (CIS) *MassHealth ACO Quality Measure (Pediatric ACOs)**
Steward:	National Committee on Quality Assurance (#0038)
NQF Endorsed:	Yes
Description	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu)

	vaccines by their second birthday. The measure calculates a rate for each vaccine.
Numerator	Children who received the recommended vaccines by their second birthday.
Denominator	Children who turn 2 years of age during the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO for Influenza: 47.6% 2021 Medicaid HMO for Combination 10: 35.9% 2021 Medicaid HMO for Combination 2: 70.4% 2021 Medicaid HMO for Combination 2: 63% 2021 Medicaid HMO for Diphtheria, Tetanus, Acellular Pertussis (DTaP/DT): 69.7% 2021 Medicaid HMO for Hepatitis B (HEP B): 84.9% 2021 Medicaid HMO for Haemophilis Influenza Type B (HIB B): 82.6% 2021 Medicaid HMO for Inactivated Polio Virus (IPV): 84.7% 2021 Medicaid HMO for Measles, Mumps, Rubella (MMR): 83.1% 2021 Medicaid HMO for Pneumococcal Conjugate (PCV): 70.7% 2021 Medicaid HMO for Varicella (VZV): 82.9% 2021 Medicaid HMO for Hepatitis A (Hep A): 79.9% 2021 Medicaid HMO for Rotavirus (RV): 68.4% Sources: https://www.ncqa.org/hedis/measures/childhood-immunization-status/; NQF.

Measure:	**Emergency Department Visits** ***MassHealth ACO Monitoring Measure**
Steward:	National Committee for Quality Assurance
NQF Endorsed:	
Description	Rate of ED visits per 1,000 beneficiary months among children up to age 19.
Numerator	Total number of children up to age 19 who had at least one ED service.
Denominator	1,000 member months among members up to age 19 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** *** MassHealth ACO Quality Measure (Pediatric ACOs)**
Steward:	National Committee on Quality Assurance (#2800)
NQF Endorsed:	Yes
Description	The percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Numerator	Children and adolescents who received glucose and cholesterol tests during the measurement year.
Denominator	Children and adolescents who had ongoing use of antipsychotic medication (at least two prescriptions).
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 36.6% Source: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/

Chapter 6: Workforce Initiatives

Measure:	**Adult Access to Preventive/Ambulatory Health Services (AAP)**
Steward:	National Committee on Quality Assurance
NQF Endorsed:	No
Description	This measure is used to assess the percentage of members 20 years of age and older who had an ambulatory or preventive care visit. Medicaid members who had an ambulatory or preventive care visit during the measurement year.
Numerator	One or more ambulatory or preventive care visits during the measurement year.
Denominator	Members 20 years of age and older as of December 31 of the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	None
Measure:	Hospital Admissions for Ambulatory Care Sensitive Conditions (Chronic ACSCs)
Steward:	AHRQ
NQF Endorsed:	
Description	Rate of admissions for members with chronic ACSCs.
Numerator	The number of acute unplanned hospital admissions for adults with chronic ACSCs (or observation stays).
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Hospital Admissions for Ambulatory Care Sensitive Conditions (Acute ACSCs)**
Steward:	AHRQ
NQF Endorsed:	
Description	Rate of admissions for members with acute ACSCs.

Numerator	The outcome measure is the observed number of acute unplanned hospital admissions for adults with acute ACSCs (or observation stays) per 1,000-member months at risk for admissions.
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Plan All-Cause Readmissions (PCR)**
Steward:	National Committee for Quality Assurance (#1768)
NQF Endorsed:	Endorsement Removed
Description	The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.
Numerator	At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.
Denominator	Patients 18 years of age and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 10% Source: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

Measure:	**Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions** ***MassHealth ACO Quality Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	Rate of ED visits for members 18 to 64 years of age identified with a diagnosis of SMI and/or substance addiction.
Numerator	The expected number of admissions (or observation stays) for members with mental illness and/or SUD and/or co-occurring conditions when adjusting for the ACO case mix.
Denominator	The expected number of admissions (or observation stays) for members with mental illness and/or SUD and/or co-occurring conditions when adjusting for the ACO case mix.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Emergency Department Visits *MassHealth ACO Monitoring Measure
Steward:	National Committee for Quality Assurance
NQF Endorsed:	
Description	Rate of ED visits per 1,000 beneficiary months among children up to 19 years of age.
Numerator	Total number of children up to 19 years of age who had at least one ED service.
Denominator	1,000 member months among members up to 19 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Hospital Admissions for Adults with Mental Illness and/or Substance Addiction
Steward:	
NQF Endorsed:	No
Description	Rate of acute hospital admissions (or observation stays) for members 18 to 64 years of age identified with a diagnosis of SMI and/or substance addiction.
Numerator	The number of hospital admissions for adults with SMI and/or SUD.
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Total Cost of Care (All Covered Services) Broken Down by Individuals with Any SUD-related Diagnosis, OUD Diagnosis, or SMI/SED Diagnosis
Steward:	None
NQF Endorsed:	No
Description	Costs of all MassHealth covered services.
Numerator	Costs of all MassHealth covered services (excludes cosmetic surgery, treatment for infertility, experimental treatment, personal comfort items, non-covered laboratory services, and other services specified as not covered by MassHealth).
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Expenditures by Service Category Broken Down by Individuals with Any SUD-related Diagnosis, OUD Diagnosis, or SMI/SED Diagnosis
Steward:	None
NQF Endorsed:	No
Description	Costs for specific categories (e.g., services included in ACO medical risk corridors) and sub-categories of services including inpatient (e.g., non-maternity physical health, maternity, BH), ED visits, outpatient non-BH ((lab and radiology, non-BH outpatient hospital), outpatient BH (e.g., Emergency Services Program, diversionary services), professional services, pharmacy, home health, durable medical equipment, emergency transportation, long-term care, other medical services, and services excluded from the TCOC (e.g., applied behavioral analysis, Children's Behavioral Health Initiative, LTSS).
Numerator	Costs for specific categories and sub-categories of services (calculated separately for each category of service).
Denominator	The person-time contributed by members in the population of interest during the measurement period.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Chapter 7: Hospital Quality and Equity Initiative

Measure:	Health-Related Social Needs Screening *MassHealth ACO Monitoring Measure
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of members who were screened for health-related social needs in the measurement year.
Numerator	Specification pending
Denominator	Specification pending
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	Childhood Immunization Status (CIS) *MassHealth ACO Quality Measure (Pediatric ACOs)
Steward:	National Committee on Quality Assurance (#0038)
NQF Endorsed:	Yes
Description	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine.

Numerator	Children who received the recommended vaccines by their second birthday.
Denominator	Children who turn 2 years of age during the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO for Influenza: 47.6% 2021 Medicaid HMO for Combination 10: 35.9% 2021 Medicaid HMO for Combination 2: 70.4% 2021 Medicaid HMO for Combination 2: 63% 2021 Medicaid HMO for Diphtheria, Tetanus, Acellular Pertussis (DTaP/DT): 69.7% 2021 Medicaid HMO for Hepatitis B (HEP B): 84.9% 2021 Medicaid HMO for Haemophilis Influenza Type B (HIB B): 82.6% 2021 Medicaid HMO for Inactivated Polio Virus (IPV): 84.7% 2021 Medicaid HMO for Measles, Mumps, Rubella (MMR): 83.1% 2021 Medicaid HMO for Pneumococcal Conjugate (PCV): 70.7% 2021 Medicaid HMO for Varicella (VZV): 82.9% 2021 Medicaid HMO for Hepatitis A (Hep A): 79.9% 2021 Medicaid HMO for Rotavirus (RV): 68.4% Sources: https://www.ncqa.org/hedis/measures/childhood-immunization-status/; NQF.

Measure:	**Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** *** MassHealth ACO Quality Measure**
Steward:	National Committee for Quality Assurance (#0059)
NQF Endorsed:	Endorsement Removed
Description	The percentage of patients 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is >9.0% during the measurement year.
Numerator	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year.
Denominator	Patients 18 to 75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 42.3% Source: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/ * Lower rates signify better performance

Measure:	Prenatal & Postpartum Care (PPC)/ Timeliness of Prenatal Care *MassHealth ACO Quality Measure
Steward:	National Committee on Quality Assurance (#1517)
NQF Endorsed:	Measure Retired and Endorsement Removed
Description	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Numerator	This measure assesses whether pregnant women had timely prenatal and postpartum care visits. It has two rates, one assessing the timeliness of prenatal visits, and one assessing the timeliness of postpartum visits.
Denominator	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO: 83.5% Source: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/

Measure:	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD and FUA-CH)
Steward:	National Committee for Quality Assurance (#3488)
NQF Endorsed:	Yes
Description	The percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and who had a follow-up visit for AOD. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).
Numerator	The numerator consists of two rates: • 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD, within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. • 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD, within seven days after the ED visit (eight total days). Include visits that occur on the date of the ED visit. These rates are stratified by age (13–17, 18 and older, total).
Denominator	ED visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the

	measurement year, where the member was 13 years or older on the date of the visit.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO for follow-up within seven days of ED visit= 11% 2021 Medicaid HMO for follow-up within 30 days of ED visit= 15.9% Source: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/

Measure:	**Follow-Up After Hospitalization for Mental Illness (FUH)** ***MassHealth ACO Quality Measure**
Steward:	National Committee for Quality Assurance (#0576)
NQF Endorsed:	Yes
Description	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within seven days after discharge.
Numerator	30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. 7-Day Follow-Up: A follow-up visit with a mental health provider within seven days after discharge.
Denominator	Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e., January 1 to December 1) for members 6 years and older.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO for follow-up within seven days post-discharge= 38.4% 2021 Medicaid HMO for follow-up within 30 days post-discharge = 58.7% Source: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/
Measure:	Maternal Morbidity
Steward:	MassHealth
NQF Endorsed:	No
Description	Specification pending.

Measure:	**Controlling High Blood Pressure (CBP-AD)**
Steward:	National Committee for Quality Assurance (#0018) *MassHealth Monitoring Measure
NQF Endorsed:	Yes

Description	The percentage of adults 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
Numerator	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.
Denominator	Patients 18 to 85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 58.6% Source: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/

Measure:	**Unnecessary C-Section**
Steward:	Joint Commission National Quality Measures (#PC-02)
NQF Endorsed:	No
Description	Nulliparous women with a term, singleton baby in a vertex position delivered by Cesarean birth.
Numerator	Patients with Cesarean births
Denominator	Nulliparous patients delivered of a live-term singleton newborn in vertex presentation.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions** *** MassHealth ACO Quality Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	Rate of ED visits for members 18 to 64 years of age identified with a diagnosis of SMI and/or substance addiction.
Numerator	Number of emergency department visits.
Denominator	Enrollees 18 to 64 years of age as of December 31 of the measurement year with a diagnosis of serious mental illness and/or substance use disorder.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Emergency Department Visits by Age (Pediatric, Adult)** ***MassHealth ACO Monitoring Measure**
Steward:	National Committee for Quality Assurance
NQF Endorsed:	

Description	Rate of ED visits per 1,000 beneficiary months among children up to 19 years of age.
Numerator	Total number of children up to 19 years of age who had at least one ED service.
Denominator	1,000 member months among members up to 19 years of age.
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Plan All-Cause Readmissions (PCR)**
Steward:	National Committee for Quality Assurance (#1768)
NQF Endorsed:	Endorsement Removed
Description	The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.
Numerator	At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.
Denominator	Patients 18 years of age and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.
Data Sources	Medicaid claims/encounters data
National Benchmark	2021 Medicaid HMO = 10% Source: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

Chapter 8: Health-Related Social Needs

Measure:	**Health-Related Social Needs Screening** ***MassHealth ACO Monitoring Measure**
Steward:	MassHealth
NQF Endorsed:	No
Description	Percentage of members who were screened for health-related social needs in the measurement year.
Numerator	Specification pending
Denominator	Specification pending
Data Sources	Medicaid claims/encounters data
National Benchmark	None

Measure:	**Controlling High Blood Pressure (CBP-AD)** *** MassHealth Monitoring Measure**
Steward:	National Committee for Quality Assurance (#0018)

NQF Endorsed:	Yes
Description	The percentage of adults 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
Numerator	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.
Denominator	Patients 18 to 85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 58.6% Source: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/

Measure:	**Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** ***MassHealth ACO Quality Measure**
Steward:	National Committee for Quality Assurance (#0059)
NQF Endorsed:	Endorsement Removed
Description	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is >9.0% during the measurement year
Numerator	Patients whose most recent HbA1c level is greater than 9.0%, is missing a result, or for whom an HbA1c test was not done during the measurement year.
Denominator	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year
Data Sources	Hybrid
National Benchmark	2021 Medicaid HMO = 42.3% Source: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/ * Lower rates signify better performance

Appendix C: MassHealth Algorithm for Determining Serious Mental Illness (SMI)/ Serious Emotional Disturbance (SEDs)

SMI Algorithm for Adults (18+)	SED Algorithm for Youth (0-17):
At least one acute psychiatric inpatient claim/encounter with any diagnosis of psychotic disorder, bipolar disorder, major depression, or PTSD OR At least two visits to outpatient, IOP, PH, ED, AMCI, or ACCS (different dates of services) with a diagnosis of psychotic disorder, bipolar disorder, or PTSD, with or without a hospitalization OR At least two visits to IOP, Psych Day Treatment PH, ED, AMCI, or ACCS (different dates of services) with a diagnosis of major depression, with or without a hospitalization	At least one acute psychiatric inpatient or CBAT claim/encounter with any diagnosis of psychotic disorder, bipolar disorder, major depression, PTSD, Autism Spectrum Disorder, ADHD, or Conduct Disorder/Oppositional Defiance Disorder OR At least two visits (different dates of service) outpatient, IOP, PH, ED, YMCI, YCCS, or CBHI with a diagnosis of psychotic disorder, bipolar disorder, or PTSD OR At least two visits (different dates of service) IOP, PH, ED, YMCI, YCCS, or CBHI with a diagnosis of major depression, Autism Spectrum Disorder, ADHD, or Conduct Disorder/Oppositional Defiance Disorder
SMI ICD-10 Codes	**SED ICD-10 Codes**
Psychotic Disorders: F20, F200-F205, F208, F2081,F2089, F209, F21-F25, F250, F251, F258, F259, F28, F29, Bipolar Disorders: F30, F301, F3010-F3013, F302-F304, F308, F309, F31, F310, F311, F3110-F3113, F312, F313, F3130- F3132, F314-F316, F3160 -F3164, F317, F3170-F3178, F318, F3181, F3189, F319 Depressive Disorders: F32, F321-F325, F328, F3281, F3289, F329, F33, F331-F334, F3340, F3341, F338-F341, PTSD: F43, F430, F431, F4310 – F4312	Psychotic Disorders: F20, F200-F205, F208, F2081, F2089, F209, F21-F25, F250, F251, F258, F259, F28, F29 Bipolar Disorders: F30, F301, F3010-F3013, F302-F304, F308, F309, F31, F310, F311, F3110-F3113, F312, F313, F3130- F3132, F314-F316, F3160 -F3164, F317, F3170-F3178, F318, F3181, F3189, F319 Depressive Disorders: F32, F321-F325, F328, F3281, F3289, F329, F33, F331-F334, F3340, F3341, F338-F341, PTSD: F43, F430, F431, F4310 – F4312 Conduct Disorders: F630-F632, F638, F6381, F6389, F639, F91, F910-F913, F918, F919, Z72810, Z72811 ADHD: F90, F900 – F902, F908, F909 Autism Spectrum Disorder: F84, F840, F842, F843, F845, F848, F849"
Inpatient: Revenue code between 100 and 219; ED: 99281, 99282, 99283, 99284, 99285, 99288 Or revenue code 450, 451, 452, 456, 459, 981; Outpatient: 95004-95199, 96900-96922, 96999, 99201-99215, 99241-99245, 99341-99350, 99354-99355, 99357-99360, 99366-99368, 99374-99397, 99432, 99450, 99455, 99460, 99499,99401-99405, 99408-99429, 99606, 99607, T1015, 99050-99058, 0500F-0503F, 90918-90925, 97802-97804, 99024, 99078, 99170-99175, 99195-99199, 99500-99599, T1502, T1023-T1026, T1028-T1030, 0001F, G0101-G0122, G0127, G0166-G0168, G0179, G0180-G0182, G0246-G0250, G0257, G0317-G0327, G0344, G0372, G0402, G0438, G0439, G0466-G0470, M0064, M0076, M1204, Q0081-Q0085, S0220, S0265, S0302, S0315-S0320, S0390, S0395, S0601-S0630, S0812, S0820, S2260, S0199, S8110, S9075, S9083-S9090, S9381-S9401,	Inpatient: Revenue code between 100 and 219; ED: 99281, 99282, 99283, 99284, 99285, 99288 Or revenue code 450, 451, 452, 456, 459, 981; CBAT: H0037 or Revenue Code 1001 Outpatient: 95004-95199, 96900-96922, 96999, 99201-99215, 99241-99245, 99341-99350, 99354-99355, 99357-99360, 99366-99368, 99374-99397, 99432, 99450, 99455, 99460, 99499,99401-99405, 99408-99429, 99606, 99607, T1015, 99050-99058, 0500F-0503F, 90918-90925, 97802-97804, 99024, 99078, 99170-99175, 99195-99199, 99500-99599, T1502, T1023-T1026, T1028-T1030, 0001F, G0101-G0122, G0127, G0166-G0168, G0179, G0180-G0182, G0246-G0250, G0257, G0317-G0327, G0344, G0372, G0402, G0438, G0439, G0466-G0470, M0064, M0076, M1204, Q0081-Q0085, S0220, S0265, S0302, S0315-

SMI Algorithm for Adults (18+)	SED Algorithm for Youth (0-17):
S9436-S9474, S9490-S9562, 90791, 90792, 90801-90802, 90804-90824, 90826-90829, 90832-90834, 90836-90847, 90849, 90853, 90855, 90857, 90862-90899, H0001-H0009, H0012-H0014, H0016-H0019, H0021-H0030, H0033-H0034, H0036, H0037, H0041-H0042, H0046-H2010, H2013-H2014, H2016-H2019, H2020-H2037, G0177, 96150-96155, T1007-T1010, H2104, H5300, HIVE2, HJ201, HOOO4, S9475-S9479, S9481-S9483, G0396, G0397, G0410-G0411, G0473, G8466, G8477, G8128, G8467, Q4094, T1006, T1012, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0373T, 0374T; Revenue codes 900-904,910,911,914-919,931,932,944,945,961,1003-1004; Outpatient Diversionary Including Intensive Outpatient, PH, Community Support Services and Psych Day Treatment: H2015 or H2016 with modifier SE or +, S9480, H2012, H0015 H0035, Revenue codes 905, 906, 907; ESP/AMCI: H2011 with or without modifier HO, HN, HB, S9484, S9485 with modifier HB, HE, U1 or plan submits claim as ESP service; ACCS S9485 with modifier ET; PACT: H0039, H0040, Revenue codes 912, 913; Psych Day Treatment: H2012	S0320, S0390, S0395, S0601-S0630, S0812, S0820, S2260, S0199, S8110, S9075, S9083-S9090, S9381-S9401, S9436-S9474, S9490-S9562, 90791, 90792, 90801-90802, 90804-90824, 90826-90829, 90832-90834, 90836-90847, 90849, 90853, 90855, 90857, 90862-90899, H0001-H0009, H0012-H0014, H0016-H0019, H0021-H0030, H0033-H0034, H0036, H0037, H0041-H0042, H0046-H2010, H2013-H2014, H2016-H2019, H2020-H2037, G0177, 96150-96155, T1007-T1010, H2104, H5300, HIVE2, HJ201, HOOO4, S9475-S9479, S9481-S9483, G0396, G0397, G0410-G0411, G0473, G8466, G8477, G8128, G8467, Q4094, T1006, T1012, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0373T, 0374T; Revenue codes 900-904,910,911,914-919,931,932,944,945,961,1003-1004; Outpatient Diversionary Including Intensive Outpatient, PH: S9480, H0015 H0035, Revenue codes 905, 906, 907 CBHI: 90791 or 90801 and modifier HA as 1st or 2nd modifier, H0038, H0023 with modifier HT, T1017 with modifier HN or HO, H2014 with modifier HN or HO, H2019 with modifier HN or HO, H2011 with modifier HN or HO, 96110, H0038; H2011, H2014, H2019, T1017 with modifier HN or HO; T1027 with modifier EP, H0023 with modifier HT Outpatient ABA: H0031, H0032, H2012,or H2019 and modifier U2 YMCI: S9485 with modifiers HA HE, HA U1; H2011 with modifier HA, HE, HO, HN, HO, and HA, or HA U1, HN, and HA YCCS: S9485 with modifier HA ET, EF, TG

Title page for the Commonwealth's Health-Related Social Needs Implementation Plan

State	Massachusetts
Demonstration Name	"MassHealth" Medicaid and Children's Health Insurance Program (CHIP) Section 1115(a) Demonstration Project Numbers 11-W-0030/1 and 21-00071/1
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Section 1. Introduction

This Health-Related Social Needs (HRSN) Implementation Plan describes the activities that Massachusetts will undertake to implement the HRSN services authorized through the MassHealth demonstration (see Special Terms and Condition (STC) 15). Massachusetts currently provides (or will begin providing in 2025) HRSN services through four programs, as detailed in the HRSN Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications (Attachment P):

- Flexible Services,
- Specialized Community Support Program (CSP) - including Specialized CSP services for Homeless Individuals (CSP-HI), Tenancy Preservation (CSP-TPP), and Individuals with Justice Involvement (CSP-JI),
- Emergency Assistance Family Shelter Program, and
- Short Term Pre-Procedure and Post-Hospitalization Housing (STPHH).

Beginning on January 1, 2025, MassHealth will combine the administration of these services into an aligned HRSN Services program as set forth in Table 1, which will include the domains of:

- Housing-related services
    - HRSN Housing – includes CSP-HI, CSP-TPP, and Flexible Services housing services
    - HRSN Temporary Housing Assistance – includes rent/temporary housing through the Emergency Assistance (EA) Family Shelter program
    - HRSN Medical Respite – includes STPHH
- HRSN Nutrition – includes Flexible Services nutrition services, and
- HRSN Justice Involved – includes CSP-JI.

Organizations and individuals providing these services will be considered "HRSN providers." MassHealth will continue to delineate the different service types within these new categories. Certain services will only be available to members who meet certain criteria such as enrollment in Accountable Care Organizations (ACOs) and MassHealth benefit type, as set forth in Table 1. Other services will be available to all MassHealth members, except MassHealth Limited.

Table 1. HRSN Service Categories and Populations Served

HRSN Service Category	Applicable Services	Delivery System Availability	Non-Eligible MassHealth Benefit Type
HRSN Housing	CSP-HI	All Plans[1] and Fee For Service	MH Limited

[1] "All Plans" refers to Accountable Care Organizations (ACOs) (which includes both Accountable Care Partnership Plans and Primary Care ACOs), Managed Care Organizations (MCOs), Primary Care Clinician (PCC) Plan, Senior Care Options (SCO) Plans, One Care Plans, and MassHealth's managed care behavioral health plan.

	CSP-TPP	All Plans and Fee For Service	MH Limited
	Flexible Services Housing	ACO only	N/A
HRSN Temporary Housing Assistance	EA Family Shelter Program	Service provided by EOHLC	MH Limited
HRSN Nutrition	Flexible Services Nutrition	ACO only	N/A
HRSN Medical Respite	STPHH	All Plans and Fee For Service	MH Limited
HRSN Justice Involved	CSP-JI	All Plans and Fee For Service	MH Limited

This reorganization will not change the nature of the services delivered in any domain, or the populations for which such services are available, but will streamline administration of the program from the state and managed care plan perspectives. MassHealth may further define clinical criteria and eligibility as described in Section 2.B.3. MassHealth will clarify the availability of the service to providers and members.

This implementation plan sets forth MassHealth's plan for implementing Specialized CSP, Flexible Services, and STPHH beginning in January, 2025 under the new combined HRSN Services program, and HRSN Temporary Housing Assistance beginning in April 2024.

Section 2. Identifying Members with HRSN and Determining Eligibility

A. Screening and Identification of Members for HRSN Services

1. Specialized CSP (April 1, 2023 – December 31, 2024)

CSP has been provided through MassHealth's managed care delivery systems for over a decade and, under prior demonstration periods, was expanded to include particular domains when delivered to individuals experiencing chronic homelessness (CSP-CHI) and justice involvement (CSP-JI). As a result, CSP and its specialized counterparts are well known within the behavioral health continuum of care in the Commonwealth.

CSP-JI, itself, was implemented following a 2019 state-funded pilot program, known as Behavioral Health Supports for Justice Involved Individuals (BH-JI), that successfully expanded state-wide in February 2022. CSP-JI provides community supports to eligible members after release from incarceration or detention and for individuals on probation or parole. CSP-JI complements the state-funded BH-JI program, which includes in-reach activities that take place in correctional facilities prior to participants' release. As a result, CSP and its specialized counterparts are well known within the behavioral health continuum of care in the Commonwealth.

Specialized CSP benefits under the current demonstration (CSP-HI, CSP-JI, and CSP-TPP) are available to all eligible Medicaid beneficiaries, except individuals enrolled in MassHealth Limited, in both managed care and fee-for-service (FFS) delivery systems.

Identification of potentially eligible members comes through referrals from care coordination entities (e.g., care management programs within ACOs, Managed Care Organizations (MCOs), and the Community Partners program), behavioral health providers, and community-based organizations. For example, many providers of Specialized CSP services are, or are affiliated with, community mental health centers or providers of services to members experiencing homelessness that, in the course of their work, interact with and may identify potentially eligible members for Specialized CSP services. Additionally, county and state correctional facilities, Probation staff, and Parole staff identify members who may be eligible for CSP-JI.

In addition to referrals from providers and community-based organizations, MassHealth's ACOs and MCOs conduct regular care needs and HRSN screenings to identify members with unmet social or health needs for referral to appropriate supports, including Specialized CSP.

2. Flexible Services (April 1, 2023 – December 31, 2024)

ACOs identify potentially eligible members for Flexible Services through a variety of methods such as: analyzing ACO data; referrals from Community Partners or other community-based organizations; and through referrals of providers or through utilization of health care (e.g., during PCP, inpatient, or ED visits). Once members are identified, ACOs conduct HRSN housing and nutrition screenings to determine eligibility for services. Members ultimately screened as qualifying for these housing and nutrition supports are referred to a Social Services Organization (SSO), housing or nutrition community-based organizations that provide Flexible Services, or an internal ACO program to provide the Flexible Services that address their HRSN(s).

3. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

MassHealth expanded HRSN housing supports and related services to include rent/temporary housing with room and board for up to six months for MassHealth-eligible pregnant individuals and families with children who are experiencing homelessness, participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program,[2] and demonstrate qualified clinical criteria. The EA program is operated by the Massachusetts Executive Office of Housing and Livable Communities (EOHLC or HLC). The EA program has been in place for several decades. As a result, EA is well known within the homelessness continuum of care in the Commonwealth.

To receive HRSN Temporary Housing Assistance, families and pregnant individuals enrolled in the EA program must also be enrolled in a full-scope MassHealth benefit (i.e., a benefit other than MassHealth Limited), and meet clinical and health-related social risk factors as set forth in Attachment P (Section E.3 and Table 7).

MassHealth anticipates that identification of potentially eligible members will come through referrals from care coordination entities (e.g., care management programs within Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs), and the Community Partners

[2] 760 CMR 67.00 Eligibility for Emergency Assistance (EA), https://www.mass.gov/doc/760-cmr-67-1/download

program), other state benefit agencies (e.g., the Department of Transitional Assistance, EOHLC staff, or the Department of Public Health), and community-based organizations. For example, many providers of EA services are, or are affiliated with, providers of services to members experiencing homelessness that, in the course of their work, interact with and may identify potentially eligible members for EA services.

4. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

In January 2025, identification of potentially eligible members for the HRSN services described above will continue to be completed by a combination of mechanisms, as described above, including:

- referrals from community-based organizations, including homeless providers, housing organizations, justice involved agencies, etc.
- referrals from justice involved agencies, including houses of corrections and departments of corrections.
- referrals from other state benefit agencies, including the Department of Transitional Assistance (DTA) and the Department of Public Health (DPH).
- referrals from health care providers, such as physicians, hospitals, community health centers, behavioral health providers, etc.
- referrals from managed care entities, including ACOs and MCOs, Community Partner organizations, or as a result of an HRSN screening or through other identification mechanisms such as those discussed above.
- referrals from EA providers, shelter and transitional housing providers

HRSN Medical Respite services will launch in January 2025 and include short-term pre-procedure and/or post-hospitalization housing, with room and board, for individuals experiencing homelessness, involving a lower-intensity care setting for individuals who would otherwise lack a safe option for discharge or recovery after hospitalization, or to prepare for certain procedures.

Post-hospitalization services through HRSN Medical Respite will be available to eligible members that have been admitted to an acute care hospital's medical or surgical service or have presented to an acute care hospital's emergency department with a medical or surgical issue. As such, identification of eligible members for this service will be conducted by staff in emergency departments and inpatient units at acute inpatient hospitals.

Pre-procedure services through HRSN Medical Respite will be available to members experiencing homelessness who have a referral for a colonoscopy procedure or a colonoscopy procedure scheduled within one day of admission to the HRSN Medical Respite service site and cannot prepare for the colonoscopy effectively due to not having consistent access to a private bathroom. MassHealth anticipates that identification of potentially eligible members will come through referrals from care coordination entities (e.g., care management programs within Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs), and the Community Partners program), direct healthcare staff (e.g., community health centers, physicians, nurses, etc.) and community-based organizations. For example, many anticipated HRSN Medical Respite providers are, or are affiliated with, providers of services to members

experiencing homelessness that, in the course of their work, interact with and may identify potentially eligible members for HRSN Medical Respite services.

B. Determination of Beneficiary Eligibility

1. Specialized CSP (April 1, 2023 – December 31, 2024)

The eligibility criteria for Specialized CSP services are set forth in Attachment P (Section C.3). MassHealth has published medical necessity guidelines that align with the criteria set forth in Attachment P (Section C.3, Table 4). MassHealth requires all plans administered by a managed care entity (see Table 1) to adopt clinical eligibility criteria for Specialized CSP services that are no more restrictive than those set by MassHealth. The guidelines are maintained on MassHealth's website[3] and are available through the managed care plans' aligning program specifications.

MassHealth has established unique code/modifier combinations for Specialized CSP services in its FFS regulation[4] and requires managed care plans to adopt MassHealth's coding conventions for these services. MassHealth has also issued guidance to Specialized CSP providers and managed care plans regarding requirements related to the use of Z59 secondary diagnosis codes to reflect social determinants of health needs faced by members, as appropriate. The Specialized CSP service regulations[5] and rate regulations as well as aligning guidance for managed care entities[6] became effective in April 2023.

2. Flexible Services (April 1, 2023 – December 31, 2024)

The eligibility criteria for Flexible Services are set forth in Attachment P (Sections B.1 and B.2 and Table 1). ACOs use these criteria to determine beneficiary eligibility.

3. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

The eligibility criteria for HRSN temporary housing assistance include the categories as set forth in Attachment P (Section E.3 and Table 7). HLC determines eligibility for participation in the EA Family Shelter Program. MassHealth determines eligibility using the criteria in Attachment P for purposes of its certified public expenditure claiming on these services. Specifically, MassHealth will use members' EA case record and MassHealth claims and encounter data to determine whether a member meets the eligibility criteria. As part of the assessment and service planning activities described below, EA program staff will document social and clinical risk data in members' EA case records. Healthcare providers will submit claims for MassHealth covered services provided to members. MassHealth will administratively determine whether members meet eligibility criteria for HRSN Temporary Housing Assistance using both social and clinical risk data collected by EA program staff and claims and encounter data. To ensure that eligibility screenings are conducted at least annually, MassHealth will limit the lookback period for claims and encounters and case record analysis to data that was recorded within 12 months of the date that the eligibility determination occurs. EA program staff update the clinical and social risk

[3] See https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-community-support-program/download
[4] See 101 CMR 362.00.
[5] See 130 CMR 461.00.
[6] See Managed Care Entity Bulletin 99.

portion of members' EA case records on a bimonthly basis as part of ongoing case management activities, as described in Attachment P (Section E.1).

4. HRSN Housing, Nutrition, Temporary Housing Assistance, Medical Respite, and Justice Involved (Effective January 1, 2025)

Eligibility for HRSN Services will be determined as set forth in Attachment P (Section B.6, D.3, E.3, and F.3). MassHealth will develop, as necessary, new or updated medical necessity guidelines for certain HRSN services to establish clinical criteria for services, as further described below. Rescreening members to ensure they still meet the eligibility criteria for the HRSN services must occur at least once per year, depending on the program and service.

For most services, ACOs and providers will be responsible for determining if a member meets the service eligibility criteria, depending on the service.

Section 3. Assessment, Service Planning, and Cultural Competence

A. Process for Developing Care Plans based on Assessment of Need

1. Specialized CSP (April 1, 2023 – December 31, 2024)

Specialized CSP providers are required to initiate service planning immediately upon intake, including communicating with the referral source, if any, determining goals, and documenting appropriateness of services. During the initial appointment, providers are required to start a needs assessment, which is described in Attachment P (Section C.1). The needs assessment informs the creation of an individualized Specialized CSP service plan, which is described in Attachment P (Section C.2). Providers are required to review and update both the needs assessment and the service plan with the member at a regular cadence specified by MassHealth and when the member has significant changes to their health or health-related social needs.

Providers are also required to ensure that staff receive documented training to enhance the quality and cultural competence of services delivered and broaden their skills related to the provision of Specialized CSP services. Training topics may include topics such as cultural competence and trauma informed care, among others. MassHealth has also made customized trainings available to Specialized CSP providers. For example, a set of trauma-informed trainings has been developed that specifically address working with the justice-involved population, particularly subpopulations and members with different backgrounds.

2. Flexible Services (April 1, 2023 – December 31, 2024)

Flexible Services will continue to operate as described in Attachment P (Sections B.1 and B.2) through December 31, 2024, including assessment and service planning processes. Additionally, ACOs are required to work with SSOs that have a demonstrated cultural competency, trauma-informed response, and adequate resources to address the needs of a diverse population (e.g., bilingual staff, staff with lived experience, or plans to contract with vendors with such staff).

3. Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

For members receiving HRSN Temporary Housing Assistance, the EA Family Shelter provider conducts the assessment and service planning, as described in Section E.1 and Section E.2 of Attachment P.

EA program staff are expected to ensure that staff receive training that enhances the quality and cultural competence of services delivered and broaden their skills related to the provision of temporary housing assistance services. Training topics may include topics such as cultural competence and trauma-informed care, among others.

4. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (January 1, 2025)

a. On January 1, 2025, providers of HRSN Housing (CSP-HI and CSP-TPP). Specialized CSP, HRSN Temporary Housing Assistance, and HRSN Justice Involved services will continue to be required to utilize the assessment and service planning approach set forth above in Section 3.A.1-3. For HRSN Nutrition services and some HRSN Housing services (i.e., Flexible Services Housing), either the ACO or the HRSN Provider will conduct the assessment and service planning.

b. Once the services launch in January 2025, for members receiving HRSN Medical Respite, the providers will conduct the assessment and service planning. The provider will complete an individualized care plan for every member receiving HRSN Medical Respite services upon completion of the comprehensive baseline needs assessment. The provider regularly reviews the individualized care plan, including, at a minimum, after each comprehensive assessment, and updates it, as necessary. The individualized care plan identifies the member's needs, goals, and priorities, and includes planned treatments, strategies and interventions to support the member's goals. The individualized care plan is developed in consultation with the member and the member's chosen support network and incorporates available records from referring and existing providers and agencies when appropriate.

As stated in Section 3.A.1-3, all HRSN providers will be required to ensure that staff receive documented training to enhance the quality and cultural competence of services delivered and broaden their skills related to the provision of HRSN services.

Section 4. Referrals to Services

A. Specialized CSP (April 1, 2023 – December 31, 2024)

Specialized CSP services include coordinating services and assisting members with obtaining benefits, housing, and healthcare and collaborating with crisis intervention and other outpatient providers. Specialized CSP providers directly connect members to community-based agencies for assistance with housing, employment, recreation, transportation, education, social services, health care, and legal services. To that end, Specialized CSP providers have knowledge of and connections with resources and services available to members and employ effective methods to promptly and efficiently refer members to health care and community-based resources.

Specialized CSP providers are required to have written policies and procedures for addressing a member's behavioral health needs. Policies and procedures must minimally include personnel, referral, coordination, and other procedural commitments to address the referral of members to the appropriate health care providers. This could include referrals to other MassHealth services

or providers such as Community Behavioral Health Centers, MassHealth long term services and supports (LTSS), and other covered medical and dental services. When appropriate, providers work with BH or LTSS Community Partners or the Flexible Services Program. When referring a member to another provider for services, Specialized CSP providers are required to ensure continuity of care, to exchange relevant health information, and to avoid service duplication between the Specialized CSP provider and the provider to whom a member is referred. Specialized CSP providers are required to ensure that the referral process is completed successfully and documented.

B. Flexible Services (April 1, 2023 – December 31, 2024)

Flexible Services will continue to operate as described in Attachment P (Section B.1 and B.2) through December 31, 2024.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

HRSN Temporary Housing Assistance providers offer care management, outreach, and education including linkages to other state and federal benefit programs, and benefit application assistance. EA program staff directly connect members to community-based agencies for assistance with stable community-based housing, employment, recreation, transportation, education, social services, health care, and legal services. To that end, EA program staff have knowledge of and connections with resources and services available to members and employ effective methods to promptly and efficiently refer members to health care and community-based resources.

When referring a member to other services, EA program staff are required to ensure continuity of care, to exchange relevant information, and to avoid service duplication between the EA program staff and the provider to whom a member is referred.

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

a. For HRSN Housing, Temporary Housing Assistance, Nutrition, and Justice Involved services, providers will continue to be required to provide the referral supports delineated in Section 4.A-C above. MassHealth will work with managed care plans and providers, to coordinate on outreach and education to referring entities and members regarding any public changes in names of HRSN services, as applicable, and consider strategies to best clarify how these services will continue in this phase. HRSN Providers that are solely responsible for providing Flexible Services (e.g., medically tailored meals, housing goods, and home modifications) will be required to refer members back to the ACO if additional needs have been identified. These providers will be required to have written policies and procedures for working with ACOs. Policies and procedures must minimally include personnel, referral, coordination, and other procedural commitments to address the referral of members back to the ACO.
b. For HRSN Medical Respite, providers will provide case management services, which includes coordinating with and facilitating connections with other providers, as well as formal and informal supports, as appropriate. Providers will also provide health and referral navigation services, which includes facilitating member access to primary care, other community and home-based health care services and equipment (e.g., Durable

Medical Equipment), coordinating referrals, when appropriate, providing assistance with member self-administration of medications and setting up and scheduling appointments, transferring health information to providers, addressing external barriers to receiving and engaging in services, and partnering with MassHealth CSP-HI providers to deliver intensive housing navigation services.

Section 5. Technical Assistance, Quality Improvement, and Sustainability Planning

A. Specialized CSP (April 1, 2023 – December 31, 2024)

MassHealth has provided ongoing training and technical assistance to new FFS Specialized CSP providers. As providers enroll in the FFS delivery system, MassHealth is engaged in direct provider support and continually explores opportunities to develop forums for collaboration, including peer-to-peer learning opportunities. MassHealth also leverages the existing BH-JI infrastructure for technical assistance, quality improvement, and sustainability planning for CSP-JI providers.

Managed care plans have developed and implemented performance specifications based on MassHealth's guidelines to govern the activities of their contracted providers. These performance specifications include requirements related to quality improvement. Managed care plans have quality assurance processes and are expected to support providers in meeting the needs of enrolled members in accessing Specialized CSP services.

MassHealth is confident about the sustainability of the Specialized CSP services model. Predominantly, the Specialized CSP services are based on pre-existing services provided by existing providers under the MassHealth program. For example, MassHealth has operated a form of CSP-HI for chronically homeless individuals through managed care for almost a decade. In addition, MassHealth launched its CSP-JI services in 2022 after successful implementation of BH-JI, a state-funded program that was launched initially in 2019 as a pilot in two counties and has since been expanded statewide. Finally, the CSP-TPP program is modeled after a successful program operated by the state's housing finance agency, MassHousing, in partnership with HLC. The experience provided by these predecessor programs, along with the established nature of the provider network, provides assurance for the sustainability of these services under the Demonstration.

B. Flexible Services (April 1, 2023 – December 31, 2024)

Flexible Services will continue to operate as outlined in Attachment P (Section B) through December 31, 2024.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

HLC is committed to ensuring that EA providers are implementing best practices. To that end HLC teams support EA providers through ongoing technical assistance for all components of service delivery. Office hours are offered by HLC teams monthly, which allows for troubleshooting and technical assistance, and regional team staff provide technical assistance and training with providers when areas of improvement are identified.

HLC ensures quality improvement in the EA system through regular engagement with EA providers. Formal program evaluations are completed annually to verify contract compliance. Program policies are reviewed and updated as needed to ensure a high quality of services.

MassHealth is confident about the sustainability of the HRSN temporary housing assistance model because the EA program has operated in the Commonwealth for several decades, as described in Section 2.A.3. The experience provided by these decades of operation, along with the established nature of the provider network, provides assurance for the sustainability of these services under the Demonstration.

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

In anticipation of the recategorization of HRSN services in 2025, MassHealth established the HRSN Integration Fund to provide financial support and technical assistance to qualified HRSN providers. MassHealth posted the opportunity to apply in 2024 and anticipates awarding funds in early 2025. The HRSN Integration Fund will support HRSN providers as they undertake various initiatives, including but not limited to, transitioning into managed care (e.g., changes to workflows, provider enrollment, system updates), adopting electronic referral, creating new partnerships, and developing workforce. Specific categories of support are laid out in Attachment P (Section C.1).

Technical assistance and learning communities have been and will continue to be available to HRSN providers. For example, as MassHealth did for Specialized CSP providers newly enrolled with MassHealth as FFS providers, in 2024 MassHealth offered support to first-time HRSN providers in obtaining the knowledge and skills necessary to operate as MassHealth providers. MassHealth will continually engage HRSN providers through 2027 to ensure successful delivery of services. MassHealth will work with providers on understanding the transition to the HRSN framework, including changes to existing service names and communicating those changes to members and referring entities.

The demonstrated stability and longevity of the Specialized CSP services and HRSN Temporary Housing Assistance, noted above in Section 5.A and 5.C respectively, supports the sustainability of the new combined HRSN services model envisioned by MassHealth. MassHealth will leverage the experiences of establishing Specialized CSP services as benefits in managed care and FFS as it moves towards a sustainable model of combined HRSN services.

HRSN Medical Respite will be a new service launching in January 2025. Prior to launch, MassHealth used funds available through the American Rescue Plan Act (ARPA) to award grants to 5 agencies to operate homeless medical respite programs. MassHealth used the learnings from this grant program, as well as findings from a formal evaluation, to help inform and shape the design and structure of the new HRSN Medical Respite services. In preparation for the launch of the HRSN Medical Respite service, MassHealth will work with the ARPA grantees, as well as other potential Medical Respite providers, to ensure that they have the knowledge and skills necessary to operate as MassHealth providers.

Section 6. Data Sharing[7]

A. Specialized CSP (April 1, 2023 – December 31, 2024)

The Commonwealth has 11 homeless Continuums of Care (CoCs) as well as the EA family shelter system administered by HLC. Each of these CoCs and the EA system utilize separate Homeless Management Information Systems (HMIS). The Commonwealth has implemented a statewide HMIS data warehouse that aggregates HMIS data from all sources, and deduplicates it. MassHealth currently has access to deidentified data from this warehouse, which can be used to identify characteristics of people experiencing homelessness, trends, and emerging themes.

Additionally, MassHealth entered into a data sharing agreement to receive ongoing data exports from the HMIS data warehouse. Specifically, on a weekly basis, MassHealth receives a list of those members who are experiencing homelessness (i.e., received services from an emergency shelter, safe haven, transitional housing program, day program, or homeless outreach agency) as documented in the HMIS data warehouse, with a special flag for those members who have been experiencing homelessness for at least six months and may therefore be eligible for continuous MassHealth eligibility.

Furthermore, over the past several years, MassHealth has grown its partnerships with justice agencies, and now has close collaborations with the Executive Office of the Trial Court, the Executive Office of Public Safety and Security (especially the Department of Correction and Parole Board), and the 14 county Sheriff's Offices. For example, MassHealth worked with the Massachusetts Probation Service to pilot a program in participating courts where Probation staff support probation-involved individuals in applying for MassHealth coverage. These partnerships assist the State in ensuring pathways to Specialized CSP services for eligible members and assist the State in monitoring the CSP-JI program.

B. Flexible Services (April 1, 2023 – December 31, 2024)

For the Flexible Services Program, MassHealth will continue to work with ACOs to collect member-level data on a quarterly basis of members that have received Flexible Services. ACOs and their SSO partners are expected to share appropriate data on members being screened and referred to services. MassHealth collects the screening and referral data at an aggregate level on a semi-annual basis.

Additionally, MassHealth has worked closely with the state agency that oversees the Supplemental Nutrition Assistance Program (SNAP) on efforts to share data to close the "SNAP Gap", as further described in Section 8.B, as well as the state agency that oversees the Women, Infants, and Children Nutrition Program (WIC) on efforts to close the "WIC Gap".

[7] In the time period from April 1, 2023 to December 31, 2024, Specialized CSP Providers utilize a care needs assessment and service plan to document beneficiary eligibility, screening results, plans of care, and referrals. For Flexible Services, ACOs and SSOs utilize a Flexible Services Plan to capture the same information. Specialized CSP services are documented through claims, whereas Flexible Services are documented through reporting from SSOs to ACOs, as well as through invoices. MassHealth expects these processes to continue into 2025 but is currently exploring potential opportunities for integrating the two approaches.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

MassHealth entered into a data sharing agreement to receive ongoing data exports from HLC. Each quarter, certain identifying information of all participants in the EA program are matched against MassHealth enrollment records to determine which individuals are enrolled in a full MassHealth benefit program. MassHealth also uses HLC clinical assessment data, collected by EA program staff as part of the assessment and service planning process, as part of the data that may be used to determine clinical eligibility, as described in Section 3.A.3.

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

In 2025, MassHealth will continue the collaborations with the Massachusetts agencies described above in Section 6.A-C. Additionally, MassHealth intends to implement an HRSN electronic referral platform that ACOs, hospitals, primary care providers, and other referring entities can use to electronically refer members with identified HRSNs to HRSN providers to address those needs. This platform would also facilitate a "closed feedback loop" process, where HRSN providers could communicate the outcomes of those HRSN referrals (e.g., whether services were provided and impact of those services on the identified HRSNs) back to ACOs, hospitals, and other referring entities. This platform will allow MassHealth to centrally track HRSN referrals and outcomes when such referrals are made. MassHealth anticipates launching the electronic referral platform in 2027. MassHealth will provide technical assistance related to the platform to ACOs, hospitals, and primary care providers, and through the HRSN Integration Fund, MassHealth will also provide infrastructure funding and technical assistance to HRSN providers. MassHealth has received approval for an Advanced Planning Document in support of state IT system implementation costs for this HRSN electronic referral platform.

Section 7. Partnerships

A. Specialized CSP (April 1, 2023 – December 31, 2024)

Specialized CSP services do not include funding to pay for housing for members, such as rent. As a result, member access to housing is not contingent on Demonstration authority and is not at risk due to the conclusion of Demonstration services. Nevertheless, forging partnerships with state and local entities that provide housing benefits is essential to the success of Specialized CSP services.

To that end, MassHealth has developed extensive partnerships with state and local entities, including housing and homeless agencies. Many homeless and housing agencies previously leveraged MassHealth CSP-CHI services to provide tenancy sustaining services to formerly homeless members residing in permanent supportive housing. In addition, during the COVID-19 pandemic, many CoCs targeted new Emergency Housing Vouchers to those people experiencing homelessness that were eligible for CSP-CHI. Similarly, MassHealth is party to a Memorandum of Understanding with HLC that prioritizes members receiving CSP-HI services for housing units created through the Section 811 Supportive Housing for Persons with Disabilities program and the Community Based Housing program. CSP-HI has been able to leverage housing opportunities, serving as the "support" in permanent supportive housing.

Additionally, MassHealth has developed extensive partnerships with state and local entities, including criminal justice agencies. Over the past years, the majority of referrals to BH-JI (and now also to CSP-JI) came from correctional facilities, Probation, and Parole offices. BH-JI providers, who provide in-reach services in correctional facilities through a state-funded program, are required to provide warm handoffs to CSP-JI providers for individuals exiting correctional facilities.

See additional information in Section 6 of the Implementation Plan regarding data sharing and collaborations with other state, local, and community-based entities.

Finally, MassHealth engaged in a regulatory promulgation process for Specialized CSP that included publication of programmatic and rate regulations, a formal public comment period, and a public hearing. MassHealth reviewed all comments received through this process prior to finalizing its regulations.

B. Flexible Services (April 1, 2023 – December 31, 2024)

The development of the Flexible Services program helped agencies across the Commonwealth connect medical and community-based organizations. Specifically, the program encouraged and facilitated health care providers, health plans, and SSOs to partner together to deliver services to members. MassHealth worked with multiple state housing agencies to educate ACOs about the housing programs in the state and the SSOs that support them. Likewise, MassHealth worked with the housing programs to educate SSOs about ACOs and the Flexible Services Program. As of November 2024, this work led to over 20 different housing organizations working with ACOs to offer over 60 Flexible Services housing programs.

MassHealth has also developed strong partnerships with several state agencies that support residents experiencing nutrition insecurity. In particular, as further discussed in Section 12, MassHealth has been a key player in a cross-agency Food Security Taskforce for the past three years. These relationships have allowed MassHealth to foster stronger connections between ACOs and the SNAP and WIC programs in support of members connecting to additional state resources, which may continue even after their Flexible Services conclude.

Through its work on implementing the Flexible Services program, MassHealth and the Department of Transitional Assistance (DTA) have built on their relationship to improve member connections to SNAP and to close the "SNAP Gap". For example, MassHealth and DTA worked together to add a checkbox on the MassHealth application to allow individuals to apply for SNAP at the same time they applied for MassHealth.

The Massachusetts Department of Public Health (DPH), the Massachusetts state agency that administers the Women, Infant, and Children Nutrition Program (WIC), and MassHealth worked together to educate providers on state-funded nutrition services and ensure members were utilizing services where applicable. Like the process previously described for ACOs and SNAP, ACOs also refer members to WIC. When a member's Flexible Services end, WIC may still be available.

DPH, in partnership with MassHealth, also administered the SSO Preparation Fund in the previous waiver period. This fund was an infrastructure grant that supported SSOs in ramping up and participating in Flexible Services. DPH also provided technical assistance and learning communities. MassHealth and DPH worked closely throughout this time to ensure the success of

the grant program, technical assistance, and learning communities. MassHealth will continue collaborating with DPH in various forms through the implementation of the HRSN Integration Fund (discussed above in Section 5.B).

Finally, MassHealth and other state agencies collaborated to facilitate ACOs and nutrition SSOs to work together to deliver nutrition Flexible Services. This led to new partnerships between the ACOs and nutrition SSOs. As a result of these partnerships, as of November 2024, over 35 nutrition organizations are providing services to over 60 nutrition programs with ACOs.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

Through HRSN Temporary Housing Assistance and other HRSN programs such as CSP-HI, MassHealth has established a strong partnership with HLC, which operates and oversees the EA family shelter program. To operate the EA family shelter program, HLC contracts with various community-based providers to offer temporary housing assistance. Additionally, it established extensive partnerships with state and local entities such as DTA, DPH, and the Department of Children and Families (DCF), which also provide a range of supportive services to families and pregnant individuals in the EA family shelter program.

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

The existing partnerships between health care providers, managed care plans and community-based organizations that have been created over the past several years will serve as a strong foundation for delivering HRSN services and ensuring successful relationships between MassHealth, plans, and future HRSN providers.

For HRSN Medical Respite, the service requires a formal partnership between a CSP-HI provider and a licensed medical provider – relying on the expertise from each agency in meeting the housing and healthcare and social needs of members experiencing homelessness. This service also requires strong partnerships with staff at acute medical inpatient facilities, who will be responsible for referring members to the HRSN Medical Respite services. MassHealth anticipates that this service will both enhance and build upon existing relationships and foster new ones. Finally, MassHealth engaged in a regulatory promulgation process for Medical Respite that included publication of programmatic and rate regulations, a formal public comment period, and a public hearing. MassHealth reviewed all comments received through this process prior to finalizing its regulations.

Section 8. Information Technology Infrastructure

A. Specialized CSP (April 1, 2023 – December 31, 2024)

Specialized CSP services are billed through regular claims processes and infrastructure for both FFS and managed care. MassHealth uses claims and encounter data to understand the beneficiaries served and the amount and duration of services provided. Claims and encounter data also support program monitoring and evaluation. Data about consent, screening, and referrals for Specialized CSP are required to be included in the member's medical record.

As part of a broader MassHealth initiative to advance health equity, MassHealth will be targeting improvements in collection of member information such as Race, Ethnicity, Language,

Disability, Sexual Orientation, Gender Identity (RELDSOGI) and Health-Related Social Needs by ACOs and MCOs and hospitals, as well as through the MassHealth application process. More complete data will allow for better monitoring of access and utilization and help identify gaps in HRSN services. (See e.g., MassHealth's Performance Year 1 Hospital Quality and Equity Initiative Implementation Plan and Performance Year 2-5 Hospital Quality and Equity Initiative Implementation Plan)

In addition, MassHealth leverages the Homeless Management Information System (HMIS) data sharing agreement mentioned previously to learn more about the housing status of members who receive these services.

B. Flexible Services (April 1, 2023 – December 31, 2024)

Flexible Services will continue to operate as it has under the prior demonstration period and as specified in Attachment P until December 31, 2024. This includes collecting member-level data on a quarterly basis on the utilization of Flexible Services via an SFTP-based submission process.

As discussed in Section 7.B, the Commonwealth has taken measures to streamline the process for SNAP and MassHealth applications. This option has improved MassHealth members' experience and is anticipated to increase the share of Medicaid members who are eligible for and enrolled in SNAP.

Additionally, in 2020 and 2021, MassHealth worked with DTA to develop a data sharing agreement that allowed the two agencies to create ACO-specific SNAP Gap lists. These lists were then distributed to each ACO to improve outreach efforts to close the SNAP Gap.

Between 2023 and 2024, MassHealth and DTA are seeking to create regular ACO SNAP Gap reports to provide ACOs. Additionally, MassHealth and DPH are exploring solutions to help minimize the "WIC gap," (i.e., MassHealth members who are eligible for, but not enrolled in, WIC). With these efforts, MassHealth hopes to better identify members in the SNAP and WIC gaps and the impact of HRSN screening and referrals on these gaps, and support ACOs' efforts in closing these gaps.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

HRSN Temporary Housing Assistance costs, service delivery, and eligibility data are captured through several sources. The costs of the services are recorded in the Massachusetts Management, Accounting, and Reporting System (MMARS), which is the official accounting system of the Commonwealth. Service delivery information including member demographics, duration of services, and assessments come from HLC's case management reporting systems which include Effort of Outcome (ETO), End to End (E2E)/Salesforce, and IEDM/RevTech. Finally, to determine eligibility, MassHealth uses member enrollment data and claims and encounters from various MassHealth data systems.

Additionally, MassHealth has received approval for an implementation Advance Planning Document to support a cloud-based case management system that will support EA applications and eligibility determinations, placements and ongoing case management services for program participants, in addition to reporting and analytics to ensure that the program is meeting CMS and Commonwealth goals. The system will be a joint effort between MassHealth and HLC.

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

For HRSN Housing, Nutrition, and Justice Involved services, MassHealth will receive claims or encounter data for all HRSN services provided to beneficiaries. Data about consent, screening, and referrals will be included in all members' medical records.

For HRSN Temporary Housing Assistance, MassHealth will continue to use the system described in Section 6.C. and 8.C. to collect data about services delivered to beneficiaries.

HRSN Medical Respite services will be billed through regular claims processes and infrastructure for both FFS and managed care. MassHealth will use claims and encounter data to understand the beneficiaries served and the amount and duration of services provided. Claims and encounter data will also support program monitoring and evaluation. Data about consent, screening, and referrals for HRSN Medical Respite are required to be included in the member's medical record.

For all HRSN Services, MassHealth will continue improvements in collection of member information such as Race, Ethnicity, Language, Disability, Sexual Orientation, Gender Identity and Health-Related Social Needs in order to better monitor access and utilization and to help identify gaps in HRSN services. MassHealth will continue efforts to better integrate SNAP and MassHealth enrollment processes. Additionally, MassHealth will continue to work with DTA and DPH to address the SNAP and WIC gaps (as discussed above).

Additionally, MassHealth is exploring the use of a state-wide, closed-loop HRSN referrals system which would further support these and other service delivery efforts throughout the Commonwealth (as further detailed in Section 6.C).

Section 9. Implementation Timeline

A. Specialized CSP (April 1, 2023 – December 31, 2024)

1. Fee-for-Service Implementation

MassHealth has promulgated programmatic and rate regulations that govern the delivery of Specialized CSP services through its FFS delivery system. MassHealth published the proposed regulations (programmatic and rates) for public comment and a public hearing was held in January 2023. MassHealth finalized the regulations[8] effective in April 2023.

In April 2023, MassHealth also published the medical necessity guidelines for Specialized CSP services and finalized Specialized CSP provider applications and related materials needed to enroll FFS providers of Specialized CSP services.

2. Managed Care Implementation

MassHealth issued guidance for managed care plans related to contracting, service delivery, and payment for Specialized CSP services. Based on this guidance, managed care plans developed performance specifications, which align to FFS regulations, that were implemented in May 2023.

[8] See 101 CMR 362 (https://www.mass.gov/regulations/101-CMR-36200-rates-for-community-support-program-services) and 130 CMR 461 (https://www.mass.gov/regulations/130-CMR-461000-community-support-program-services)

MassHealth has directed plans to pay at least the rate established for Specialized CSP services delivered through FFS. Specialized CSP services were incorporated in managed care contracts and rates, effective April 1, 2023.

B. Flexible Services (April 1, 2023 – December 31, 2024)

Between April 1, 2023 and December 31, 2024, MassHealth has and will continue to administer the Flexible Services Program as it did under the prior Demonstration, providing nutrition and housing goods and services allowable in the STCs and in accordance with Attachment P. During this time, MassHealth undertook activities to move Flexible Services into the ACO managed care structure and combine Flexible Services with Specialized CSP, where appropriate, to create a combined HRSN Services program.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

HLC has continued to administer the EA Family Shelter program. CMS approved MassHealth's CPE claiming methodology for Temporary Housing Assistance Services on September 30, 2024.

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

Starting January 1, 2025, MassHealth will recategorize Specialized CSP and Flexible Services Program into a combined HRSN Services programs. To account for these changes, prior to 2025 MassHealth has updated regulations and contracts and issue managed care bulletins, as necessary. In these documents, MassHealth has included updates to medical necessity criteria, rates and payment mechanisms, provider qualifications, network adequacy standards, and service delivery specifications to support plans in administering these services.

HRSN Temporary Housing Assistance has been implemented as an HRSN Service as of April 2024.

HRSN Medical Respite service will be implemented in January 2025 for both Fee For Service and managed care.

- For FFS, MassHealth has promulgated programmatic and rate regulations that govern the delivery of services through its FFS delivery system. MassHealth published the proposed regulations (programmatic and rates) for public comment and a public hearing was held in October 2024. MassHealth plans to finalize the regulations effective in January 2025. In January 2025, MassHealth will also finalize FFS provider applications and related materials needed to enroll FFS providers of Medical Respite services.
- For Managed care implementation, MassHealth provided guidance for managed care plans related to contracting, service delivery, and payment for Medical Respite services. Based on this guidance, managed care plans are expected to operate the service in accordance with FFS regulations and pay at least the rate established for Medical Respite services delivered through FFS. Medical Respite services will be incorporated in managed care contracts and risk-based rates, effective January 1, 2025.

Section 10. Maintenance of Effort

To document its maintenance of effort (MOE), MassHealth gathered data from state agencies about SFY 22 expenditures for programs that provide ongoing housing or nutrition services and goods to individuals at risk of homelessness, experiencing homelessness, or at risk of food insecurity. Programs providing housing or nutrition goods or services were included in the baseline spending if:

1. The services or goods provided are similar or the same as those provided by Specialized CSP or Flexible Services; and
2. Services or goods are provided to members who are at risk of homelessness, experiencing homelessness, or at risk of nutrition insecurity; and
3. The provision of services or goods is partially or fully funded by the Commonwealth of Massachusetts; and
4. Funding is ongoing as opposed to time-limited investments, such as those implemented in response to the COVID pandemic or those funded through the American Rescue Plan Act; and
5. Funding amounts are distinguishable from funding for other services or goods also provided in the program; and
6. Funding amounts are not already included in a different MOE requirement.

MassHealth has provided the Maintenance of Effort deliverable to CMS under separate submission, which sets forth the total Maintenance of Effort baseline of state expenditures for programs that meet the criteria above.

After MassHealth's submission of its Maintenance of Effort SFY22 baseline of state expenditures, CMS subsequently approved EA Family Shelter and STPHH services. MassHealth has described its approach to incorporating the expenditures of services or goods similar to EA Family Shelter and STPHH in its SFY23 Maintenance of Effort submission.

MassHealth will report updated spending yearly on an aggregate basis in annual demonstration monitoring reports.

Section 11. Payment for HRSN Services

A. Specialized CSP (April 1, 2023 – December 31, 2024)

MassHealth has developed rates for Specialized CSP services through the same regulatory process it utilizes for the development of state plan rates. Proposed rates were published for public comment and a public hearing was held on the proposed rates in January 2023. Once finalized in April 2023, the rates were published on MassHealth's website. MassHealth will pay these regulatory rates for all Specialized CSP services provided to individuals who receive services through the FFS delivery system.

Specialized CSP services are covered services under MassHealth's managed care plan contracts. Cost and utilization assumptions for the services were built into managed care capitation rates and total cost of care benchmarks. MassHealth directs its managed care plans to pay a minimum fee schedule using the MassHealth regulatory rate for Specialized CSP pursuant to 42 CFR 438.6(c).

For all HRSN Services, rates approved by CMS pursuant to this Demonstration authority are treated as state plan rates for purposes of 42 CFR 438.6(c)(1)(iii)(A), and therefore, in accordance with 42 CFR 438.6(c)(2)(i) MassHealth is not required to submit a state directed payment (SDP) preprint unless, within a reasonable time before the end of the relevant managed care rating period or other applicable deadline for such preprint, CMS directs the state to submit a directed payment preprint. MassHealth is required to incorporate all SDPs, including those that do not require CMS prior approval, as a contractual obligation within their managed care contracts and appropriately document the SDP within the applicable rate certification(s) in accordance with the Medicaid Managed Care Rate Development Guide. States are also still required to submit other SDPs that do not meet the requirements outlined in 42 CFR 438.6(c)(1)(iii)(A) to CMS for prior approval in accordance with 42 CFR 438.6(c)(2).

B. Flexible Services (April 1, 2023 – December 31, 2024)

Flexible Services will continue to operate as it has under the prior demonstration period and as specified in Attachment P until December 31, 2024. Each year, MassHealth allocates an enrollment-based amount of Flexible Services funding to each ACO to provide allowable Flexible Services. ACOs work with their contracted SSOs to develop a budget and submit this budget to MassHealth for approval. After approval, MassHealth pays ACOs prospectively on a quarterly basis based on the ACOs' approved budgets.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

HRSN Temporary Housing Assistance services claimed by the Commonwealth under its 1115 Demonstration are paid for by HLC and claimed using a certified public expenditure (CPE) process as outlined in the approved CPE Methodology.[9]

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

1. Specialized CSP

Specialized CSP will continue to be paid as set forth in Section 11.A. Cost and utilization assumptions for the services will be built into managed care capitation rates and total cost of care benchmarks. For FFS members, MassHealth will pay providers directly.

2. Flexible Services Housing and Nutrition

Flexible Services will only be available to members enrolled in ACOs. ACOs may select which of these services they offer to members. The payment approach for Flexible Services is as follows:

- For Accountable Care Partnership Plans (ACPPs), Flexible Services will operate under a non-risk construct, with the option of moving into a risk construct in future years. Under the non-risk construct, MassHealth anticipates that it will prospectively provide funds to ACPPs on a quarterly basis to pay for the delivery and administrative costs of Flexible

[9] https://www.mass.gov/doc/masshealths-cpe-methodology-for-the-masshealth-temporary-housing-assistance-for-families-and-pregnant-individuals-program/download

Services. After each year concludes, MassHealth anticipates comparing actual costs (up to the rates approved in MassHealth's HRSN Fee Schedule, or up to the overall amount of expenditure authority that MassHealth has for HRSN Services) with the prospectively provided funds, and reconciling any differences with the ACPPs.

- For Primary Care ACOs (PCACOs), MassHealth has partnered with the State's managed behavioral health vendor, the Massachusetts Behavioral Health Partnership (MBHP), to administer the delivery of Flexible Services on behalf of MassHealth (e.g., processing claims, making payments to providers, submitting encounter data to MassHealth).[10] MBHP and the PCACOs will be contractually required to coordinate and align on roles and responsibilities in the administration of the services. Flexible Services will operate under a non-risk construct, implemented by MBHP, with the option of moving into a risk construct in future years. Under the non-risk construct, MassHealth anticipates that it will prospectively provide funds to MBHP on a quarterly basis to pay for the delivery and administrative costs of Flexible Services for PCACO enrollees. After each year concludes, MassHealth anticipates comparing actual costs (up to the rates approved in MassHealth's HRSN Fee Schedule, or up to the overall amount of expenditure authority that MassHealth has for HRSN Services) with the prospectively provided funds, and reconciling any differences with MBHP.

MassHealth's Accountable Care Partnership Plans and managed behavioral health vendor will be required to pay for Flexible Services in accordance with the HRSN Fee Schedule approved by CMS.

3. HRSN Temporary Housing Assistance

HRSN Temporary Housing Assistance will continue to be paid as set forth in Section 11.C.

4. HRSN Medical Respite

MassHealth has developed rates for HRSN Medical Respite services through the same regulatory process it utilizes for the development of state plan rates. Proposed rates were published for public comment and a public hearing was held on the proposed rates in October 2024. Once the rates are finalized in January 2025, the rates will be published on MassHealth's website. MassHealth will pay these regulatory rates for all HRSN Medical Respite services provided to individuals who receive services through the FFS delivery system.

HRSN Medical Respite services are covered services under MassHealth's managed care plan contracts. Cost and utilization assumptions for the services were built into managed care risk-based capitation rates and total cost of care benchmarks. MassHealth directs its managed care plans to pay a minimum fee schedule using the MassHealth regulatory rate for Medical Respite pursuant to 42 CFR 438.6(c).

All HRSN rates approved by CMS pursuant to this Demonstration authority are treated as state plan rates for purposes of 42 CFR 438.6(c)(1)(iii)(A), and therefore, in accordance with 42 CFR 438.6(c)(2)(ii) MassHealth is not required to submit a state directed payment (SDP) preprint unless, within a reasonable time before the end of the relevant managed care rating period or

[10] All PCACO enrollees are also enrolled with the BH vendor for delivery and management of their behavioral health services.

other applicable deadline for such preprint, CMS directs the state to submit a directed payment preprint. MassHealth is required to incorporate all SDPs, including those that do not require CMS prior approval, as a contractual obligation within their managed care contracts and appropriately document the SDP within the applicable rate certification(s) in accordance with the Medicaid Managed Care Rate Development Guide. States are also still required to submit other SDPs that do not meet the requirements outlined in 42 CFR 438.6(c)(1)(iii)(A) to CMS for prior approval in accordance with 42 CFR 438.6(c)(2).

Section 12. Alignment with Other State Initiatives

A. Specialized CSP (April 1, 2023 – December 31, 2024)

Specialized CSP services are well aligned with other state initiatives. For example, MassHealth is a member of the Massachusetts Interagency Council on Housing and Homelessness. MassHealth housing supports, such as Specialized CSP, are a critical component of the Commonwealth's efforts to address homelessness. Examples of recognition of these MassHealth housing supports include:

- CSP-HI is specifically cited as a resource for preventing and ending homelessness in the Commonwealth's updated Olmstead Plan.
- Members receiving CSP-HI services are prioritized for vacant housing units created through HLC's Section 811 Supportive Housing for Persons with Disabilities program and Community Based Housing program.

Multiple Permanent Supportive Housing (PSH) projects have been created that leverage CSP-HI for the supportive services component. The Affordable Homes Act recently passed by the state Legislature includes a new Supportive Housing Pool Fund that could leverage CSP-HI resources. In 2024, HLC, in partnership with MassHealth and other state agencies, was selected to participate in the federal Housing and Services Partnership Accelerator initiative with the goal of better utilizing Medicaid services, specifically CSP-HI with HLC housing resources for the creation and expansion of PSH.

MassHealth has also partnered with HLC and MassHousing to provide "upstream" tenancy preservation services for people who have unstable housing, but who are not eligible for CSP-TPP because they are not yet being formally evicted. In addition, HLC offers the Residential Assistance for Families in Transition (RAFT) program, which provides funds for rent and utility arrearages to families and individuals who are at risk of homelessness. CSP-TPP providers are required to leverage RAFT and work closely with other state funded "upstream" initiatives.

CSP-JI coordinates with an established state-funded program, Behavioral Health Supports for Justice Involved Individuals (BH-JI) that began as a geographically limited demonstration in September 2019 and expanded statewide in February 2022. BH-JI is a partnership between the Massachusetts Executive Office of Health and Human Services and the Massachusetts Executive Office of the Trial Court, that developed in close collaboration with the Massachusetts Parole Board, the Massachusetts Department of Corrections, and county Sheriff's Offices. These entities and additional partners meet monthly to discuss implementation and other needs, and beginning in October 2022, the BH-JI agencies have conducted regional coordination meetings. Through the close partnerships with the Commonwealth's criminal justice agencies, the

interagency work on BH-JI/CSP-JI has led to other initiatives such as Parole/Probation statewide Sober Housing programs for justice involved members.

MassHealth will continue collaborating with other state agencies to identify opportunities to partner.

B. Flexible Services (April 1, 2023 – December 31, 2024)

As noted in Section 7, MassHealth continues partnerships across various state agencies on several initiatives to ensure food access including, but not limited to, efforts to improve the SNAP and WIC Gaps, a common application, and engaging members in connecting to SNAP and WIC.

Additionally, in April 2020, Massachusetts created a COVID-19 Food Security Task Force comprised of a broad group of public and private members charged with ensuring food insecurity and food supply needs be addressed during the COVID-19 public health emergency. MassHealth participated in this task force helping to synthesize and prioritize recommendations. The COVID-19 Food Security Task Force concluded in September 2021 and a Food Security Workgroup made up of several agencies, including MassHealth, was created. The group includes representatives from ten different state agencies all of which have a role in food access, food security, and the food system. They meet monthly to collaborate and provide updates on new initiatives, track on-going projects, and identify new opportunities and interventions. The goal of the group is to coordinate food security resources and funding sources across all agencies and secretariates involved in the food system with a goal of maximizing use of all available food assistance programs and revenue sources.

C. HRSN Temporary Housing Assistance (April 19, 2024 – December 31, 2024)

As described earlier, the design and implementation of the HRSN Temporary Housing Assistance services is based on a strong partnership between HLC and MassHealth, working together to address the significant number of families and pregnant individuals experiencing homelessness in the Commonwealth.

D. HRSN Housing, Temporary Housing Assistance, Medical Respite, Nutrition, and Justice Involved (Effective January 1, 2025)

In 2025 and beyond, MassHealth will continue to play a critical role in other state initiatives aligned with HRSN Services.

Additionally, MassHealth will work closely with housing and nutrition state agencies to develop and operationalize these HRSN services to optimize services for members.

Maintenance of Effort, State of Massachusetts for Medicaid 1115 Waiver

In the baseline (SFY22) submission, nine HCBS waiver programs reported expenditure amounts that reflected the gross spend, not the state's portion. The nine waiver programs with updated state expenditure amounts are part of the following HCBS waivers:
1) Moving Forward Plan Residential Supports (MFP-RS) Waiver,
2) Frail Elder Waiver,
3) Moving Forward Plan Community Living (MFP-CL) Waiver,
4) Acquired Brain Injuries Non-Residential Waiver, and
5) Traumatic Brain Injury Waiver.
The programs updated in the baseline (SFY22) submission are noted in green.

When updating the state expenditure amounts for the waiver programs, the federal medical assistance percentages (FMAP) applied were 66.2% from July 2021 to March 2022 and 56.2% from April 2022 to June 2022.

As a result of the updated FMAP:
- the total housing supports for SFY22 amounted to $14,110,710.82, which was $1,427,674.19 lower than the original amount submitted.
- the total nutritional supports for SFY22 amounted to $29,730,214.93, which was $4,492,288.34 lower than the original amount submitted.
- the total HRSN MOE baseline amount was $43,840,925.74, which was $5,919,962.54 lower than the original HRSN MOE baseline amount.

Original Baseline (SFY22) Maintenance of Effort State of Massachusetts for Medicaid 1115 Waiver	
Housing Supports	
Pre-tenancy and tenancy sustaining services	$4,545,226.16
One time transition or moving costs and housing deposits	$5,986,014.72
Medically necessary home modifications and medically necessary air conditioners	$5,007,144.13
Total Housing Supports	**$15,538,385.01**
Nutritional Supports	
Home delivered meals	$32,741,031.38
Medically tailored or nutritionally appropriate food prescriptions	$1,471,527.00
Nutrition counseling	$9,944.89
Total Nutritional Supports	**$34,222,503.27**
TOTAL HRSN MOE BASELINE:	**$49,760,888.28**

Housing Support Programs include SFY22 state expenditures on portions of the following programs*:
- Department of Children and Families (DCF): Housing Services Unit
- Executive Office of Housing and Livable Communities (HLC): Public Housing Compliance Reserves
- Executive Office of Housing and Livable Communities (HLC): Alternative Housing Voucher Program (AHVP)
- Executive Office of Housing and Livable Communities (HLC): Residential Assistance for Families in Transition (RAFT)
- Department of Mental Health (DMH): Homeless Support Services - Program Staffing Supports
- Executive Office of Elder Affairs (ELD): Older Adult Homeless Program (9110-1700)
- MassHousing: Tenancy Preservation Program
- Executive Office of Housing and Livable Communities (HLC): Tenancy Preservation Program
- MassHealth: Moving Forward Plan Residential Supports (MFP-RS) Waiver
- MassHealth: Frail Elder Waiver
- MassHealth: Moving Forward Plan Community Living (MFP-CL) Waiver
- MassHealth: Acquired Brain Injuries Non- Residential Waiver

Nutritional Support Programs include SFY22 state expenditures on portions of the following programs*:
- Department of Developmental Services (DDS): Children's Autism Waiver Program
- Department of Public Health (DPH): WIC (Women, Infants, Children)
- Department of Public Health (DPH): Metabolic Food and Formula Program
- Executive Office of Elder Affairs (ELD): ELD Home Care Programs - (Home Delivered Meals and Nutrition counseling and assessment)
- MassHealth: Frail Elder Waiver
- MassHealth: Moving Forward Plan Community Living (MFP-CL) Waiver
- MassHealth: Acquired Brain Injuries Non- Residential Waiver
- MassHealth: Traumatic Brain Injury Waiver

*Note: Some programs are included in both the Housing and Nutrition Support Program categories because they have expenditures in both categories.

Updated Baseline (SFY22) Maintenance of Effort State of Massachusetts for Medicaid 1115 Waiver	
Housing Supports	
Pre-tenancy and tenancy sustaining services	$4,477,226.16
One time transition or moving costs and housing deposits	$4,847,086.70
Medically necessary home modifications and medically necessary air conditioners	$4,786,397.96
Total Housing Supports	**$14,110,710.82**
Nutritional Supports	
Home delivered meals	$28,248,743.04
Medically tailored or nutritionally appropriate food prescriptions	$1,471,527.00
Nutrition Counseling	$9,944.89
Total Nutritional Supports	**$29,730,214.93**
TOTAL HRSN MOE BASELINE:	**$43,840,925.74**

Housing Support Programs include SFY22 state expenditures on portions of the following programs*:
- Department of Children and Families (DCF): Housing Services Unit
- Executive Office of Housing and Livable Communities (HLC): Public Housing Compliance Reserves
- Executive Office of Housing and Livable Communities (HLC): Alternative Housing Voucher Program (AHVP)
- Executive Office of Housing and Livable Communities (HLC): Residential Assistance for Families in Transition (RAFT)
- Department of Mental Health (DMH): Homeless Support Services - Program Staffing Supports
- Executive Office of Elder Affairs (ELD): Older Adult Homeless Program (9110-1700)
- MassHousing: Tenancy Preservation Program
- Executive Office of Housing and Livable Communities (HLC): Tenancy Preservation Program
- MassHealth: Moving Forward Plan Residential Supports (MFP-RS) Waiver
- MassHealth: Frail Elder Waiver
- MassHealth: Moving Forward Plan Community Living (MFP-CL) Waiver
- MassHealth: Acquired Brain Injuries Non- Residential Waiver

Nutritional Support Programs include SFY22 state expenditures on portions of the following programs*:
- Department of Developmental Services (DDS): Children's Autism Waiver Program
- Department of Public Health (DPH): WIC (Women, Infants, Children)
- Department of Public Health (DPH): Metabolic Food and Formula Program
- Executive Office of Elder Affairs (ELD): ELD Home Care Programs - (Home Delivered Meals and Nutrition counseling and assessment)
- MassHealth: Frail Elder Waiver
- MassHealth: Moving Forward Plan Community Living (MFP-CL) Waiver
- MassHealth: Acquired Brain Injuries Non- Residential Waiver
- MassHealth: Traumatic Brain Injury Waiver

*Note: Some programs are included in both the Housing and Nutrition Support Program categories because they have expenditures in both categories

Noted in green are the waiver service programs that Massachusetts updated its state expenditure numbers. In the original SFY22 baseline submission, the amounts for these waiver services reflected gross spending, rather than state only funding. Numbers were then updated to reflect state spending and a FMAP of 66.2% from Jul 2021 to Mar 2022 and 56.2% from Apr 2022 to Jun 2022.

Difference in Reported vs Actual SFY22	
Housing Supports	
Pre-tenancy and tenancy sustaining services	$68,000.00
One time transition or moving costs and housing deposits	$1,138,928.02
Medically necessary home modifications and medically necessary air conditioners	$220,746.17
Total Difference in Housing Supports	**$1,427,674.19**
Nutritional Supports	
Home delivered meals	$4,492,288.34
Medically tailored or nutritionally appropriate food prescriptions	$0.00
Nutrition Counseling	$0.00
Total Difference in Nutritional Supports	$4,492,288.34
Total Difference in HRSN MOE BASELINE:	**$5,919,962.54**

Maintenace of Effort, State of Massachusetts for Medicaid 1115 Waiver - SFY23

The same programs included in SFY22 were also part of SFY23. Total state expenditures increased by $16,447,830.20, driven by three main factors:

- the FMAP decreased to 56.2% from July 2022 to March 2023 and 55% from April 2023 to June 2023
- Residential Assistance for Families in Transition (RAFT), categorized under one time transition costs, moving costs and housing deposits, increased by $11,883,060.49. This increase was primarily due to no longer having access to the federal Emergency Rental Assistance Program funds.
- ELD Home Care Programs- Home Delievered Meals, categorized under home delivered meals, increased by $3,632,053.52. This increase was due to the official end of the federal COVID Public Health Emergency and an increase in the number of consumers in the program.

SFY 23 Maintenance of Effort State of Massachusetts for Medicaid 1115 Waiver	
Housing Supports	
Pre-tenancy and tenancy sustaining services	$4,062,785.10
One time transition or moving costs and housing deposits	$17,024,801.04
Medically necessary home modifications and medically necessary air conditioners	$5,114,112.58
Total Housing Supports	**$26,201,698.72**
Nutrition Supports	
Home delivered meals	$32,630,947.24
Medically tailored or nutritionally appropriate food prescriptions	$1,442,119.36
Nutrition Counseling	$13,990.63
Total Nutritional Supports	**$34,087,057.23**
Total HRSN FY23 MOE	**$60,288,755.95**

Housing Support Programs include SFY22 state expenditures on portions of the following programs*:
- Department of Children and Families (DCF): Housing Services Unit
- Executive Office of Housing and Livable Communities (HLC): Public Housing Compliance Reserves
- Executive Office of Housing and Livable Communities (HLC): Alternative Housing Voucher Program (AHVP)
- Executive Office of Housing and Livable Communities (HLC): Residential Assistance for Families in Transition (RAFT)
- Department of Mental Health (DMH): Homeless Support Services - Program Staffing Supports
- Executive Office of Elder Affairs (ELD): Older Adult Homeless Program (9110-1700)
- MassHousing: Tenancy Preservation Program
- Executive Office of Housing and Livable Communities (HLC): Tenancy Preservation Program
- MassHealth: Moving Forward Plan Residential Supports (MFP-RS) Waiver
- MassHealth: Frail Elder Waiver
- MassHealth: Moving Forward Plan Community Living (MFP-CL) Waiver
- MassHealth: Acquired Brain Injuries Non- Residential Waiver

Nutritional Support Programs include SFY22 state expenditures on portions of the following programs*:
- Department of Developmental Services (DDS): Children's Autism Waiver Program
- Department of Public Health (DPH): WIC (Women, Infants, Children)
- Department of Public Health (DPH): Metabolic Food and Formula Program
- Executive Office of Elder Affairs (ELD): ELD Home Care Programs - (Home Delivered Meals and Nutrition counseling and assessment)
- MassHealth: Frail Elder Waiver
- MassHealth: Moving Forward Plan Community Living (MFP-CL) Waiver
- MassHealth: Acquired Brain Injuries Non- Residential Waiver
- MassHealth: Traumatic Brain Injury Waiver

*Note: Some programs are included in both the Housing and Nutrition Support Program categories because they have expenditures in both categories.

Maintenance of Effort State of Massachusetts for Medicaid 1115 Waiver			
	SFY22 Baseline	**SFY23**	**Difference**
Total Housing Supports	$14,110,710.82	$26,201,698.72	$12,090,987.90
Total Nutritional Supports	$29,730,214.93	$34,087,057.23	$4,356,842.30
Total HRSN MOE	$43,840,925.74	$60,288,755.95	**$16,447,830.20**

ATTACHMENT U
Primary Care Payment Protocol

The Commonwealth must complete this Protocol and submit to CMS for annual review and approval, in accordance with STC 8.7 and the Schedule of Deliverables for the Demonstration Period in the STCs.

Section 1: General Information and Updates

1. **Summary of changes since previously approved protocol, if applicable:**

   N/A - RY23 is the initial year of implementation.

2. **Timeframes for the primary care payment arrangement with Primary Care ACOs and participating primary care practices.**
   a. Applicable period for this payment arrangement (e.g., performance year beginning Jan. 1, 2024 through Dec. 31, 2024): *April 1, 2023 through December 31, 2023 (RY23)*
   b. Requested start date for payments (for example, Jan. 1, 2024): *April 1, 2023*

3. **Estimated total dollar amount (federal and non-federal dollars) of this primary care payment:** *The estimated payment amount for this primary care initiative for Primary Care ACOs (PCACOs) for RY23 is $153.2M.*
   a. Estimated federal share: *The estimated federal share is $91.9M, or approximately 60% of the total primary care sub-capitation amount*
   b. Estimated non-federal share: *The estimated non-federal share is $61.3M, or approximately 40% of the total primary care sub-capitation amount.*

   The estimated total dollar amount and the estimated federal share should be described for the period in Question 2. For mid-year adjustments, the Commonwealth should include the change from the total and federal share estimated in the previously approved Protocol.

Section 2: Payment Methodology

1. **Describe how the payment arrangement intends to recognize value or outcomes over volume of services.**

   Practice rates include a "Tier" add-on. Practices attest to one of three clinical Tiers (e.g., Tier 1, Tier 2, or Tier 3) with each subsequent Tier corresponding to increased clinical requirements and correspondingly higher rates. Tier criteria focus on team-based care, behavioral health integration, health-related social needs screening and referral, population health management, access during expanded hours, and, for practices serving members under age 21, child and family-focused care. Since rates increase by Tier, practices are incentivized to meet higher clinical standards to advance in Tier status.

Payments from PCACOs to primary care practices are prospective and therefore not based on volume during the payment period and will not be reconciled to utilization after the payment period. This shift away from fee for service represents a fundamental recognition of value over volume.

2. **Provide a detailed description of the payment methodology, including utilization of services, provider types in this payment arrangement, provider requirements for the payments, payment adjustments (e.g., clinical tiers and criteria), the timeframes for payments, and any supporting documentation describing how the primary care payments were developed.**

   MassHealth members select their primary care provider practice when they are enrolled in a PCACO. For members who do not select voluntarily, MassHealth assigns a primary care provider practice and informs the member of the assignment. Each primary care practice in the ACO program only works with one PCACO. At any given time, all members in a PCACO are attributed to a primary care provider practice, and PCACOs and PCPs track this attribution in close to real time. PCACOs are required to make prospective payments to primary care practices on a per member per month (PMPM) basis, based on attributed population and a defined set of services/codes. Sub-capitation rates are based on historic utilization, including considerations for relevant demographics and risk.

   All primary care practices participating in a PCACO are eligible for and required to participate in the primary care payment methodology described in this Protocol. Rates are set at a "Primary Care Entity" level, which corresponds to the Tax ID of the primary care practice. Primary Care Entities include hospital outpatient departments, physicians and group practices, and community health centers. Primary Care Entities may be comprised of multiple primary care practice sites. Payment rates for Primary Care Entities are set based on the tier and provider type of their constituent primary care practices.

   Annually, each primary care practice site in a Primary Care Entity will attest as to whether it meets the clinical Tier criteria for Tier 1, Tier 2, or Tier 3. Through the tiered primary care payment model, increased payment is tied to enhanced care delivery expectations and responsibilities. There are three different tier levels at which practices can participate. Tier criteria focus on team-based care, behavioral health integration, health-related social needs screening and referral, population health management, access during expanded hours, and, for practices serving members under age 21, child and family-focused care (e.g., fluoride varnish, coordination with schools and early education settings). As practices develop clinical capacities, they will have the opportunity to participate in higher Tiers, through an anticipated annual process.

   The development of Rate Year 2023 primary care payment rates uses the same base data and follows a similar methodology to that used in developing the Rate Year 2023 Total Cost of Care Benchmarks for PCACOs. Primary care rates are developed for each Rating Category.

   Claims and encounters included in the primary care payment base data meet the following criteria:

1. *Primary Care Entity: The provider billing the claim must be in the same Primary Care Entity as the primary care provider to which the member is assigned.*
2. *Service: Claims must contain at least one primary care service, defined by a set of codes.*
3. *Specialty: Claims must be for services rendered by a primary care provider (excludes specialists).*

Individual claims are excluded from the base data if they do not meet these criteria. Base data is price-normalized to align unit cost levels to the applicable MassHealth standard unit price for primary care services.

Primary care trend assumptions are applied consistent with the underlying trend assumptions used for ACO market rate development. These trend assumptions include adjustments for the Coronavirus Disease Public Health Emergency, among other assumptions. Adjustments were also applied to the Primary Care Entity-specific rates to minimize volatility associated with a small membership and/or claims volume.

Primary Care Entity-specific blended rates are developed by applying base adjustments, trend and prospective adjustments to the Primary Care Entity-specific unadjusted base data at the Rating Category level.

MassHealth will make prospective payments to PCACOs at the beginning of each month. PCACOs must make the PMPM payments to Primary Care Entities after receiving payment from MassHealth.

MassHealth will continue to ensure that any FQHCs that participate in the primary care payment program as part of a PCACO are paid an amount at least equal to what they would be paid under their applicable PPS rates. Calculation of the PPS wrap payments for FQHCs participating in this payment arrangement through a PCACO are set forth in the FQHC SPA .

Please refer to Section 4 of this document for additional detail about payment requirements.

Section 3: Quality of Care and Health Outcomes

1. **Describe how Primary Care ACOs and participating primary care practices will be assessed on access to care and health outcomes for beneficiaries receiving services through this payment arrangement.** Please include a table with performance measure information (i.e., measure title, identifiers (NQF # and ACO #), and measure steward), the defined performance period, and the performance baseline and targets for the performance period. Note, indicate the year of data used to establish the performance baselines and targets. These may be added after the first year of the payment arrangement.
   The State will assess Primary Care ACOs and participating primary care practices on access to care and health outcomes for beneficiaries receiving services through this arrangement through the independent evaluation of the State's 2022-2027 1115 Demonstration, as well as through an evaluation of the Quality Measures listed below.

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target
Follow-Up After Emergency Dept Visit for Mental Illness (7 day); NCQA	*CY 2023*	*TBD (Expected Q1 2025)*	*Attainment: 63.00 Goal: 76.00*
Follow-Up After Emergency Dept Visit for AOD Abuse & Dependence (7-day); NCQA	*CY 2023*	*TBD (Expected Q1 2025)*	*Attainment: 19.00 Goal: 26.00*
Screening for Depression and Follow Up Plan; CMS	*CY 2023*	*TBD (Expected Q1 2025)*	*Attainment: 29.00 Goal: 58.00*

Section 4: ACO Contracts

1. **Describe the contractual obligations in the ACO's contract for this primary care payment.**

   Detailed contract obligations are outlined in the MassHealth PCACO Contract in Section 2.14.A.

   Participation in this payment model is a requirement of PCACO-participating primary care practices.
   MassHealth will make payments for certain primary care services to PCACOs in the form of a capitated, PMPM payment. PCACOs will then be required to make prospective payments to their participating primary care provider practices. MassHealth will specify a per-member per-month rate for each Primary Care Entity.
   The primary care payment program includes three Tiers, at which primary care practices may participate, with increasing sets of clinical expectations by tier. Tier 1 site expectations will target primary care practices in earlier stages of practice improvement, while Tier 2 and Tier 3 practices will have higher clinical expectations. Criteria for each Tier are outlined in PCACO Contract Appendix D.

   MassHealth will work with PCACOs to collect information on payment, utilization, and quality.

ATTACHMENT U
Primary Care Payment Protocol

The Commonwealth must complete this Protocol and submit to CMS for annual review and approval, in accordance with STC 8.7 and the Schedule of Deliverables for the Demonstration Period in the STCs.

Section 1: General Information and Updates

1. **Summary of changes since previously approved protocol, if applicable:**

   Amended submission per CMS guidance. Timeframes and fiscal estimates updated from RY23

2. **Timeframes for the primary care payment arrangement with Primary Care ACOs and participating primary care practices.**
   a. Applicable period for this payment arrangement (e.g., performance year beginning Jan. 1, 2024 through Dec. 31, 2024): *January 1, 2024 through December 31, 2024 (RY24)*
   b. Requested start date for payments (for example, Jan. 1, 2024): *January 1, 2024*

3. **Estimated total dollar amount (federal and non-federal dollars) of this primary care payment:** *The estimated payment amount for this primary care initiative for Primary Care ACOs (PCACOs) for RY24 is $245M.*
   a. Estimated federal share: *The estimated federal share is $147M, or approximately 60% of the total primary care sub-capitation amount*
   b. Estimated non-federal share: *The estimated non-federal share is $97M, or approximately 40% of the total primary care sub-capitation amount.*

   The estimated total dollar amount and the estimated federal share should be described for the period in Question 2. For mid-year adjustments, the Commonwealth should include the change from the total and federal share estimated in the previously approved Protocol.

Section 2: Payment Methodology

1. **Describe how the payment arrangement intends to recognize value or outcomes over volume of services.**

   Practice rates include a "Tier" add-on. Practices attest to one of three clinical Tiers (e.g., Tier 1, Tier 2, or Tier 3) with each subsequent Tier corresponding to increased clinical requirements and correspondingly higher rates. Tier criteria focus on team-based care, behavioral health integration, health-related social needs screening and referral, population health management, access during expanded hours, and, for practices serving members under age 21, child and family-focused care. Since rates increase by Tier, practices are incentivized to meet higher clinical standards to advance in Tier status.

Payments from PCACOs to primary care practices are prospective and therefore not based on volume during the payment period and will not be reconciled to utilization after the payment period. This shift away from fee for service represents a fundamental recognition of value over volume.

2. **Provide a detailed description of the payment methodology, including utilization of services, provider types in this payment arrangement, provider requirements for the payments, payment adjustments (e.g., clinical tiers and criteria), the timeframes for payments, and any supporting documentation describing how the primary care payments were developed.**

   MassHealth members select their primary care provider practice when they are enrolled in a PCACO. For members who do not select voluntarily, MassHealth assigns a primary care provider practice and inform the member of the assignment. Each primary care practice in the ACO program only works with one PCACO. At any given time, all members in a PCACO are attributed to a primary care provider practice, and PCACOs and PCPs track this attribution in close to real time. PCACOs are required to make prospective payments to primary care practices on a per member per month (PMPM) basis, based on attributed population and a defined set of services/codes. Sub-capitation rates are based on historic primary care utilization specific to each practice.

   All primary care practices participating in a PCACO are eligible and required to participate in the primary care payment methodology described in this Protocol. Rates are set at a "Primary Care Entity" level, which corresponds to the Tax ID of the primary care practice. Primary Care Entities include hospital outpatient departments, physicians and group practices, and community health centers. Primary Care Entities may be comprised of multiple primary care practice sites. Payment rates for Primary Care Entities are set based on the tier and provider type of their constituent primary care practices.

   Annually, each primary care practice site in a Primary Care Entity will attest as to whether it meets the clinical Tier criteria for Tier 1, Tier 2, or Tier 3. Through the tiered primary care payment model, increased payment is tied to enhanced care delivery expectations and responsibilities. There are three different tier levels at which practices can participate. Tier criteria focus on team-based care, behavioral health integration, health-related social needs screening and referral, population health management, access during expanded hours, and, for practices serving members under age 21, child and family-focused care (e.g., fluoride varnish, coordination with schools and early education settings). As practices develop clinical capacities, they will have the opportunity to participate in higher Tiers, through an anticipated annual process.

   The development of Rate Year 2024 primary care payment rates uses the same base data and follows a similar methodology to that used in developing the Rate Year 2024 Total Cost of Care Benchmarks for PCACOs. Primary care rates are developed for each Rating Category.

   Claims and encounters included in the primary care payment base data meet the following criteria:

1. *Primary Care Entity: The provider billing the claim must be in the same Primary Care Entity as the primary care provider to which the member is assigned.*
2. *Service: Claims must contain at least one primary care service, defined by a set of codes.*
3. *Specialty: Claims must be for services rendered by a primary care provider (excludes specialists).*

Individual claims are excluded from the base data if they do not meet these criteria. Base data is price-normalized to align unit cost levels to the applicable MassHealth standard unit price for primary care services.

Primary care trend assumptions are applied consistent with the underlying trend assumptions used for ACO market rate development. These trend assumptions include adjustments for the Coronavirus Disease Public Health Emergency, among other assumptions. Adjustments were also applied to the Primary Care Entity-specific rates to minimize volatility associated with a small membership and/or claims volume.

Primary Care Entity-specific blended rates are developed by applying base adjustments, trend and prospective adjustments to the Primary Care Entity-specific unadjusted base data at the Rating Category level.

MassHealth will make prospective payments to PCACOs at the beginning of each month. PCACOs must make the PMPM payments to Primary Care Entities after receiving payment from MassHealth.

MassHealth will continue to ensure that any FQHCs that participate in the primary care payment program as part of a PCACO are paid an amount at least equal to what they would be paid under their applicable PPS rates. Calculation of the PPS wrap payments for FQHCs participating in this payment arrangement through a PCACO is set forth in the FQHC SPA.

Please refer to Section 4 of this document for additional detail about payment requirements.

Section 3: Quality of Care and Health Outcomes

1. **Describe how Primary Care ACOs and participating primary care practices will be assessed on access to care and health outcomes for beneficiaries receiving services through this payment arrangement.** Please include a table with performance measure information (i.e., measure title, identifiers (NQF # and ACO #), and measure steward), the defined performance period, and the performance baseline and targets for the performance period. Note, indicate the year of data used to establish the performance baselines and targets. These may be added after the first year of the payment arrangement.
   The State will assess Primary Care ACOs and participating primary care practices on access to care and health outcomes for beneficiaries receiving services through this arrangement through the independent evaluation of the State's 2022-2027 1115 Demonstration, as well as through an evaluation of the Quality Measures listed below.

Measure Name and NQF # (if applicable)	Base line Year	Baseline Statistic	Performance Target	Notes
Topical Fluoride for Children; ADA	CY 2024	TBD (Expected Q1 2026)	TBD	Performance target pending an initial calculation of measure for CY 2022 across applicable MassHealth managed care plans (expected Q4 2024).
Comprehensive Diabetes Care: HBA1c Poor Control (0059;) NCQA	CY 2024	TBD (Expected Q1 2026)	Attainment: 40.00 Goal: 26.00	
Controlling High Blood Pressure (0018); NCQA	CY 2024	TBD (Expected Q1 2026)	Attainment: 60.00 Goal: 76.00	
Initiation/Engagement of Alcohol/Drug Abuse Treatment; NCQA	CY 2023	TBD (Expected Q1 2025)	Initiation Attainment: 40.00 Goal: 60.00 Engagement Attainment: 13.00 Goal: 19.00	
Follow-Up After Emergency Dept Visit for Mental Illness (7 day); NCQA	CY 2023	TBD (Expected Q1 2025)	Attainment: 63.00 Goal: 76.00	
Follow-Up After Emergency Dept Visit for AOD Abuse & Dependence (7-day); NCQA	CY 2023	TBD (Expected Q1 2025)	Attainment: 19.00 Goal: 26.00	
Immunizations for Adolescents; NCQA	CY 2024	TBD (Expected Q1 2026)	Attainment: 34.00 Goal: 57.00	
Childhood Immunization Status; NCQA	CY 2024	TBD (Expected Q1 2026)	Attainment: 48.00	

			Goal: 65.00	
Screening for Depression and Follow Up Plan; CMS	*CY 2023*	*TBD (Expected Q1 2025)*	*Attainment: 29.00 Goal: 58.00*	

Section 4: ACO Contracts

1. **Describe the contractual obligations in the ACO's contract for this primary care payment.**

   Detailed contract obligations are outlined in the MassHealth PCACO Contract in Section 2.14.A.

   Participation in this payment model is a requirement of PCACO-participating primary care practices.
   MassHealth will make payments for certain primary care services to PCACOs in the form of a capitated, PMPM payment. PCACOs will then be required to make prospective payments to their participating primary care practices. MassHealth will specify a per-member per-month rate for each Primary Care Entity.
   The primary care payment program includes three Tiers, at which primary care practices may participate, with increasing sets of clinical expectations by tier. Tier 1 site expectations will target primary care practices in earlier stages of practice improvement, while Tier 2 and Tier 3 practices will have higher clinical expectations. Criteria for each Tier are outlined in PCACO Contract Appendix D.

   MassHealth will work with PCACOs to collect information on payment, utilization, and quality.

Attachment V

Massachusetts Hospital Quality and Equity Initiative Related Provider Payment Increase Assessment – Attestation Table		
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		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	96%	90%
	Ratio determined by calculating the MassHealth percent of each individual primary care service (effective 8/1/2021) of the corresponding 2022 Medicare rate (CMS RVU File link: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22b), and taking the weighted average of all percents, as described in STC 21.1(a). The codes for primary care services are the same codes listed in Zuckerman et al., 2021, appendix exhibit 1. The ratio includes primary care services in group practice organizations, community health centers, hospital licensed health centers, and the primary care subcapitation rates for PCPs participating in a Primary Care ACO effective April, 2023.	The ratio was determined by extracting encounters for managed care primary care codes (effective 11/1/22). The codes for primary care services are the same codes listed in Zuckerman et al., 2021, appendix exhibit 1. The ratio includes primary care services in group practice organizations, community health centers, hospital licensed health centers, and the primary care subcapitation rates for PCPs participating in an Accountable Care Partnership Plan effective April, 2023. MassHealth used the 2022 Medicare rate (CMS RVU File link: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22b) in our analysis.
Obstetric Care Services	87%	87%
	Ratio determined by calculating the MassHealth percent of each individual obstetric care service (effective 8/1/2021) of the corresponding 2022 Medicare rate(CMS RVU File link: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22b), and taking the	The ratio was determined by extracting encounters for managed care obstetric care codes (effective 11/1/22). The codes for obstetric care services are the same codes listed in Zuckerman et al., 2021, appendix exhibit 1.

	weighted average of all percents, as described in STC 21.1(a). The codes for obstetric care services are the same codes listed in Zuckerman et al., 2021, appendix exhibit 1.	MassHealth used the 2022 Medicare rate (CMS RVU File link: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22b) in our analysis.
Behavioral Health Care Services	86%	98%
	Ratio determined by calculating the MassHealth percent of each individual behavioral health services (effective 8/1/2021) of the corresponding 2022 Medicare rate (CMS RVU File link: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22b), and taking the weighted average of all percents, as described in STC 21.1(a). The codes for behavioral health services are codes listed in ClemansCope et al., 2021	The ratio was determined by extracting encounters for managed care behavioral health codes (effective 11/1/22). The codes for behavioral health services are codes listed in Clemans-Cope et al., 2021 MassHealth used the 2022 Medicare rate (CMS RVU File link: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22b) in our analysis.

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*].

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.

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.

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.

[*Select the applicable effective date, must check either a. or b. below*]

☑ a. The effective date of the rate increases is the first day of DY27 and will be at least sustained, if not higher, through DY32

☐ 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*].

Massachusetts does 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 June 2023 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 June 2023

Massachusetts does 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 June 2023

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, Mohamed Sesay, *Chief Financial Officer*, attest that the above information is complete and accurate. Mohamed Sesay, March 6, 2023 Mohamed Sesay

ATTACHMENT W
Service Definitions for the Reentry Demonstration Initiative

Covered Service	Definition
Case Management	Case management will be provided in the period up to 90 days immediately prior to the expected date of release and post-release, as needed, to be further defined in the Implementation Plan. Case management is intended to facilitate reentry planning into the community in order to: (1) support the coordination of services delivered during the prerelease period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care and prerelease services delivered in the community. Services shall include: • Conducting a health risk assessment, as appropriate; • Assessing the needs of the individual in order to inform development, with the client, of a discharge/reentry person-centered care plan, with input from the clinician providing consultation services and correctional facility's reentry planning team; ○ While the person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN identified, the scope of the plan extends beyond release; • Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages to a post-release care manager, which includes sharing discharge/reentry care plans with the post-release care manager upon reentry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs, with behavioral health coordinators and post-release care managers are arranged; • Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid or CHIP state plan or other waiver or demonstration authority;

Covered Service	Definition
	• Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared with post-release care managers, and, as relevant, to physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release.
Medication-Assisted Treatment	MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT.
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.
Laboratory and Radiology Services	Laboratory and radiology services will be provided consistent with the State Plan.
Physical and Behavioral Health Clinical Consultation	Physical and behavioral health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services. Clinical consultation services are intended to support the creation of a comprehensive, robust and successful reentry plan, including: • Conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications);

Covered Service	Definition
	• Providing recommendations or orders for needed medications and medical supplies, equipment, and appliances (i.e. durable medical equipment (DME)) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for clients to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between prerelease providers and the providers who will be caring for the client after release. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional care facilities; • Diagnosing and stabilizing individuals while incarcerated, preparing them for release; • Providing treatment, as appropriate, in order to ensure control of conditions prior to release (e.g. to suggest medication changes or to prescribe appropriate medical supplies, equipment, or appliances for post-release); • Supporting reentry into the community; and • Providing behavioral health clinical consultation services authorized by the State Plan or the existing 1115 Demonstration including but not limited to clinical assessment, patient education, therapy, counseling, peer support services, and recovery coach services.
Services Provided Upon Release	Covered outpatient prescribed medications and prescribed over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the State Plan). Medical supplies, equipment, and appliances (i.e. DME) consistent with Medicaid State Plan requirements.

Attachment X
Submitted: August 16, 2024
Approved: May 29, 2025

Attachment X: Reentry Demonstration Initiative Implementation Plan

Introduction:

On April 19, 2024, the Centers for Medicare & Medicaid Services (CMS) approved Massachusetts' request to amend its Section 1115(a) demonstration "MassHealth Medicaid and Children's Health Insurance Plan (CHIP) Section 1115 Demonstration" (hereinafter "the Demonstration" or "the Reentry Demonstration") to provide coverage for certain pre-release services furnished to MassHealth Medicaid and CHIP-eligible incarcerated individuals for up to 90 days immediately prior to their expected dates of release.[1]

MassHealth Medicaid and CHIP Section 1115 Demonstration Special Terms and Conditions (STC) 22.9[2] requires Massachusetts to submit a Reentry Demonstration Initiative Implementation Plan (hereinafter "Implementation Plan"). The following Implementation Plan details Massachusetts' approach for meeting the five milestones outlined in STC 22.9 and additional considerations articulated in the CMS State Medicaid Director (SMD) Letter# 23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated."[3]

The Implementation Plan is organized around the following five Reentry Section 1115 Demonstration milestones:

1. Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.
2. Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.
3. Milestone 3: Promoting continuity of care.
4. Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.
5. Milestone 5: Ensuring cross-system collaboration.

For each milestone, the Implementation Plan describes (1) a summary of how the State already meets any expectations and specific activities related to each milestone, (2) anticipated challenges and any mitigation strategies the State will advance to address them, and (3) planned actions to be completed by the State to meet all the expectations for each milestone, including the persons or entities responsible for completing these actions and the timelines and activities the State will undertake to achieve the milestone.

Please see the table below for the total number of facilities anticipated for each facility type once the Reentry Demonstration Initiative is fully implemented. MassHealth intends to phase in facilities throughout the Demonstration period.

	State Prisons	County Correctional Facilities & Jails	Youth Correctional Facilities
Total	**9**	**19**	**35**
DY29	0	0	0
DY30	1	4	0
DY31	4	10	18
DY32	9	19	17

Please note the total number of youth correctional facilities is defined as the total number of youth correctional programs; some of these programs are in the same facility but are operated separately, with differing program types. The total number of youth correctional programs may change. Additionally, the numbers estimated within the above chart for state prisons and county correctional facilities and jails are subject to change, and facilities could be onboarded sooner or later than anticipated, based on readiness.

MassHealth's post-release case management structure will support driving positive changes by allowing multiple different entities to provide case management services that will best fit each facility and each member. This structure is designed to provide various options for demonstration beneficiaries to receive post-release case management under the Reentry Demonstration authority and provides flexibility for the pre-release case manager and facility to work with the post-release partner that best meets the members' needs. Additionally, the warm handoff requirements, especially the post-release case manager follow-up on appointments and community service connections and with the individual will facilitate improvements in health equity and reduce disparities in access to care as the post-release case managers can directly support appropriate navigation. MassHealth also intends to leverage the Readiness Assessment as a tool to address long-term health care quality for demonstration beneficiaries, as most of the readiness components directly impact a correctional facility's ability to implement the Reentry Demonstration Initiative successfully. Of the required components of determining readiness, the enhanced application processes, pre-release eligibility and behavioral health link screening, pre-release service delivery, case management and warm handoffs, and facility oversight, project management, and collaboration with MassHealth will play a crucial role in reducing barriers to access to care and how care is delivered and utilized for individuals releasing from correctional facilities.

Lastly, MassHealth recognizes the statutory requirements in the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L 117-328), which was signed into law on December 29, 2022.[4] In parallel to planning for the implementation of the Reentry Demonstration, MassHealth is developing guidance for facilities to assist with the implementation of the required coverage described in section 5121 of the CAA, 2023. As correctional

facilities go live with the delivery of services under the Demonstration, MassHealth intends to subsume the CAA case management and screening and diagnostic service requirements into the provision of the demonstration pre-release services in those facilities.

Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.

STC 22.9(a). The state must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid and CHIP eligible individuals or individuals who would be eligible for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid and CHIP application, enrollment, and renewal processes. Additionally, the state must describe how it will notify individuals of any Medicaid and CHIP eligibility determinations or actions. Other aspects to be included in the Implementation Plan related to this milestone include the state's plan to make available a Medicaid and CHIP and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid and CHIP application, including providing information about where to complete the Medicaid and CHIP application for another state (e.g., relevant state Medicaid agency website) if the individual will be moving to a different state upon release.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
1.a. Implement a State policy for a suspension strategy during incarceration (or implement an alternative proposal to ensure that only allowable benefits are covered and paid for during incarceration while ensuring coverage and payment of full benefits as soon as possible upon release), with up to a two-year glide path to fully effectuate.	

	Current state: • Per State law, MassHealth has an existing suspension process in place for incarcerated adults. The Massachusetts legislative directive to suspend was included in the Fiscal Year 2015 State Budget, Section 227[5]. This suspension process applies to Medicaid-eligible incarcerated adults. • The suspension process for incarcerated adults is currently operationalized as follows: When MassHealth is informed that an individual enters a jail, county correctional facility, or Department of Corrections (DOC) facility, MassHealth suspends their eligibility in its eligibility systems by moving them into a special aid category for incarcerated individuals. This aid category allows payment only for inpatient hospitalizations lasting longer than 24 hours. When individuals are suspended, they are also disenrolled from their Managed Care Entity (MCE) (also referred to as "managed care plan" or "health plan"). • Upon release from an adult facility (jail, county correctional facility, or DOC facility), individuals are moved back into a community benefit aid category, and full coverage is restored. To promote continuity of care and ensure that an individual's benefit is active on the day of their release, this process may begin 30 days before an individual's release date. If the individual chooses an MCE, they are manually enrolled in the health plan of their choice, prospective to the day of release. If they do not choose a health plan, their managed care assignment follows existing MassHealth policy (non-dual-eligible, under-65 members are auto-assigned to an MCE after a 14-day plan selection period; dual eligible members are not assigned but can choose to select an MCE). • The processes described above are effectuated via data exchange processes between MassHealth Enrollment Centers (MECs) and administrative staff in carceral settings. The exact form and frequency of these data exchanges differ by the type of carceral setting and are specified by data-sharing agreements in place with the county correctional facilities or Department of Correction (DOC). The DOC data-sharing agreement requires that information on new individuals in custody and releases be shared weekly; for county correctional facilities, the frequency of data sharing varies, and information may be shared on a daily or weekly basis. Data is exchanged via a secure file exchange platform.

	• For Medicaid and CHIP-eligible youth, MassHealth provides coverage to individuals upon entry to Department of Youth Services (DYS) care and/or custody, and until they are discharged from DYS care and/or custody. During a youth's stay in DYS care and/or custody, DYS provides medical services to youth who are incarcerated in a DYS facility. • MassHealth does not suspend coverage for these youth and instead medical services are provided at all state cost. • This process is effectuated via daily data exchange between MassHealth and DYS.
	Future State: Planned Activities and Associated Timeline: • MassHealth will be updating its existing suspension and coverage processes to implement pre-release coverage of approved services. • MassHealth is in the process of outlining the system changes required to its eligibility systems (HIX and MA-21) and payment systems (MMIS) to ensure that an individual's coverage includes the authorized pre-release services 90 days prior to release. **(System changes: targeting Q2 CY 2026)** • While system changes are being built, MassHealth will pursue manual processes effectuated by a dedicated team of Eligibility workers (BERS) at its Charlestown MassHealth Enrollment Center. The Charlestown team is an existing small team that specializes in eligibility for incarcerated individuals; MassHealth plans to expand the size of this team to absorb the required manual processes until the full system goes live. **(Manual processes go live: targeting Q3 CY 2025)** • System and process changes will also include the implementation of 12 months of continuous eligibility for members releasing from carceral settings. Continuous eligibility will be effective on the date of release, and further the demonstration goals of increased coverage and continuity of care. **(Manual process go live: targeting Q3 CY 2025)** • MassHealth is also revising its data-sharing processes with DOC & county correctional facility partners. Anticipated release information from DOC & county corrections will be shared with MassHealth earlier and with a more regular frequency. Instead of 30 days prior to release, release

	dates will be shared prior to the 90-day release period. Furthermore, file sharing will be standardized on set timelines for DOC and county correctional facilities. Increased regularity of file sharing with county corrections is critical because these facilities house the majority of Massachusetts' pre-trial population, which often has very short-term stays. MassHealth is in the process of revising its data-sharing agreements with county correctional facilities & DOC and plans for amendments to be made to these agreements. **(Timeline: targeting Q2 CY 2025)** • Similar to the current state process, full coverage will be restored to those eligible immediately upon release across both county corrections & DOC facilities. **(Timeline: ongoing)** • To promote continuity of care, MassHealth is evaluating changing the timeline for when incarcerated members are re-enrolled in MCEs. Earlier enrollment into managed care plans could allow pre-release case managers to make appointments with community providers that will be in-network for the member's health plan post-release, thereby minimizing the disruption that may occur if a member needs to switch providers because of their managed care plan's network. o As stated above, today, members are re-enrolled in a managed care plan upon release. In implementing this demonstration, MassHealth is exploring re-enrolling members in the MCE of their choice upon activation of their pre-release coverage, 90 days prior to their release. Like today, members will be given the opportunity to select a specific health plan. o MassHealth is currently evaluating the system changes needed to implement this change and, if this policy is pursued, expects them to be live alongside other planned system changes **(Timeline: targeting Q2 CY 2026).**
	Challenges and Mitigation Approaches: • **Challenge**: MassHealth will be asking facilities to share more data and to share data at an increased frequency. o **Mitigation approach:** MassHealth has existing data-sharing agreements in place with DOC & county corrections departments. MassHealth will revise these data-sharing agreements far in advance of the implementation of the first-wave sites (e.g., revisions ongoing for

	initial launch, targeted for July 2025) to allow for sufficient ramp-up and testing of new data exchange processes.
	
	• **Challenge:** Release dates are changeable, and often unknown (especially for the pre-trial population). This fact makes it difficult for MassHealth to time the re-activation of full community benefits with release dates.
	  ○ **Mitigation Approach**: In addition to standardized data-sharing, MassHealth will implement and strengthen processes to allow for rapid communication between carceral facility staff and eligibility workers. These communication lines can be used to alert eligibility workers of an individual who was released prior to their expected release date and needs immediate re-activation of their full community benefit. As previously mentioned, MassHealth has a dedicated team of eligibility workers who specialize in coverage for incarcerated individuals, and this team has a unit focused specifically on managing communications with correctional facilities. MassHealth plans to assess the staffing levels of this team ahead of the implementation of the Demonstration to ensure that facilities can reach MassHealth to report unanticipated releases promptly. Additionally, since many pre-trial members are released from courts, MassHealth is working closely with the Commissioner of Probation, within the Office of the Trial Court, on identifying methods by which post-release touchpoints may be leveraged to meet with individuals to confirm MassHealth eligibility. In 2023, Probation began a pilot where Probation staff could train as Certified Application Counselors (CACs) to assist members to apply for or renew their MassHealth coverage. MassHealth is discussing methods by which this program may be expanded, potentially with capacity-building funds, if appropriate.
	
	• **Challenge:** The changeability/unpredictability of release dates makes it difficult to know when incarcerated individuals are within 90 days of release to start pre-release services.
	  ○ **Mitigation Approach:** MassHealth proposes to use a statewide average approach for providing pre-release services. The rationale behind this approach is that as long as the statewide average length of time that pre-release services are provided is less than 90 days, it is not necessary to pause or re-set the pre-release “90-day clock” in the case that a release date shifts. MassHealth believes that utilizing an average length of stay approach is the best way to maintain continuity of care for members and meet the core goals of the

	Demonstration. This proposal would apply to both the pre-trial and sentenced populations, and would be operationalized as follows: ▪ MassHealth will begin to cover pre-release services for pre-trial members immediately upon notification of their incarceration. MassHealth will continue to cover these services through the member's release, regardless of individual length of stay. ▪ MassHealth will begin to cover pre-release services for all sentenced members 90 days prior to the member's release date as identified by the facility, considering anticipated earned and good time. These services will continue through the member's release, even if the release date shifts. ▪ MassHealth will track the days that each member receives pre-release services and the total number of members receiving such services and report the average number of days that a member receives pre-release services to CMS every 6 months. If the average number of days is equal to or fewer than 90 each quarter, MassHealth will continue to rely on this method of averages. ▪ Given that 86% of the pre-trial members in Massachusetts had a length of stay of fewer than 90 days and release dates for the sentenced population are far more predictable, MassHealth is confident that the average number of days that a member receives pre-release services under the Demonstration will be fewer than 90 days.
1.b. Ensure that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42	**Current State:** • Carceral settings in Massachusetts already have processes in place to support individuals applying for Medicaid and CHIP. Across carceral settings, when an individual enters the facility, the facility checks their insurance coverage as part of the intake process. • MassHealth and CHIP-eligible youth who enter DYS custody without MassHealth coverage are provided coverage at all state cost. This process is effectuated by daily data exchange between MassHealth and DYS (i.e., to identify members without coverage at entry), and eligibility processes are further supported by DYS staff as relevant.

CFR § 435.906 and § 435.908. This could include applications online, by telephone, in person, or via mail or common electronic means in accordance with 42 CFR § 435.907. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.	• All adult correctional facilities currently have access to MassHealth's Eligibility Verification System (EVS), which allows them to check whether an individual has active MassHealth coverage. If an incarcerated adult does not have MassHealth, the facility will help them apply. Facility intake staff, case managers, or reentry staff may assist with applications, and the timing of when an application is submitted varies across facilities. Some facilities begin assistance with applications immediately upon intake, particularly for the pre-trial population with anticipated short-term stays. Other facilities, including all DOC facilities, submit applications when an individual is either (a) 30 days pre-release, or (b) requires inpatient services. Applications are currently submitted via mail or fax. • Today, every adult correctional facility (DOC & county corrections) in the Commonwealth has at least one Certified Application Counselor on-site to assist individuals with completing applications and to coordinate with MassHealth. As previously mentioned, MassHealth has a dedicated "Outreach Unit" of eligibility workers at the Charlestown Enrollment Center who communicate with these Application Counselors regarding individual member cases via phone and email. • For adults enrolled in MassHealth, coverage is suspended according to the processes described in Section 1.a. During the period of their incarceration, the correctional facility is listed as the member's address and notices are sent to the facility. Facilities are expected to provide notices to members in a timely manner and to allow members to access modes of communication to respond to MassHealth notices when necessary. Many correctional facility CACs submit Permission to Share Information (PSI) along with application materials so that they also can receive notices on behalf of the member. When the member returns to the community, MassHealth and the facility work together to update the address on file and send notices to that address. • When notices are sent to incarcerated members, MassHealth alerts them to their right to a Fair Hearing to dispute the eligibility decision. Members are permitted to attend Fair Hearings remotely. • As previously mentioned, all youth who enter DYS care and/or custody are provided MassHealth coverage until they are discharged from DYS care and/or custody.
	Future State: Planned Activities and Associated Timeline:

	• For Medicaid-eligible adults, MassHealth will continue to provide access to EVS so that facilities can identify individuals who are not enrolled in Medicaid and support them in completing an application. For Medicaid and CHIP-eligible youth, MassHealth will continue and augment existing data exchanges. **(Timeline: ongoing)** • MassHealth will work with county correctional facilities & DOC to strengthen and standardize existing processes around MassHealth applications. In its forthcoming Policy & Operations Guide, MassHealth will issue guidance for the period in which facilities should screen individuals for existing MassHealth coverage and assist them in completing an application (with differing timelines/expectations for short-term stay pre-trial vs. sentenced individuals). This guidance will include requirements that carceral facilities support Medicaid applications as close to intake as possible, to ensure that applications are submitted for individuals with short-term stays. **(Timeline: targeting Q2 2025)** ○ To support this process, MassHealth will make available Capacity Building Funds that facilities can use to implement any needed process changes to fully support Medicaid applications prior to release. For example, facilities may use Capacity Building Funds to train or hire additional CACs. • MassHealth currently holds regular education and training opportunities for all its Certified Application Counselors through the Massachusetts Health Care Training Forum (MTF), a monthly workgroup on eligibility & application topics. MassHealth will host specific MTF sessions focused on training for facility CACs. **(Timeline: ongoing)** • MassHealth will continue to allow incarcerated members to attend Fair Hearings remotely. As part of the readiness review and its ongoing training of carceral facility-based CACs, MassHealth will educate CACs on the Fair Hearings processes for individuals who wish to dispute a MassHealth decision. MassHealth will work to ensure that all correctional partners are equipped with the technology to support a member appearing remotely at a Fair Hearing if so desired (and explore Capacity Building Funds to support). MassHealth will also accept incarceration as a valid reason to reschedule a Fair Hearing if necessary. **(Timeline: ongoing)**
	Challenges and Mitigation Approaches:

	• **Challenge:** The average length of incarceration for the pre-trial population is short, so a MassHealth application may not be submitted or approved in time for MassHealth to provide pre-release services for this population.
	  ○ **Mitigation approach:** The most important way to mitigate this challenge is to encourage facilities to promptly screen individuals for insurance coverage and submit MassHealth applications for those without coverage. As previously referenced, MassHealth will issue guidance in its Policy & Operations Guide to specify the time period in which facilities should screen individuals for health insurance and support new applications. These timelines will differ for short-term stays.
	
	• **Challenge:** If MassHealth applications received for individuals in carceral settings are incomplete or filled out incorrectly, this lack of necessary information causes administrative back-and-forth between the MassHealth Enrollment Center workers and the Certified Application Counselors at the correctional facilities, which can delay processing of the application and activating coverage.
	  ○ **Mitigation approach**: MassHealth will make Capacity Building Funds available to facilities that wish to strengthen their application processes with additional training. In addition, as previously referenced, MassHealth will leverage the Massachusetts Health Care Training Forum (MTF) to educate facility CACs. MassHealth will dedicate certain MTF sessions to topics for correctional facilities; this will give correctional partners an opportunity to raise common issues with the MassHealth application process and to collaboratively create solutions with MassHealth.
	
	• **Challenge:** In the case that a member requests a Fair Hearing, carceral facilities may not have the technology or processes to allow a member to attend their Fair Hearing remotely.
	  ○ **Mitigation Approach:** If necessary, MassHealth will make Capacity Building Funds available to facilities that need to add technology/processes to support incarcerated members appearing remotely at Fair Hearings.

1.c. Ensure that all individuals at a participating facility who were enrolled in Medicaid prior to their incarceration are offered assistance with the Medicaid renewal or redetermination process requirements in accordance with 42 CFR § 435.908 and § 435.916. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.	**Current State:** • As previously mentioned, while a member is incarcerated, relevant eligibility determinations and notices are sent to the designated facility address on file for the member. • Facilities are expected to provide this information to individuals in a prompt manner and to give them access to the necessary modalities to respond if necessary. Currently, facilities vary in the level of support that they provide to members in interpreting and responding to eligibility information.
	Future State: Planned Activities and Associated Timeline: • In implementation of this Demonstration, MassHealth will require that participating facilities offer assistance to incarcerated members in responding to eligibility-related information, including their annual renewals. This requirement will be laid out in the Policy & Operations Guide that MassHealth will publish for correctional facilities. (**Timeline: targeting Q2 2025)** ○ MassHealth may make available capacity-building funds to facilities to implement and/or strengthen processes to support members with renewals. • MassHealth intends to facilitate renewals for incarcerated individuals on an *ex parte* basis to the greatest extent possible. This will minimize the need for individuals to respond to renewal forms while incarcerated. **(Timeline: targeting Q3 2025)**

	• To facilitate *ex parte* renewals for this population, MassHealth will utilize existing federal verification rules and sub-regulatory guidance. Specifically, updating its verification plan where necessary, MassHealth will:
	  ○ Assume no change in income or assets for incarcerated members, and
	  ○ Use State data sources, including data sharing agreements with state-run carceral settings, to verify residence and incarceration status. As part of its review, MassHealth will check to ensure the following data remains accurate: (1) that the individual is a resident of Massachusetts, (2) that the individual is incarcerated, and (3) that the individual is not deceased.
	
	• To execute the approach described above, MassHealth will use data from State correctional facilities. This data is acquired via the data exchange processes between MassHealth and DOC / Sheriffs/DYS, as described in Section 1.a.
	  ○ In implementing this approach, MassHealth intends to add this data source to its State Verification plan (**Timeline: targeting Q3 2025**)
	
	• When *ex parte* renewal is not possible, a renewal form will be sent to the facility for completion by the member. As described above, facilities will be expected to provide the renewal package to the members in a timely fashion and support them in completing the required forms, and MassHealth may make available capacity-building funds in order to support these processes.

	Challenges and Mitigation Approaches: • **Challenge:** The *ex parte* approach described above requires system changes in order to do automated verifications **(Timeline: targeting Q2 CY 2026)** ○ **Mitigation approach:** While system updates are being built, MassHealth will perform manual verifications. As previously discussed, MassHealth plans to increase the size of the team of eligibility workers (BERS) who specialize in the incarcerated population. MassHealth will utilize this larger team in order to execute manual processes. • **Challenge:** It may be difficult for incarcerated individuals who are not renewed *ex parte* to complete the necessary renewal paperwork while incarcerated (e.g., because of the challenges of collecting financial information while living in a carceral setting).

	○ **Mitigation approach:** MassHealth will require correctional facility staff to assist members in completing annual renewals, when applicable. These requirements will be laid out in the Policy & Operations Guide which MassHealth is targeting for publication in Q2 2025 . As part of the readiness review, MassHealth will also require facilities to attest that they are ready to assist members with renewals. • **Challenge:** When a member is released into the community, MassHealth may require additional information from the individual if an *ex parte* renewal is unsuccessful or due to a change in circumstance, such as their community address and new household composition. ○ **Mitigation approach:** MassHealth is committed to collecting the member information needed for an accurate eligibility determination while minimizing administrative burdens for members and facility staff and not requiring a new application. Therefore, MassHealth is creating a unique, short-format change-of-circumstances form to collect essential information. It will be as short as possible and collect the minimum information required (e.g., income, community address) for an updated eligibility determination. These forms will be processed manually by MassHealth, and MassHealth will work with facilities to maintain member coverage. • **Challenge:** It can be difficult for incarcerated members to receive mail, and therefore be informed of eligibility determinations made during their incarceration. ○ **Mitigation approach:** MassHealth will require that carceral facilities provide renewal and redetermination materials that arrive via mail to individuals promptly.
1.d. Implement a State requirement to ensure that all Medicaid-enrolled individuals who are incarcerated at a participating facility have Medicaid and/or managed care plan cards or some other Medicaid and/or managed care enrollment documentation (e.g., identification number,	**Current State:** • MassHealth ID Cards: MassHealth currently makes MassHealth ID cards available electronically via its member portal (MyServices). When a member's coverage is re-activated, they retain the same MassHealth ID number that they had prior to entering the carceral facility, so their original MassHealth ID card is still valid. When coverage is re-activated, this also triggers the mailing of a replacement MassHealth ID card to their community address.

digital documentation, instructions on how to print a card) provided to the individual upon release, along with information on how to use their coverage (coordinated with the requirements under milestone #3 below).	• Managed care entity (MCE) cards: As described in Section 1.a., members who have been suspended are allowed to select an MCE prior to release or are auto-assigned an MCE according to existing MassHealth policy. During their plan selection period, these members are mailed an Enrollment Package and information on how to choose a managed care plan based on their community address. A managed care entity card is sent to their community address once they make a selection or are auto-assigned.
	Future State: Planned Activities and Associated Timeline: • MassHealth ID cards: MassHealth will continue to provide electronic benefit cards via MyServices. As part of the Readiness Review, MassHealth will ensure that facilities are aware of this option for accessing cards and will provide guidance, consistent with state and federal privacy requirements, on how facility-based CACs can assist members in accessing their electronic cards. In addition, MassHealth seeks to implement a new step in its eligibility process to ensure that members have replacement ID cards in hand at release. Upon activation of a member's pre-release coverage, eligibility workers will be instructed to request a replacement MassHealth ID card, sent to the facility's address. This would be in addition to the MassHealth ID card sent to the member's community address upon release. **(Timeline: targeting Q3 2025)** ○ MassHealth will provide further guidance to carceral facilities and case managers in the Policy & Operations Guide regarding expectations for ensuring that individuals have access to Medicaid documentation, including their benefits card, during the reentry planning and handoff process. **(Timeline: targeting Q2 2025**) • Managed care entity (MCE) cards: MassHealth is currently working with its MCEs to ensure that managed care entity cards are provided to members in a timely fashion **(Timeline: ongoing)**
	Challenges and Mitigation Approaches: • **Challenge**: There may be cases in which a member has such a short stay that there is not sufficient time for a new MassHealth ID card to be mailed to the facility before the member is released. ○ **Mitigation Approach**: As mentioned above, MassHealth makes virtual member ID cards available through the MyServices portal. If members have access to an electronic device

	while incarcerated (a tablet, for example), they may access this portal. MassHealth will provide guidance, consistent with state and federal privacy requirements, on how facility CACs can assist members in accessing the portal in its forthcoming Policy & Operations Guide. Members also have the option to call the MassHealth customer service center and order a new ID card either through the self-service feature or by speaking to a representative.
1.e. Establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another State (e.g., relevant State Medicaid agency website, if the individual will be moving to a different State upon release).	**Current State:** • As described in Section 1.b., Massachusetts has existing processes in place to ensure that incarcerated adults have the opportunity to apply for Massachusetts Medicaid. The details and timing of processes vary across facilities, and applications for MassHealth are submitted via mail or fax. In the implementation of this demonstration, MassHealth will strengthen and standardize existing processes. • This process differs for releasing individuals moving out of state. A handful of facilities in Massachusetts assist individuals with applying for out-of-state Medicaid. However, this is not currently standard practice across facilities.
	Future State: Planned Activities and Associated Timeline: • In implementing this Reentry Demonstration, MassHealth will require all participating correctional facilities to assist members intending to move to another state with Medicaid applications. This guidance will be required in the Policy & Operations Guide, which MassHealth is targeting for publication in Q2 2025. At a minimum, facilities will be required to provide individuals with information on where to complete a Medicaid application for another State. As previously mentioned, MassHealth will make Capacity Building Funds available to facilities that need to implement or strengthen their application support processes. **(Timeline: targeting Q2 2025)** • MassHealth will leverage the experience of carceral settings that already support out-of-state applications and share best practices. For example, MassHealth intends to publish resources for carceral facilities on how to support out-of-state Medicaid applications. These resources will include

	Medicaid application links and agency contact information for the most common out-of-state moves (e.g., Connecticut, Maine, Vermont, New Hampshire), as well as information such as which states permit applications pre-release and whether coverage is retroactive. **(Timeline: targeting Q2 2025)**
	Challenges and Mitigation Approaches: • **Challenge:** Application processes, forms, and timelines differ significantly from state to state. It is very time intensive for facility staff to familiarize themselves with this wide, diverse set of requirements to assist individuals applying out-of-state (e.g., one facility described "hours of Googling"). ○ **Mitigation Approach:** As mentioned above, MassHealth intends to publish resources for carceral facilities on how to support out-of-state Medicaid applications.

Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community.

STC 22.9(b). The state must detail how the Medicaid agency and the carceral facilities will ensure that beneficiaries can access the pre-release benefit package, as clinically appropriate. The state must describe its approach and plans for implementing processes to ensure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers know of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release

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2.a. Implement State processes to identify individuals who are incarcerated who qualify for pre-release services under the State's proposed demonstration design (e.g., by chronic condition, incarceration in a participating facility).	**Current State:** • As described in Section 1.a., MassHealth suspends eligibility via data exchange processes between MassHealth Enrollment Centers (MECs) and administrative staff in carceral settings. Facilities provide health care services to incarcerated individuals, but service offerings vary across facilities. Generally, all facilities conduct a clinical assessment by correctional health care staff to determine appropriate health care services and medication needs. Facilities are responsible for fulfilling medication orders as determined to be clinically necessary.
	Future State: Planned Activities and Associated Timeline: • To qualify for pre-release services, individuals must meet the definition of an inmate of a public institution, as specified in **42 CFR 435.1010,** and be incarcerated in a state prison, county jail, house of correction, or youth correctional facility as defined in **STC 22.4.** MassHealth and facilities will offer pre-release services to all qualifying individuals who are incarcerated in a facility that has met the readiness requirements, described in more detail in Section 5.a. There are no clinical or other needs-based requirements for qualifying for pre-release services. The expectation is that correctional facilities will screen for MassHealth eligibility to identify who among their population is eligible or enrolled in MassHealth at the point of entry into the facility. **(Timeline: targeting Q2 2025)** • Prior to launch, facilities will need to meet readiness requirements for providing access to pre-release services to qualifying individuals, as outlined in the Policy & Operations Guide. Services will be offered to all qualifying individuals, and member receipt of services will require the member to opt in. **(Timeline: targeting Q2 2025)** • Capacity-Building Funds may be used to support facilities' development of materials that communicate the availability of pre-release services, including case management, to incarcerated individuals. **(Timeline: Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge**: Facilities and MassHealth may face challenges in supporting individuals' engagement in pre-release services.

	○ **Mitigation Approach:** Facilities will work with existing and new case management service providers to encourage individuals' engagement and opt-in to pre-release services, through education and information sharing and will document the parts of the care plans that individuals do and do not accept. MassHealth will work with facility partners to understand pre-release service uptake rates and any variance in engagement rates across facilities. Facilities may change or enhance their case management approach as needed based on the engagement rates.
2.b. Cover and ensure access to the minimum short-term, pre-release benefit package, including case management to assess and address physical and behavioral health needs and HRSN, MAT services for all types of SUD as clinically appropriate with accompanying counseling, and a 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release, to Medicaid-eligible individuals identified as participating in the Reentry Section 1115 Demonstration Opportunity. In addition, the State should specify any additional pre-release services that the State proposes to cover for beneficiaries.	**Current State:** Some services covered under the STCs are currently provided by facilities and/or their contracted health care vendors such as laboratory and radiology services; other examples are described below. The bullets below describe examples of services facilities are currently providing: **Case Management** • Currently, facilities are providing case management services, but there are some variations of these services as described in Section 2.c. **Medication-Assisted Treatment (MAT)** • Currently, any psychosocial services and biological products delivered in conjunction with MAT for Opioid Use Disorders (OUD), Alcohol Use Disorder (AUD), and/or Non-Opioid Substance Use Disorders are provided directly by a facility or via a contractor. Currently, the majority of county correctional facilities are certified Opioid Treatment Programs (OTPs), and all Department of Corrections (DOC) facilities are OTPs. Of the facilities providing MAT/Medications for Opioid Use Disorder (MOUD), all are continuing treatment for individuals who arrive on medication, once staff verify the community prescription, for both the sentenced and pre-trial population. Certified OTP facilities are inducing sentenced individuals, per facility procedures, but facility procedures are not standardized for individuals with a pre-trial status. Facilities also vary in procedures for continuing MAT treatment upon release. MAT is currently being provided at some DYS facilities if a youth has an existing prescription. • While some facilities may provide MAT services today, as described above, the Reentry Demonstration will enhance, expand, and augment this service for qualifying individuals.

	Medications and Medication Administration The Commonwealth's county correctional facilities and DOC facilities do not have pharmacies on-site; they have stock medications filled by either the State Office for Pharmacy Services (SOPS) or a vendor and dispense medications on-site. All DOC facilities and most county correctional facilities primarily fulfill prescription medication orders through SOPS. Nearly half of all facilities utilize a vendor, in addition to SOPS, to fulfill over-the-counter medications (OTC).
	Future State: Planned Activities and Associated Timeline MassHealth is planning several approaches to support facilities with the provision of the pre-release services specified in STC Attachment W. This includes the following: • MassHealth will provide guidance to facilities for case management, MAT, medications and medication administration , physical and behavioral health consultations, laboratory services, radiology services, and durable medical equipment. Guidance will reference the STC requirements and note that pre-release services must be delivered in accordance with the STCs and MassHealth's Policy & Operations Guide. These guidance documents will also include information from existing MassHealth programs and regulations that are relevant to the provision of these services in facilities. In general, MassHealth will have similar requirements for facility provision of services as currently exist for community providers of similar services, although the difference in providing services in correctional facilities may require some adjustments. MassHealth will review all guidance recommendations set forth in the Policy & Operations Guide with county correctional facilities, DOC, DYS, and Parole and Probation partners to ensure alignment. **(Timeline: targeting Q2 2025)** • MassHealth aims to provide centralized training and development resources for providers delivering pre-release services to meet care standards. This may include providing training on case management services for this population for in-house and vendor providers and facilitating clinical training from experts on MAT provision and standards. **(Timeline: TBD)**

	• MassHealth intends to work closely with facilities to develop reporting and billing tools that provide the needed information for claiming, care management, and monitoring while minimizing the administrative and cost burden on facilities. **(Timeline: targeting Q2 2025)** In addition, MassHealth will set the following parameters for provider enrollment and Readiness Assessments that must be completed prior to facilities going live: **Correctional Provider Enrollment** • MassHealth will require that all participating county correctional, DOC facilities, and DYS enroll as MassHealth providers. Correctional facility-based providers who are authorized to order, refer, or prescribe services and medications will be required to enroll in MassHealth and meet applicable State requirements. MassHealth will conduct routine oversight and monitoring of prescribers' ordering and prescribing activities. **(Timeline: targeting Q2 2025)** • MassHealth will provide a Policy & Operations Guide that includes provider enrollment processes and pre-release service guidelines, among other information, to assist facilities. MassHealth may consider the use of Capacity Building Funds to support these activities. **(Timeline: targeting Q2 2025)** **Readiness Assessments** • As required by the Reentry Demonstration STCs, MassHealth will require all participating correctional facilities to demonstrate their readiness to deliver pre-release services, before go-live; further description can be found in Section 5.a. Facilities must be ready to provide the required pre-release services by their requested go-live date. **(Timeline: targeting Q2 2025)**

	Challenges and Mitigation Approaches:
	
	• **Challenge:** Facilities have different, non-claims billing processes, and are not accustomed to Medicaid billing. In addition, some facilities work with multiple vendors for health care provision, which further complicates the billing and reporting process.
	  ○ **Mitigation:** MassHealth will work with facilities to implement a claims process to be scaled across facilities. MassHealth intends to provide technical assistance to facilities on this claims process and reporting and to provide detailed written documentation on how to report the provision of services. MassHealth anticipates using capacity-building funds to support the development of an administratively simple financial process across facilities.
	
	• **Challenge**: MassHealth recognizes the additional challenges of obtaining and transporting medications from the State Office of Pharmacy Services (SOPs) to the county correctional facilities and DOC from the wholesaler and understands that timely on-site medication access and availability is crucial to ensure medications in hand upon release.
	  ○ **Mitigation:** MassHealth will work with correctional partners to establish new processes to ensure a supply of medications in hand upon release.
	
	• **Challenge:** For individuals with short-term stays, or who do not have a scheduled release date, providing the pre-release benefit package is more challenging.
	  ○ **Mitigation:** To mitigate these challenges, MassHealth intends to provide clinical guidance requiring facilities to conduct clinical assessments and plans for needed medications (including MAT as appropriate) within a short time frame from the date of incarceration, so all members have a plan for medications early in their incarceration period. Clinical guidance will also set time frames for when care management assessments and other pre-release services need to be offered.
	
	• Discussed further under challenges identified in Sections 3.b. and 4.d., MassHealth will work with Probation and Parole to identify and support members post-release who were released unexpectedly from a Correctional Facility with connection to post-release case management and other post-release services.

2.c. Develop State processes to ensure care managers have knowledge of community-based providers in communities where individuals will be returning upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.	**Current State:** • Case management processes vary across facilities. MassHealth provides case management supports to certain incarcerated individuals in certain adult correctional facilities through Behavioral Health for Justice Involved Individuals (BH-JI) at all state cost. Once released, these individuals will often receive community supports from a Community Support Program for Justice Involved Individual (CSP-JI) provider. CSP-JI is provided to FFS and managed care enrollees to address the health-related social needs of Individuals with Justice Involvement who have a barrier to accessing or consistently utilizing medical and behavioral health services. CSP-JI includes behavioral health and community tenure sustainment supports. • In addition, county corrections, DOC, and DYS facilities have some other case management supports in place. Reentry planning and case management services generally begin months before release and vary according to many factors, such as a person's HRSNs. Within county correctional facilities, reentry case management support varies based on facility, population, and incarceration status (lock-up, pre-trial, or sentenced). • While some facilities may provide similar services today, the Reentry Demonstration will enhance, expand, and augment this service for qualifying individuals.
	Future State: Planned Activities and Associated Timeline: MassHealth expects to structure pre-release and post-release case management services as follows: • MassHealth intends to have *pre-release case management service*s provided by the facilities. Facilities will have the option to either provide the case management service in-house, or contract with a vendor to provide the case management service. MassHealth will provide clinical guidance on case management service requirements. Facilities will be required to attest to meeting those requirements through either an in-house service or vendor contract before going live under the demonstration. Facilities will be required to account for a member's intended post-release geography when creating post-release appointments. MassHealth

	intends to include other upcoming federal requirements for targeted case management under Section 5121 of CAA, 2023 in the Reentry guidance requirements. MassHealth intends to support *post-release case management* through a few avenues described below, designed to provide flexibility for the pre-release case manager and the facility to work with the post-release partner that best meets the member's needs. 1. MassHealth plans to define a new 30-day post-release case management service that encompasses both the post-release case management defined under the waiver STCs, and the post-release case management requirements under the Consolidated Appropriations Act. These services will be defined and priced within existing regulations, and case management providers will be able to enroll in MassHealth to provide the 30-day post-release case management service. These providers will have arrangements with MCEs and will be expected to coordinate with the member's MCE if applicable. These providers will be expected to have knowledge of community-based providers to ensure continuity of coverage. 2. There may be MCEs that are ready and able to provide the 30-day post-release case management service directly. In those cases, pre-release case managers will work directly with MCEs to conduct the warm handoff. MCE case managers would be expected to have knowledge of community-based providers to ensure continuity of care. 3. A few facilities may provide post-release services in-house for members who intend to stay in the geographic area following release. MassHealth plans to explore post-release case management for facilities that have strong case management programs and can demonstrate ability to meet post-release case management requirements in their Readiness Assessment. Correctional facilities that provide post-release case management will be expected to have knowledge of community-based providers to ensure continuity of care. 4. Within youth carceral settings, DYS provides targeted case management (TCM) services to youth who are committed to DYS post-adjudication. TCM services provided include the major elements of the STC requirements. Youth continue to receive TCM until they are

	discharged from DYS care and custody. MassHealth and DYS will consider the extent to which these case management services may be expanded, if necessary. 5. There may be other instances of appropriate post-release case management identified by facilities or MassHealth, which meet the STC requirements and readiness requirements, such as engagement with community providers who can provide these services or engagement with other care coordination providers who operate under different regulations or contracts. MassHealth will allow alternative models of post-release requirements, subject to these arrangements meeting the STCs, readiness requirements, and all other applicable requirements. **(Timeline: targeting Q2 2025)**
	Challenges and Mitigation Approaches: • **Challenge:** For facilities that contract for case management services, there may be challenges with coordinating the assignment of individuals to case managers, and scheduling case management services quickly. Additionally, preparing/delivering services for individuals with unknown or abrupt release dates presents a significant challenge. Pre-trial members are frequently released unexpectedly, there is relatively short notice for Parole releases, and certain programming within some facilities can result in good-time credits toward reducing sentences, which can result in changes in release dates as well. This uncertainty leads to pre-release case managers not always having timely information on the individuals they are assigned to support. o **Mitigation:** MassHealth may provide capacity-building funds to expand the facilities' abilities to coordinate the case management assignment and follow-through. MassHealth will also work with correctional partners through existing forums to provide technical assistance and facilitate group learning on this topic. • **Challenge:** It may not be possible for facilities to provide the full pre-release service package for members with short stays, or members with pre-release dates announced with less than 90 days' notice. o **Mitigation:** For short term stays, the Policy & Operations Guide will lay out best practices for pre-release services based on the individual's length of stay**.** MassHealth will also ensure members have post-release dedicated case managers for the first 30

	days after incarceration, who will be expected to engage with all members who opt in to the service, regardless of whether there was a full pre-release case management plan.

Milestone 3: Promoting continuity of care.

STC 22.9(c). The state must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, including HRSN and LTSS, as applicable. The state must detail its plans and timeline for implementing state policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. The state must describe its processes for promoting and ensuring collaboration between case managers, providers of pre-release services, and providers of post-release services, to ensure that appropriate care coordination is taking place. As applicable, the state must also describe the planning or project activities to ensure that Medicaid and CHIP managed care plan contracts include requirements and processes for the transfer of relevant health information from the carceral facility, community-based providers, and/or state Medicaid agency to the managed care plan to support continuity and coordination of care post-release.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
3.a. Implement a state requirement that individuals who are incarcerated receive a person-centered care plan prior to release to address any physical and behavioral health needs, as well as HRSN and consideration for long-term services and supports (LTSS) needs that should be coordinated post-release, that were identified as part of pre-release care management activities and the development of the person-centered care plan.	**Current State:** • Current services around person-centered care plans, physical and behavioral health needs as well as HRSN and LTSS support vary across correctional facilities. There is not a standard or uniform approach to case management across adult facilities. DYS provides targeted case management (TCM) services to post-adjudication youth who are committed to DYS until they are discharged from DYS care and custody.
	Future State: • Pre-release case management, including the development of a person-centered care plan, will be delivered in accordance with Attachment W by facility staff in the correctional facility, a contracted vendor, or a combination of these entities in the period up to 90 days prior to the expected date of release and post-release, as needed. Facilities will be encouraged to consider the strength of the warm handoff as well as community relations in decision-making around which entities will provide

	pre-release case management. The entity/providers that will be providing pre-release case management will be determined at the discretion of each correctional facility but must meet the criteria specified in the service descriptions in Attachment W and STC 22.8 and be assessed in the Readiness Review. **(Timeline: targeting Q2 2025)** • Pre-release case managers will play an integral role in supporting smooth reentry into the community by: 1. Assessing physical and behavioral health needs and HRSN, as indicated in STC 22.8. These assessments will inform what resources will be needed in the reentry period and from post-release case management. 2. Developing a person-centered care plan. 3. Facilitating warm hand-offs between the individual and post-release case management. 4. Setting up appointments with physical and behavioral health providers in the post-release period as appropriate (note that setting up appointments may be conducted by other providers); and connecting the individual to community service providers. As indicated in the STCs, the person-centered care plan should encompass all needs related to physical and behavioral health, and primary and specialty treatment to be provided either pre-release or post-release in the community. Additionally, the person-centered care plan should address social, educational, and other underlying needs, such as vocational services or employment. **(Timeline: targeting Q2 2025)** • As described in Section 2.c., there will be instances where the pre- and post-release case managers are different, and MassHealth expects the pre-release case managers will conduct the warm handoff to a post-release case manager. The pre-release case manager will be expected to arrange appointments in the community for the individual and post-release providers. **(Timeline: targeting Q2 2025)** • MassHealth is in the process of working with facilities to structure the warm hand-off requirements. MassHealth intends to use the current warm handoff expectations in the BH-JI

	contracts as the model for warm handoffs for higher acuity members in facilities and to inform policy development of warm handoff requirements for other members. MassHealth intends for these warm hand-off requirements to apply to pre-release case managers for all members who opt for case management services. Pre-release case managers will need to hand off medical records and assessments as appropriate and permissible by law to the new 30-day post-release case management provider. MassHealth anticipates pre- and post-release requirements will be published in the Policy & Operations Guide. **(Timeline: targeting Q2 2025)** To support facilities in meeting these care management requirements: • MassHealth will detail pre-release care planning requirements and the warm hand-off process in the Policy & Operations Guide to share with correctional partners. **(Timeline: targeting Q2 2025)** • MassHealth will assess readiness for pre-release case management, including, warm hand-offs, data-sharing coordination, community supports coordination, and physical and behavioral provider referral capacity. **(Timeline: targeting Q2 2025)** • MassHealth will consider using capacity funds for facilities to fund data-sharing and security protocols with community partners to facilitate connections between pre-release case managers and community partners/post-release care managers, to the extent feasible and permissible by law. Currently, many BH-JI/CSP-JI providers have Memorandums of Understanding with correctional agencies regarding the sharing of information relating to member assessments, treatment and discharge plans. Correctional agencies may build upon these agreements or use them as templates for existing and/or new community provider relationships. **(Timeline: targeting Q2 2025)**
	Challenges and Mitigation Approaches: • **Challenge*:*** Primary care, specialty and behavioral health care staff capacity shortages persist in the Commonwealth and scheduling appointments in the post-release period may be challenging.

	○ **Mitigation:** MassHealth will work closely with facilities and community providers to address identified barriers to making post-release appointments. MassHealth is considering the use of capacity-building funds for facilities to set up arrangements for community providers to in-reach to facilities for pre-release appointments, to the extent feasible and permissible by law, so members can have an established provider relationship in the post-release period. Additionally, MassHealth will develop plans to support facilities and community providers as further described in Section 4.a. As part of stakeholder engagement, MassHealth will provide trainings to facility staff and community providers on best practices to support post-release appointments. Furthermore, MassHealth will also host regular meetings with these groups to learn about barriers, challenges, and successes to better understand how to provide technical assistance to streamline processes and communication lines.
3.b. Implement State policies to provide or facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs identified in the course of care management and the development of the person-centered care plan.	**Current State:** • Some members may currently receive support in accessing post-release health care services through BH-JI and/or CSP-JI. Through BH-JI, reentry support includes assistance in making appointments with a primary care provider and, if needed, a clinician licensed to prescribe therapeutic medications, as well as with a licensed behavioral health clinician. Through CSP-JI, services include ensuring the member is linked to ongoing medication monitoring services and regular health maintenance, coordinating services and care, and providing members with education and training about behavioral health and substance use disorders and recovery. • A few of the Sheriffs across the Commonwealth have grant-funded or facility-funded positions that allow staff from the respective county correctional facilities to support individuals upon their return to the community, particularly within the immediate period after release to help pick up prescriptions at the pharmacy and provide transportation, as well as offer social service navigation support for a period of time. • In the DOC, Spectrum (substance use vendor staff) recovery support navigators schedule SUD appointments post-release and meet with individuals in the community to assist with substance use-related reentry needs.
	Future State: Planned Activities and Associated Timelines

	• MassHealth is planning on enhancing, expanding, and augmenting post-release case management options from the current state offerings. As described in the future state of Section 3.a., post-release case management providers will receive the warm handoff from the pre-release case manager. Following the warm handoff, the post-release case manager will follow up on appointments and community service connections that were made or need to be made, and services that were scheduled and need to be scheduled, and coordinate with the MCEs as applicable. **(Timeline: Ongoing)** • MassHealth and partners will leverage best practices of BH-JI/CSP-JI in providing timely access to services. For instance, post-release case managers will make every effort to meet the member in person on the day of release. Post-release case managers will adjust the level of support in accordance with a member's needs, including providing more intensive support during periods when the member's needs are more acute. Post-release case managers may attend necessary medical, behavioral health, and other appointments with the members as needed to assist with care planning, engagement in treatment, and fostering relationships with other providers. Post-release case managers may accompany the members to apply for benefits and community services and help them access social supports. **(Timeline: targeting Q2 2025)** • MassHealth will work with facilities to adjust processes so members who leave facilities have at minimum a 30-day supply of all covered medications (including prescriptions and over-the-counter), as clinically appropriate, per STC 22.3. MassHealth may also require that facilities provide durable medical equipment and supplies as clinically appropriate immediately upon release as a condition of participation in the Reentry Demonstration. MassHealth will work with facilities to set up processes to provide these services consistent with the STCs and provide detailed guidance in the Policy & Operations Guide. **(Timeline: targeting Q2 2025)**

	Challenges and Mitigation Approaches: • **Challenge*:*** We anticipate that there will be challenges with providing care to members with short-term stays. These challenges will include time constraints preventing the delivery of the full suite of pre-release services as well as unexpected release dates. ○ **Mitigation:** MassHealth will provide facilities with a Policy & Operations Guide as mentioned in Section 2.b. This guidance will outline a short-term pre-release service delivery model and a schedule for facilities to use as a guide to understand how to adapt the model to their specific short-term stay scenarios. Additionally, MassHealth is working closely with the Commissioner of Probation on identifying methods by which post-release touchpoints may be leveraged to facilitate members connecting with services. Since many pre-trial members are released from courts, MassHealth is exploring the possibility of leveraging Probation and contracted staff to assist with ensuring appropriate referrals are made for members to post-release case management.
3.c. Implement State processes to ensure, if applicable, that managed care plan contracts reflect clear requirements and processes for transfer of the member's relevant health information for purposes of continuity of care (e.g., active prior authorizations, care management information, or other information) to another managed care plan or, if applicable, State Medicaid agency (e.g., if the beneficiary is moving to a region of the State served by a different managed care plan or to another State after release) to	**Current State:** • MassHealth does not currently have processes in place to transfer member eligibility and health care information from the facilities to MCEs. For members in BH-JI who will be transferring to CSP-JI post-release, providers are required to share the assessments, support plan, safety plan and disenrollment plan with MCEs when an individual has selected an MCE. Additionally, the providers should coordinate with MCEs to ensure transition to other providers as appropriate. MCEs are required to provide CSP-JI (and therefore contract with CSP-JI providers).
	Future State: Planned Activities and Associated Timeline: • MassHealth plans to work with MCEs on care coordination of members upon reentry. MassHealth is exploring options to provide MCEs with information about returning members, or members who have newly selected a managed care plan, as soon as possible prior to the release of the member. The MCE is not currently expected to provide care in the pre-release period but may set up systems

ensure continuity of coverage and care upon release (coordinated with the requirements under milestone #1 above).	to evaluate the member's needs and consider referral to a care coordination or care management program, as appropriate. **(Timeline: targeting Q3 2025)** • MCEs have several care coordination programs that can offer support to members post-release. In addition, MassHealth will explore updating MCE contracts to: 1) Define how MCEs will be informed of a member who is enrolled in the MCE in the 90-day pre-release period, 2) Define MCE obligations for members who are in the pre-release period, such as sending out member cards. 3) Require MCEs to directly contract with providers of the new 30-day post-release case management service and incorporate their data into their own case management services. **(Timeline: targeting Q3 2025)** • In addition, MassHealth may make additional adjustments to specific MCE contracts. Integrated Care contracts (including the Senior Care Option contracts and One Care contracts) may be updated to include expectations that care coordinators work directly with facilities to conduct post-release case management following a member's release. ACO and MCO contracts may be updated to require MCEs to consider a member's recent former incarceration in their risk stratification process to determine eligibility for enhanced care coordination. **(Timeline: targeting Q3 2025)** • MassHealth has regular engagement with MCEs, and contractual requirements on reporting key information. MassHealth will use existing engagement structures to work with managed care plans on the implementation of new requirements. **(Timeline: ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** The lack of data exchange systems between correctional facilities and MCEs to communicate about members' plan enrollments and allow plans to prepare for care coordination will be a challenge. ○ **Mitigation Approach:** MassHealth plans to mitigate the care coordination challenges by requiring MCEs to contract with all post-release case management providers enrolled

	under the new service described in Section 2.c., so that they have contractual arrangements for sharing data and exchanging information.
3.d. Implement State processes to ensure care managers coordinate with providers of pre-release services and community-based providers, if they are different providers. Implement a State policy to require care managers to facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care and seamless transitions without administratively burdening the beneficiary (e.g., identifying providers of post-release services, making appointments, having discussions with the post-release	**Current State:** • There are no consistent practices across facilities for post-release connections with community providers. There are often challenges with creating these connections due to data-sharing challenges, and facilities having different Electronic Health Record (EHR) systems than community providers. Further, frequently community providers have not had a mechanism to be reimbursed for services during the pre-release period. Some correctional facilities have built strong partnerships with local health and behavioral health care providers to continue care provided within the correctional facility. Correctional staff frequently identify providers of post-release services and schedule post-release appointments. Some facilities currently provide some post-release services including case management. • Correctional facility staff can refer individuals to in-reach supports in limited instances, through the BH-JI program (pre-release), and CSP-JI (post-release) to support individuals in addressing their health-related social needs and meeting the goals of their care plan, as described in Sections 2.c. and 3.b. Through these programs, individuals can develop a relationship and rapport with a navigator prior to release during the reentry process as they navigate their healthcare and health-related social need services.

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<td rowspan="2">care manager, if different, to facilitate a warm handoff and continuity of services). A simple referral is not sufficient. Warm hand-offs to a post-release care manager and follow-up are expected, consistent with guidance language in the care management section.</td>
<td>Future State: Planned Activities and Associated Timeline:

• As described in Sections 3.a., and 3.b., MassHealth intends to require strong connections between pre- and post-release case management, and between a post-release case manager and the member's MCE if applicable. (Timeline: targeting Q2 2025)

• The pre- and post-release case manager will be different in many cases and therefore the pre-release case manager and additional facility staff will work closely to support a relationship between the post-release case manager and individual, using techniques for effective warm hand-off described in Section 3.a. (Timeline: targeting Q2 2025)

• MassHealth will apply lessons learned from the BH-JI and CSP-JI initiatives related to warm hand-offs between pre- and post-release case managers. This includes robust regular coordination between correctional and community providers to discuss processes of referral, data-sharing, and facilitating connections. This coordination may require MOUs between entities to ensure efficient processes for sharing assessments, and treatment plans including medication lists, post-release appointments, and discharge plans. (Timeline: ongoing)</td>
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<td>Challenges and Mitigation Approaches:

• Challenge: Creating data-sharing and care management coordination arrangements between facilities and post-release community providers is challenging.
○ Mitigation approach: MassHealth intends to offer Capacity Building Funds to offset the costs of setting up data-sharing and engagement relationships with community-based providers and encourage facilities to offer in-reach behavioral and physical health screenings from community providers, to minimize the care transitions, as feasible and permissible by law.
• Challenge: Members may move to regions outside of the area where they were incarcerated in the post-release period, making coordination with appropriate post-release providers in the pre-release period challenging.</td>
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	○ **Mitigation approach:** MassHealth intends to use capacity-building funds to help correctional facility partners develop the capabilities to provide enrollment support in the pre-release period. Facilities will be directed to use existing MassHealth plan choice materials and resources, to ensure that members can make informed, unbiased choices around MCEs that take into account their geographic location and post-release needs. MassHealth will ensure written guidance to select health plans is available to members in the pre-release period. Pre-release case managers will be expected to consider the member's anticipated post-release geography when scheduling appointments in the post-release period, and when connecting with the appropriate post-release case management provider.

Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.

STC 22.9(d). The state must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate timeframe. The Implementation Plan must also capture how the state will monitor and adjust, as needed, ongoing post-release case management and describe its process to help ensure the scheduling and receipt of needed services. The state must describe how it will connect demonstration beneficiaries to other services needed to address HRSN, LTSS, and other social supports as identified in the development of the person-centered care plan. Additionally, the state must describe how it will ensure that case managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
4.a. Develop State systems to monitor individuals who are incarcerated and their person-centered care plans to ensure that post-release services are delivered within an appropriate time frame. We expect this generally will include a scheduled contact	**Current State:** • The Commonwealth does not currently have a specific system in place to monitor incarcerated and recently released individuals' person-centered care plans. Information on post-release service delivery is limited. Since many correctional facilities only provide pre-release services, they do not currently track this data.
	Future State: Planned Activities and Associated Timeline:

between the reentering individual and the care managers that occurs within one to two days post-release and a second appointment that occurs within one week of release to ensure continuity of care and seamless transition to monitor progress and care plan implementation. These short-term follow-ups should include the pre-release and post-release (if different) care managers, as possible, to ensure longer-term post-release care management is as seamless as possible. In keeping with the person-centered care plan and individual needs, CMS is providing these general time frames as suggestions but recognizes that depending on the beneficiary's individualized needs and risk factors, a care manager may determine that the first scheduled contact with the beneficiary should occur, for example, within the first 24 hours after release and on a more frequent cadence in order to advance the goals of this demonstration.	• MassHealth will provide written guidance that the pre-release case management process is intended to begin as soon as possible after the member is eligible for pre-release services. **(Timeline: targeting Q2 2025)** • As described in the future state Sections of 3.a., 3.b., and 3.d., pre-release case managers, if different from post-release case managers, will be expected to provide a warm hand-off to the post-release case manager. MassHealth recognizes that it may be difficult for pre-release case managers to complete all components of the work at pre-determined time frames, as the ability to schedule appointments and warm linkages depends on community health and service providers' availability. MassHealth will set guidance for when, in general, aspects of the pre-release case management services are expected to be conducted. **(Timeline: targeting Q2 2025)** • To support the connections between pre-release case managers and post-release case managers, MassHealth will work with facilities to develop data sharing arrangements with post-release case managers and other community providers, as feasible and permissible by law. These data sharing procedures would support the identification of the individual's post-release needs. MassHealth may use capacity-building funds to help facilities set up these data sharing agreements, including with community partners that may also be able to provide in-reach appointments, as feasible and permissible by law. **(Timeline: ongoing)** • MassHealth intends to set guidance requiring post-release case management follow-up consistent with Appendix W (follow-up with community providers and individuals within 30 days), but strongly encouraging follow-up on a much quicker time frame, consistent with the CMS Medicaid Director Letter. **(Timeline: targeting Q2 2025)** **Challenges and Mitigation Approaches:** • **Challenge:** It may be difficult for a post-release case manager to engage and maintain contact with members following release. ○ **Mitigation Approach:** MassHealth will mitigate this challenge by: 1) requiring pre-release case managers to collect contact information for individuals post-release to minimize the risk of disruption in services, 2) potentially use Capacity Building Funds to facilitate pre- and post-release case manager connections before release (such as with

	in-person or telehealth in-reach visits), as feasible and permissible by law, 3) exploring in-reach or telehealth visits with the post-release case manager to build rapport and develop a relationship prior to release, as feasible and permissible by law, 4) request for alternative contacts (such as family or significant others) if the member cannot be reached and 5) defining a first-30 day post-release case management service specific to justice-involved individuals that will meet the post-release requirements of both the Reentry Demonstration and the Consolidated Appropriations Act justice-involved populations component.
4.b. Develop State processes to monitor and ensure ongoing care management to ensure successful transitions to the community and continuity of care post-release; to provide an assessment; monitor the person-centered care plan implementation and to adjust it, as needed; and to ensure scheduling and receipt of needed covered services.	**Current State:** • MassHealth monitors the case management supports provided by the BH-JI program described in the current state section of Section 2.c. MassHealth conducts periodic reviews of members engaged in the service and other contract oversight, including one-on-one monthly check-ins with each individual provider, monthly trainings on special topics for case management staff, and periodic audits and site visits. Further, MassHealth engages in oversight and enforcement activities related to the CSP-JI services members receive post-release.
	Future State: Planned Activities and Associated Timeline: • MassHealth intends to understand the results of the pre- and post-release case management, and opportunities for improvement, by leveraging reporting and claims information to obtain data about access to care. MassHealth will, among other monitoring described in Section 5.d., evaluate trends in members who had pre-release case management services, but not post-release case management services (due to opt-outs or loss of contact with the post-release case manager). MassHealth will work with relevant providers or facilities on improvement solutions. **(Timeline: targeting Q4 2025)** • In addition, MassHealth will work directly with case management providers to get feedback on warm handoffs and post-release case management implementation. MassHealth has existing engagement structures that will be used to collect this feedback; these structures are described in more detail in Section 5.b. **(Timeline: targeting Q4 2025)**

	• MassHealth will consider other methods for obtaining on-the-ground feedback, which may include leveraging similar engagement strategies as those used for BH-JI Supports and CSP-JI services, including regional coordination meetings, trainings, and justice agency coordination. **(Timeline: ongoing)** • Additionally, MassHealth will leverage the forums identified in Section 5.b. to solicit feedback on these activities, including from the Community Feedback Forum and the Justice Partner workgroup (both described further below). **(Timeline: ongoing)** • MassHealth will also monitor utilization and outcomes from these services as part of the evaluation and monitoring plan. **(Timeline: ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** MassHealth anticipates possible challenges with having potentially multiple care transitions: one from the pre-release case manager to the 30-day post-release case manager, and then potentially a second transition to an MCE program. ○ **Mitigation Approach:** MassHealth intends to mitigate this challenge by setting up flexibility for fewer care transitions as facilities and MCEs can take on broader case management services. For instance, a facility with a strong pre-release case management service and post-release case management service may be allowed to provide both pre- and post-release case management services if they can do so in a way that meets the service requirements. In addition, if MCEs can work directly with facilities to provide case management immediately following release, allowing for just one transition between the pre-and post-release period, MassHealth and facilities will work to support those direct connections, as feasible and permissible by law. Over time, MassHealth will work to reduce the number of members who have multiple care transitions.
4.c. Develop State processes to ensure that individuals who are receiving services through the Reentry Section 1115	**Current State:** • MassHealth is currently limited in its processes to connect individuals under the Demonstration to post-release long-term services or health-related social needs (HRSN) services; two exceptions are

Demonstration Opportunity are connected to other services needed to address LTSS and HRSN, such as housing, employment support, and other social supports as identified in the development of the person-centered care plan.	the existing BH-JI/CSP-JI and DYS targeted case management programs in which case managers frequently connect members to post-release health care and HRSN services and supports.
	Future State: Planned Activities and Associated Timeline: • MassHealth intends for the pre-release case manager to conduct HRSN screening for the individual as part of pre-release case management service. With member consent, the completed screening will be shared with the post-release case manager. The pre-release case manager will make appointments and connections to community providers who can meet identified LTSS and HRSN; the post-release case manager will follow up on those appointments. MassHealth will require that in any warm handoff, the screening is shared (if member consent is provided), and any gaps in service connections are identified. The post-release case manager (described in Section 2.c. will be required to follow up on the services in the first 30 days. **(Timeline: targeting Q2 2025)** • Currently, if a member is enrolled in an MCE, they will be screened for certain HRSN and referred to services to address HRSN as appropriate once enrolled in the MCE. MassHealth will work with MCEs and facilities on the best approach to avoid unnecessary duplication of screenings; however, in some cases, an additional HRSN screening from the MCE once the member is post-release will be helpful. **(Timeline: targeting Q2 2025)** • MassHealth will engage with community providers who are serving high volumes of post-release members to understand their experiences connecting this population to services, and any opportunities for improved engagement. **(Timeline: ongoing)**
	Challenges and Mitigation Approaches: • **Challenge**: MassHealth anticipates potential challenges with the number of community HRSN and LTSS providers and available resources not matching the identified needs in the post-release population. Other factors affect these needs as well. For instance, like many areas in the country, housing costs have risen sharply in recent years, presenting challenges for a population already experiencing barriers to housing. Per MassHealth's approved 1115 demonstration, there may also be waitlists for accessing HRSN services for enrollees in Accountable Care Organizations (ACOs, a type of MCE).

	○ **Mitigation approach:** MassHealth will work directly with facilities to understand their community provider services and any capacity constraints they anticipate. MassHealth may provide capacity-building funding opportunities to facilities for setting up data sharing procedures with community providers, as feasible and permissible by law. Additionally, MassHealth will explore potential opportunities for reinvestment into HRSN supports for reentering populations to better support these members.
4.d. Implement State policies to monitor and ensure that care managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.	**Current State:** • MassHealth has some infrastructure in place via the BH-JI and CSP-JI programs, for monitoring case managers and/or a mechanism for ensuring case managers have appropriate time and resources to engage and respond effectively with incarcerated individuals. The BH-JI/CSP-JI meetings, as described in Section 5.b., frequently discuss issues of identifying members in need of navigation support and how to time referrals to allow for appropriate time to connect with members pre-release to ensure a warm hand-off. More policies and mechanisms will need to be developed to support the implementation of pre-release services.
	Future State: Planned Activities and Associated Timeline: • As described in earlier sections, MassHealth intends to continue the processes for connecting high-need individuals with high-touch CSP-JI services. Additionally, MassHealth is identifying other options for less intensive, or differentially appropriate, post-release case management services, also described in Section 2.c. Multiple options for case management will help tailor care options to an individual's needs and maintain provider capacity to engage the highest-need members with additional support. **(Timeline: targeting Q2 2025)**
	Challenges and Mitigation Approaches: • **Challenge:** It may be more difficult for an individual with a short-term stay or short turn-around between notice of release and release date to access pre-release services. ○ **Mitigation Approach:** In guidance, MassHealth will distinguish between best practices and requirements for individuals with long-term stays and individuals with short-term stays. Pre-release case manager requirements may vary based on length of stay, the time at which the facility was informed of the release date, and other factors. If there

	has not been time for the pre-release case manager to conduct a meeting with the member, the post-release case manager will follow up with the individual and attempt to connect them with primary care and work with the facilities to receive any relevant data (e.g., assessments, treatment information, etc.) to improve the transition of care. In addition, if the member is in managed care, they may be eligible for post-release care coordination services under those contracts. Additionally, as also discussed in Section 3.b., MassHealth works closely with the Commissioner of Probation as well as Parole (which is part of the Executive Office of Public Safety and Security that oversees DOC) and is identifying methods by which members with short notice of releases may be referred to services post-release if there wasn't sufficient time to provide a warm hand-off. Probation and Parole both have programs where staff ensure members are connected to appropriate health care and HRSN services, including the BH-JI and CSP-JI programs.

Milestone 5: Ensuring cross-system collaboration.

STC 22.9(e). The state must provide an assessment that outlines how MassHealth and participating correctional systems will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to how correctional facilities will facilitate access to incarcerated beneficiaries for community health care providers, including case managers, either in person or via telehealth. The state must also document its plans for establishing communication, coordination, and engagement between corrections systems, community supervision entities, health care provider and provider organizations, the Commonwealth Medicaid agency, and supported employment and supported housing organizations. The Commonwealth must also develop a system (for example, a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release, and identify anticipated challenges and potential solutions. Further, the Commonwealth must develop and share its strategies to improve awareness and education about Medicaid/CHIP coverage and health care access among stakeholders, including those who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).

5.a. Establish an assessment outlining how the State's Medicaid agency and participating correctional system/s will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to how facilities participating in the Reentry Section 1115 Demonstration Opportunity will facilitate access within the correctional facilities for community health care providers, including care managers, in person and/or via telehealth, as appropriate. A State could phase in implementation of pre-release services based on the readiness of various participating facilities and/or systems.	**Current State:** • Currently, there is no assessment mechanism in place for outlining how MassHealth and participating correctional systems will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries.

	Future State: Planned Activities and Associated Timeline: • As referenced in Section 2, MassHealth will be drafting a readiness assessment tool and process, in addition to the publication of the Policy & Operations Guide, and will seek input from facilities through existing engagement forums while developing these materials. MassHealth intends to require facilities to be ready to deliver both the required minimum and the additional pre-release services before being active under the demonstration, although this may change as work with facilities moves forward. The readiness assessment will evaluate the: 1. Eligibility procedures, and data transfer processes set up with MassHealth; 2. Pre-release case management approach, including HRSN screenings; 3. Service provision for the minimum required pre-release services and additional services as well; 4. Process for reporting claims and pre-release service data that aligns with the processes laid out by MassHealth; and 5. Engagement processes with post-release case management providers that facilitate a warm handoff for services. Readiness assessments will be conducted and reviewed on a rolling basis. The earliest facilities may go-live is around July 1, 2025, subject to readiness. **(Timeline: targeting Q2 2025)** • MassHealth will communicate information about the Readiness Assessment process to all participating facilities and may work with a vendor to facilitate and conduct readiness assessment evaluations. MassHealth will continue several engagement processes with facilities to discuss readiness, including the Justice Partner workgroup, the first wave facility workgroup, and the correctional partner leadership call, described further in Section 5.b. **(Timeline: targeting Q2 2025)**
	Challenges and Mitigation Approaches: • **Challenges:** MassHealth expects that facilities will be in different stages of readiness for enrollment, billing, and case management services. This variation in current state services and processes may make the readiness process more complex. ○ **Mitigation:** MassHealth plans to mitigate this challenge through a few avenues:

	1. A staged approach to implementation facility by facility, that will allow facilities implementing in subsequent waves to learn from the first wave facilities. 2. Regular engagement with facilities through several avenues, including a Justice Partner workgroup and first wave workgroup which are described in more detail in Section 5.b. 3. Targeted use of capacity-building funds to support facilities in reaching the readiness guidelines and setting up systems to lessen the workload on facilities to reach these guidelines.

5.b. Develop a plan for organizational-level engagement, coordination, and communication between the corrections systems, community supervision entities, health care providers and provider organizations, State Medicaid agencies, and supported employment and supported housing agencies or organizations.	**Current State:** • The Commonwealth's internal governance and decision-making structure as it relates to the Reentry Initiative consists of senior-level Project Managers, and Program Directors spanning the health and justice program team, strategy, and finance. In addition, this work is supported by a program Chief, legal support, and executive-level leadership. The team collaborates closely with various subject matter experts throughout MassHealth, including those who specialize in MCEs, operations-related topics, eligibility, pharmacy, clinical topics, and case management. • The finance team leads key workstreams related to finance and provides expertise related to the financing of covered services, provider payments, and capacity-building funds. The reentry and strategy teams provide policy expertise, lead stakeholder engagement, coordinate across the agency, and drive forward information gathering for key decisions. The program Chief assists in gathering key decision points, provides crucial guidance on landing decisions, and funnels key questions to MassHealth leadership for decision-making. • MassHealth has also engaged significantly in external stakeholder engagement processes, including the following with correctional providers: o **Justice Partner Workgroup:** Over the past 3.5 years, MassHealth established monthly meetings for staff at all carceral agencies, including DYS, to share updates and discuss topics related to the Demonstration request and subsequent approval. MassHealth sought feedback and guidance on potential pathways to implementation and used these meetings to maintain trusted relationships. These monthly meetings have become known as the Justice Partner's Workgroup; MassHealth continues to engage this group monthly. As MassHealth moves towards implementation, the goal of this group is to maintain close partnerships and provide a forum that is focused on key updates related to planning, readiness, and first-wave sites, and collect feedback on key questions that can help shape our decision-making. o **Weekly Correctional Partner leadership Workgroup:** Since 2020, MassHealth has held weekly calls with key correctional leaders of the Massachusetts Sheriffs Association and the Massachusetts Executive Office of Public Safety and Security (EOPSS) to touch base on all matters related to the Reentry Demonstration development, request, and implementation.

	○ **First-wave facility workgroup:** MassHealth convenes a stakeholder workgroup with facilities that have been identified as potential participants for the first wave of implementation to share updates, collaborate with key correctional stakeholders as thought partners, and collect feedback on implementation strategies. These meetings are virtual sessions that are focused on discussing best practices identified by facilities and potential challenges in upcoming implementation, and that allow MassHealth to identify system and process changes required to support reentry. MassHealth plans to continue these meetings while organizing additional convenings with sub-groups of subject matter experts who can provide targeted feedback in certain areas, such as clinical, finance, and eligibility processes. • Additionally, MassHealth has developed strong working relationships with correctional facilities across the Commonwealth via regular engagement, presentations, one-on-one meetings, and group feedback opportunities. MassHealth conducts site visits to facilities regularly to learn about facility protocols, practices, and processes to ensure the Demonstration implementation is feasible and impactful. During these site visits, MassHealth and consulting staff often spoke with individuals who were currently incarcerated to discuss their experience with MassHealth and the reentry process to inform the development of Demonstration policies. • MassHealth also has engaged with correctional providers in our BH-JI and CSP-JI programs and has convened regular implementation meetings with partners on the BH-JI initiative since 2019. BH-JI Statewide meetings launched in 2021 with stakeholders including new providers, the statewide justice partners, and county correctional facilities. Of note, each county correctional facility has participated in the BH-JI initiative. • MassHealth and consultants frequently meet with the BH-JI providers, including monthly check-ins, site visits, and ad hoc meetings. These meetings are very useful in addressing issues around correctional facility clearance, staffing needs, provision of pre- and post-case management supports, and many other topics. These meetings helpfully include BH-JI and/or CSP-JI providers who are working directly with the members and frequently embedded within correctional facilities and courts.

	Through meetings with BH-JI stakeholders, MassHealth has engaged with members as appropriate, asking about their experience with the program and any issues that would better support transitions to the community.
	
	• To note, MassHealth also is part of a national reentry learning collaborative (NASHP/HARP State Reentry Learning Collaborative) bringing together states whose 1115 waiver Reentry Demonstration requests have been approved or are pending. The Learning Collaborative will provide MassHealth with opportunities including:
	  ○ Engaging with subject matter experts on a national, state, and local level.
	  ○ Receiving both tools and resources to support policy and implementation.
	  ○ Receiving tailored technical assistance (TA), a strategic work plan, bi-monthly calls to raise emerging TA needs, and introductions to external experts when needed, all to ensure a smooth and successful implementation of the Demonstration.
	  ○ Developing relationships with community-based organizations to ensure HRSN are being met for individuals to transition back into the community.

	Future State: Planned Activities and Associated Timeline: • MassHealth plans to continue all current engagements and expand the current workgroup session for potential first-wave sites to other facilities as they are ready. In addition, MassHealth plans to work on a one-on-one basis with facilities as needed to facilitate readiness. **(Timeline: ongoing)** • In addition, MassHealth plans to launch the Community Feedback Forum, a procured group that will consist of approximately 13 individuals who will advise the Executive Office of Health and Human Services (EOHHS) on the implementation of pre-release coverage for incarcerated MassHealth members as outlined in the 1115 Demonstration. MassHealth seeks to ensure that the Forum includes people with lived experience in Massachusetts carceral facilities or family members or guardians of those with such lived experience. EOHHS will present policy matters to the Community Feedback Forum and seek feedback from the group. MassHealth is currently reviewing nominations for this Forum, intending to convene the group later in 2024. **(Timeline: ongoing)** • MassHealth will explore additional avenues for engaging other stakeholders including members with lived experience with the justice system, legal advocates, community-based providers, community providers, managed care entities, and other groups. **(Timeline: ongoing)**
	Challenges and Mitigation Approaches: • **Challenges:** This is a complex, multi-stakeholder engagement process, and there will be challenges in coordinating feedback from multiple partners and being able to engage partners on the implementation timeline. ○ **Mitigation approach:** MassHealth plans to mitigate these challenges through continued and increased engagement with correctional facilities and other partners, and by having the internal staff or vendor capacity to engage individually with facilities as needed for scheduling or coordination purposes. MassHealth also plans to have a rolling process for implementation, and to engage in stages with facilities on their current state process and readiness, to mitigate some of the coordination challenges. The implementation planning process may include one-on-one technical assistance and discussions with each correctional agency to identify community provider engagement strategies and next steps.

5.c. Develop strategies to improve awareness and education about Medicaid coverage and health care access among various stakeholders, including individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).	**Current State:** • The BH-JI/CSP-JI programs and stakeholder opportunities described in Section 5.b. have been beneficial venues to discuss education on Medicaid coverage and health care access. We have used these meeting series to discuss new services, such as the Community Based Health Centers. • Additionally, all correctional facilities have Certified Application Counselors who received about 40 hours of training to support members with applying for or renewing MassHealth coverage, and/or selecting a post-release MCE.
	Future State: Planned Activities and Associated Timeline: • MassHealth intends to develop guidance on approaches to reentry. MassHealth will release a Policy & Operations Guide that will include information on communication with eligible individuals. **(Timeline: targeting Q2 2025)** • MassHealth intends to update Managed Care Entity contracts, as needed. **(Timeline: targeting Q3 2025)** • MassHealth will develop Provider and/or Managed Care Entity Bulletins, as needed. **(Timeline: targeting Q2 2025)** • MassHealth will communicate about Medicaid coverage through existing stakeholder engagement (see 5.b.) **(Timeline: ongoing)** • MassHealth plans to leverage other communication avenues to improve awareness and education on these topics, including MassHealth's website, press releases, and virtual training or webinars. **(Timeline: ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** Medicaid service provision, provider enrollment, and billing are complex, and may be new to some facility staff who have not been involved in these aspects.

	○ **Mitigation Approach:** MassHealth will develop and release a comprehensive Policy & Operations Guide to provide details on eligibility, care models, and reporting and billing, and provide summarized information in the engagement structures set up with facilities described above. MassHealth will bring key Medicaid policy experts from across the agency to speak directly to facilities in these forums. In addition, MassHealth and/or consultants will be available to work directly with facilities on answering questions on Medicaid and facilitating readiness.
5.d. Develop systems or establish processes to monitor the health care needs and HRSN of individuals who are exiting carceral settings, as well as the services they received pre-release and the care they received post-release. This includes identifying any anticipated data challenges and potential solutions, articulating the details of the data exchanges, and executing related data-sharing agreements to facilitate monitoring of the demonstration, as described below.	**Current State:** • MassHealth does not have systems or processes for monitoring the services received by individuals in facilities, or for monitoring the health care needs and HRSN of these individuals.
	Future State: Planned Activities and Associated Timeline: • MassHealth will establish a process to track the health care needs and HRSN of members post-release. MassHealth will submit a Monitoring Protocol to CMS and submit monitoring reports required under the waiver. **(Timeline: ongoing)** • MassHealth will work with facilities and provider partners on designing and implementing processes to monitor care. Some of these processes are described in (4b). **(Timeline: targeting Q2 2026)** • MassHealth plans to set up a system of reporting and claiming that will enable MassHealth to track some of the implementation measurement reporting from the same tool that is used by facilities to report services used for claiming. **(Timeline: targeting Q2 2025)** • MassHealth also anticipates on-site visits and one-on-one sessions will continue after the Readiness Assessment and be part of ongoing monitoring processes. As part of the Policy & Operations Guide, MassHealth will identify an approach for continued assessments after launch, and a policy around corrective action plans if deficiencies are identified. **(Timeline: ongoing)** • Lastly, as required by CMS, MassHealth will contract with an independent entity to, per STC 16.6 "conduct a mid-point assessment of the Reentry Demonstration initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment Report." **(Timeline: ongoing)**

	Challenges and Mitigation Approaches: • **Challenges:** Monitoring the uptake of services requires facilities to provide detailed information on identified HRSN needs of members. This will be a new process for many facilities. ○ **Mitigation approach:** MassHealth intends to set up a clear and streamlined reporting process to gather the information needed for monitoring. MassHealth will release detailed written guidance and will provide several options for training for facilities in the reporting tool.

[1] "MA 1115 Waiver Amendment Approval." Available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-ca-04192024.pdf.

[2] "MassHealth Medicaid and Children's Health Insurance Program (CHIP) Section 1115 Demonstration: Special Terms and Conditions 11-W-00030/1 and 21-W-00071/1" Amended April 19th, 2024. Available at https://www.mass.gov/doc/masshealth-amendment-stcs-4-19-24-0/download

[3] SMD# 230-3, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated," April 17, 2023. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

[4] "PUBLIC LAW 117–328," December 29th, 2022. Available at https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf.

[5] FY 2015 Final Budget. Available at https://malegislature.gov/Budget/FY2015/FinalBudget.

ATTACHMENT Y
Reentry Demonstration Initiative Reinvestment Plan (Reserved)

Attachment Z
Approved List of Designated State Health Programs (DSHPs)

The DSHP-eligible expenditures in this list exclude prohibited costs, in accordance with STC 23.2.

Program	Description	DSHP-Eligible Expenditures
Family Resource Centers	The Massachusetts Family Resource Centers (FRCs) help families and individuals resolve challenges, strengthen their bonds, connect to others, and engage in their communities. They provide clinical and community support for children who are experiencing mental/behavioral health challenges by connecting them to a licensed mental health clinician and through programs and activities offered at the FRC.	$26,000,000
Oral Healthcare for Developmentally Disabled	Dental care services for individuals with intellectual disabilities that cannot be served in traditional dental care settings.	$1,445,018
Community and School Therapeutic Support	Support to families of children with mental health challenges, and school and community interventions that improve access to services. Services include information and referral, individual and community advocacy and parent support groups, express yourself and community interventions post traumatic events.	$3,070,765
Day services	Day Services - Support voluntary, highly structured, therapeutic milieu for children and/or adolescents who have serious emotional disturbance or mental illness.	$9,811,273
Individual and Family Flexible Support	Individual and Family Flexible Support - Support voluntary, highly structured, therapeutic milieu for children and/or adolescents who have serious emotional disturbance or mental illness.	$25,158,407
MA Child Psychiatric Access Project	Massachusetts Child Psychiatric Access Project (MCPAP) provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care. We encourage and supports PCPs integrating behavioral health resources into their practices and work with behavioral health providers as well as primary care providers.	$4,258,890
Recovery and Learning Community	Peer to peer services that are recovery based.	$6,050,304
Growth and Nutrition Program	The Growth and Nutrition Program (GNP) provides multidisciplinary outpatient evaluation and treatment for children under the age of 7 with growth delay, also referred to as "failure to thrive", via six contracted health care institutions across the state.	$2,623,585
Multiple Sclerosis	Multiple sclerosis screening, information, education and treatment programs and the Multiple Sclerosis Home	$150,000

Program	Description	DSHP-Eligible Expenditures
	Living Independently Navigating Key Services program administered by the Greater New England Chapter of the National Multiple Sclerosis Society.	
Naloxone Project	This funding provides naloxone to first responders. DPH tracks first responder recipients of units naloxone, but not who naloxone was administered to.	$1,250,413
Postpartum Community Health Workers Pilot Program	The pilot program operates from community health centers in the cities of Holyoke, Lynn, Worcester, Fall River and Salem and the Jamaica Plain section of the city of Boston. The program funds the salaries of Community Health Workers (CHWs) who are public health workers who apply their unique understanding of the experience, language and/or culture of the populations they serve in order to carry out one or more of the following roles: providing culturally appropriate health education, information and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses and community centers.	$660,731
Prescription Monitoring Program	The Prescription Monitoring Program tracks statewide Schedule II-V prescriptions. With this system in place, we can give practitioners the tools they need to make the best clinical decisions.	$2,322,392
Enhanced Community Options	Home care services to non-MassHealth clients at a nursing home level of care.	$155,003,148
Grants to Councils on Aging	EOEA distributes grants to 350 cities and towns to support local councils on aging, which provide meals, information and referrals, activities and other services to older adults. The grants are distributed by statutory formula.	$56,000,000
Home Care Case Management and Admin	Administrative costs associated with home care case management.	$102,365,388
Home Care Services	Services provided to clients in home settings to support activities of daily living.	$214,707,336
Prescription Advantage	Supplementary prescription drug benefit program.	$29,709,562
Turning 22 Program – client supplies	Supplies, equipment and devices related to a client's vision loss (i.e. magnifiers, low vision lamps, braille and large print writing devices, assistive listening devices, adaptive kitchen aids, etc.	$58,536
Turning 22 Program – co-op funding	Supplemental services in the form of additional staff assistance (1:1) to enable client participation in the day habilitation program.	$713,970

Program	Description	DSHP-Eligible Expenditures
Turning 22 Program – homemaker	Services to clients with additional medical needs to assist them to continue to live safely and independently in their home. Services are typically limited to household support and does not include personal care.	$48,912
Turning 22 Program – mobility	Orientation and mobility services including travel training, for the blind and visually impaired.	$287,823
Turning 22 Program – respite	Supervision and care provided in the home of the client, by qualified staff, on a short-term basis, including on a short-term overnight basis, where there is an absence or need for relief of those persons who normally provide care for the participant.	$445,584
Turning 22 Program – training	Specialized training provided to the client to gain community, independent living skills and instruction as it relates to their vision and/or hearing loss.	$160,637
Turning 22 Program – vision aids	"Specialized vision aids necessary for the client to enhance functional vision and are not covered by insurance.	$19,534
Veteran's Benefits	Provide financial support for food, shelter, clothing, fuel, medical care, and dental assistance to eligible veterans and their dependents based on a means-test requirements.	$132,260,362
Behavioral Health Help Line	The Behavioral Health Help Line (BHHL) connects individuals and families to the full range of treatment services for mental health and substance use offered in Massachusetts, including outpatient, urgent, and immediate crisis care. Call for real-time support, initial clinical assessment, and connection to the right evaluation and treatment.	$4,770,920
Head Injury Program	Provides services to eligible people with external traumatic brain injuries	$39,347,194
Transition to Adulthood Program	Turning 22 Services (TAC) help students with disabilities prepare for the transition from special education to adulthood, regardless of their type of disability. Examples of services range from Transition to Adulthood Programming, Employment and Day Services, Adult Long Term Residential - services and occupancy for consumers, etc.	$6,013,549
Suicide Prevention and Intervention Program	The Program provides support to community agencies, education and training for professionals and caregivers, and funds programs working with youth, veterans and older adults. We use data to identify populations and geographic areas of the state that need assistance. We also support and encourage communities to collaborate across disciplines to prevent suicide and suicide attempts across the lifespan.	$16,828,289
Universal Immunization Program	The state account supports the purchase of vaccines for un/underinsured adults (over 18 years of age) vaccinated	$4,089,640

Program	Description	DSHP-Eligible Expenditures
	at public provider sites (CHCs, LBOHs, HOCs, STI clinics, etc.).	
Clinical Team Services	This service provides a clinical resource team with expertise in intellectual disabilities, autism spectrum disorder, behavior analysis and therapy, and other clinical interventions to prevent and/or mitigate acute behavioral and/or psychiatric episodes which may result in an out of home placement.	$15,000,000
Total Allowable DSHP-Eligible Expenditures		$860,632,161
Total Allowable DSHP-Eligible Expenditures with Adjustment		$826,206,875
Total DSHP Cap. The Commonwealth must not claim more than the capped amount of DSHP.		$647,500,000

Attachment AA

DESIGNATED STATE HEALTH PROGRAMS (DSHP) CLAIMING PROTOCOL

The Commonwealth may claim Federal Financial Participation (FFP) for designated state health program (DSHP) expenditures made through December 31, 2027, subject to the limits described in the Special Terms and Conditions (STCs). DSHPs are specified in Attachment Z Approved Designated State Health Programs (DSHP) List. This Attachment AA contains the protocol for DSHP claiming.

A. Accounting Systems and Reporting Mechanisms

Massachusetts Management, Accounting, and Reporting System (MMARS)
MMARs is the Commonwealth's official accounting system. Each agency enters costs and expenditures into MMARS and is responsible for ensuring that all expenditures and other information reported in MMARS is accurate and meets all the financial requirements under Office of the Comptroller (CTR) guidelines and applicable laws. Each agency reviews, approves, and then processes all state agency vendor payments through MMARS. Expenditures in MMARS indicate the appropriation from which the expenditure is made. In addition, there are oversight agencies including CTR and the Executive Office of Administration and Finance (ANF) that perform budget checks.

Certified Public Expenditure (CPE)
The CPE report will be the primary mechanism for reporting the amount expended on the approved DSHP. The CFO or Budget Director of the state agency that oversees the DSHP will certify the amount of costs it has incurred commensurate with actual program service delivered. The actual expenditure data will be queried from MMARS to develop the CPE report.

B. DSHP Claiming Process

For each program in Attachment Z, the Commonwealth will perform the following steps to determine the amount of DSHP expenditure eligible for FFP:

1. The state agencies that oversee the DSHP will document and track program spending through the Massachusetts Management, Accounting, and Reporting System (MMARS)
2. Interdepartmental Service Agreements (ISAs) will document the CPE process and responsibilities of all parties.
3. The state agencies will send the Executive Office of Health and Human Services (EOHHS) a CPE report each quarter that provides the actual total and claimable spending incurred for each DSHP.
4. Any unallowable costs will be excluded from the total costs.
5. An additional 4.4% of expenditures is removed from the actual totals to account for services delivered to individuals who do not meet citizenship or immigration status requirements.

6. After these exclusions are deducted from the total expenditure amount, the DSHP eligible amount remains.
7. EOHHS will review the DSHP CPE reports and claim the allowable expenditures on the CMS 64. EOHHS will also provide a worksheet of the DSHP projects and actual spending each quarter to the regional office that reviews the CMS 64.

ATTACHMENT AB
DSHP Sustainability Plan (Reserved)

Attachment AC
Waiver Authorities for the Consolidated Appropriations Act, 2023 Demonstration Amendment

All Medicaid and Children's Health Insurance Program (CHIP) requirements expressed in law, regulation, and policy statement not expressly waived shall apply to the demonstration project through December 31, 2027, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions.

Title XIX Waiver Authority

Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release Section

Section 1902(a)(84)(D)

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

Title XXI Waiver Authority

Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for Targeted Low-Income Children in the 30 Days Prior to Release

Section 2102(d)(2)

To enable the state not to provide coverage of the screening, diagnostic, referral, and case management services identified in section 2102(d)(2) of the Act for a targeted low-income child as a state plan benefit in the 30 days prior to the release of such targeted low-income child from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment with section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.