

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

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts MassHealth section 1115(a) Medicaid demonstration (hereinafter “Demonstration”). The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (which is the single state agency that oversees the MassHealth program), (State/Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the Commonwealth’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the State’s expenditures relating to dates of service during this demonstration extension, unless otherwise specified. The demonstration is set to expire on June 30, 2019.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Demonstration Programs and Benefits
- VI. Delivery System
- VII. Cost Sharing
- VIII. The Safety Net Care Pool
- IX. General Reporting Requirements
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- XI. Monitoring Budget Neutrality for the Demonstration
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Attachment A.	Overview of Children’s Eligibility in MassHealth
Attachment B.	Cost Sharing
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Attachment D.	MassHealth Historical Per Member/Per Month Limits
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II. PROGRAM DESCRIPTION AND OBJECTIVES

The MassHealth demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types and benefit levels. The demonstration was initially implemented in July 1997, and expanded Medicaid income eligibility categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility has been since expanded further, and the demonstration also supports affordable private market insurance for low income beneficiaries.

The 2016 amendment to the demonstration implements new demonstration components to support a value-based restructuring of MassHealth’s health care delivery and payment system, including a new Pilot Accountable Care Organization (ACO) program, building toward a transition to fuller accountable care models in the future. In addition, behavioral health services authorized under the demonstration have been expanded to strengthen Massachusetts’ system of recovery-oriented Substance Use Disorder treatments and supports, in large part with the goal of addressing the opioid addiction epidemic. The amendment also expands CommonHealth eligibility for adults over 65 who choose to continue to work; enables MassHealth to require enrollment in Student Health Insurance Plans (SHIP) when deemed cost effective and to provide for continuous eligibility for the duration of the SHIP coverage year; and expands the availability of Health Connector subsidies to include cost sharing for Health Connector enrollees with incomes up to 300 percent of the FPL.

III. GENERAL PROGRAM REQUIREMENTS

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

discretion of the secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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

demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 C.F.R. §§ 431.412 and the public notice and tribal consultation requirements outlined in STC 15 as well as include the following supporting documentation:

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

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

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

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

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

coverage for eligible individuals, as well as any community outreach activities.

- c) **Phase-out Procedures:** The state must comply with all notice requirements found in 42 C.F.R. section 431.206, section 431.210, and section 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 C.F.R. section 431.220 and section 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 C.F.R. section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.
 - d) **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to, normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
 - e) **Post Award Forum:** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held, as required in the General Reporting Requirements section. The state must also include the summary in its annual report, as required in the General Reporting Requirements section.
11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. The CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
14. **Adequacy of Infrastructure.** The Commonwealth will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements at outlined in the state's approved state plan, when any program changes to the demonstration including (but not limited to) those referenced in STC 5, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state must to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 C.F.R. section 447.205 for changes in statewide methods and standards for setting payment rates.
16. **Quality Review of Eligibility.** The Commonwealth will continue to submit by December 31st of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by federal regulations at 42 C.F.R. section 431.812(c). Based on the approved MEQC activities, the Commonwealth will be assigned a payment error rate equal to the FFY 1996 state error rate for the duration of this section 1115 demonstration project.
17. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.
18. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The State shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter. CMS expects the state to implement both an interim and long-term plan to collect, validate and report managed care encounter data, per required T-MSIS reporting and 1115 evaluation. The interim plan must be submitted to CMS by January 31, 2017. The long-term plan must be submitted to CMS no later than June 30, 2017. The system costs associated with this work are eligible for enhanced match. Failure to achieve this condition may result in a reduction in systems FFP for the costs associated with operations of the State's current data warehouse solution.

IV. ELIGIBILITY AND ENROLLMENT

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

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

MassHealth defines the age of a dependent child for purposes of the parent/caretaker relative

coverage type as a child who is younger than age 19. A caretaker relative is eligible under this provision only if the parent is not living in the household.

20. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance to Table D.
21. **Calculation of Financial Eligibility.** Financial eligibility for demonstration programs is determined by comparing the family's Modified Adjusted Gross Income (MAGI) with the applicable income standard for the specific coverage type, with the exception of adults aged 19 and above who are determined eligible on the basis of disability and whose financial eligibility is determined as described below. MAGI income counting methodologies will also be applied to disabled adults in determining eligibility for MassHealth Standard and CommonHealth; however, household composition for disabled adults will always be determined using non-tax filer rules, regardless of whether the individual files income taxes or is claimed as a dependent on another person's income taxes. In determining eligibility for MassHealth Standard and CommonHealth for disabled adults, the Commonwealth will apply the five percent income disregard that is also applied to non-disabled adults.
22. **Streamlined Redeterminations.** Under the streamlined renewal process, enrollees are not required to return an annual eligibility review form if they are asked to attest whether they have any changes in circumstances (including household size and income) and do not have any changes in circumstances reported to MassHealth. The process applies to the following populations:
- a) Families with children under the age of 19 who have gross income as verified by MassHealth at or below 150 percent FPL and who are receiving SNAP benefits with SNAP verified income at or below 180 percent FPL.
 - b) Families with children up to age 21 whose SNAP verified income is at or below 180 percent FPL, effective to the extent that the state uses an Express Lane eligibility process under its state plan for children up to the age of 21.
 - c) Childless adults whose SNAP verified income is at or below 163 percent FPL.

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

23. **TANF and EAEDC Recipients.** The Medicaid agency shall extend MassHealth eligibility to individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. MassHealth eligibility for individuals in this demonstration population does not involve an income determination, but is based on receipt of TANF/EAEDC benefits. Individuals in this demonstration population would not be described in the new adult group, because that is a group defined by an income determination. Therefore, the enhanced match for individuals in the new adult group is not available for this population. If an individual loses his/her TANF/EAEDC eligibility then he/she must apply for MassHealth benefits and receive an income eligibility determination in order to receive MassHealth benefits.
24. **Hospital-Determined Presumptive Eligibility for Additional Eligibility Groups.** Qualified hospitals that elect to do so may make presumptive eligibility determinations for individuals who

appear eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment demonstration Program eligibility groups under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan.

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

25. **Provisional Eligibility.** MassHealth will accept self-attestation for all eligibility factors, except for disability status, immigration and citizenship status, in order to determine eligibility, and may require post-eligibility verification from the applicant. If MassHealth is unable to verify eligibility through federal and state data hubs, or if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, MassHealth can enroll individuals for a 90-day “provisional eligibility period,” during which MassHealth will require further verifications from the applicant.

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

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

Benefits for all other individuals who have been determined provisionally eligible begin on the date that MassHealth sends the notice of the provisional eligibility determination. If all required verifications are received before the end of the provisional eligibility period, retroactive coverage is provided for the verified coverage type in accordance with Table D. 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.

26. 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 section IV “Eligibility and Enrollment” of the STC . 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.

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

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

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

29. Twelve Month Continuous Eligibility for Student Health Insurance Program Population.

Individuals who are enrolled in a cost-effective Student Health Insurance Plan will be continuously eligible for a period of no greater than 12 months while enrolled in the SHIP, until the end of the policy year date. The policy year will end on either July 31 or August 31 of each year. The Commonwealth will redetermine the individual’s eligibility at the completion of each policy year to ensure that the individual remains eligible.

- a) Exceptions. Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual’s 12 month continuous eligibility period, the individual’s Medicaid eligibility shall, after appropriate process, be terminated:

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

Table A. MassHealth State Plan Base Populations¹ (See section X for terminology)

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

<p>AFDC-Poverty Level Children and Independent Foster Care Adolescents</p>	<ul style="list-style-type: none"> • Age 1 - 5: 0 through 133% • Age 6 - 17: 0 through 114% • Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets • Former Foster Care Adolescents until the age of 26 without regard to income or assets (effective January 	<p>Title XIX</p>	<p><u>Base Families</u></p>	<p>Standard</p>	
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¹ Massachusetts includes in the MassHealth demonstration almost all the mandatory and optional populations aged under 65 eligible under the state plan. All Standard and CommonHealth members who have access to qualifying private insurance may receive premium assistance plus wrap-around benefits. The Massachusetts state plan outlines all covered populations not specifically indicated here.

	1, 2014)				
AFDC-Poverty Level Children Medicaid Expansion Children I	<ul style="list-style-type: none"> Age 6 – 17: 114.1% through 133% Age 18: 0 through 133% 	<ul style="list-style-type: none"> Title XIX if insured at the time of application Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted 	<p><u>Base Familles</u></p> <p><u>Base Familles XXI RO</u></p>	Standard	

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

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

Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	<u>Base Disabled</u>	CommonHealth	Must spend-down to medically needy income standard to become eligible as medically needy
Pregnant women	185.1 through 200%	Title XIX	<u>1902(r)(2) Children</u>	Standard	

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

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

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

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

Table A. MassHealth Demonstration Expansion Populations *

Groups with a Categorical Link Made Eligible through the Demonstration (“Hypotheticals”)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Higher income children with disabilities	<ul style="list-style-type: none"> · < Age 1: 200.1 through 300% · Ages 1 - 18: 150.1 through 300% 	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI via the separate XXI program (Funded through title XIX if title XXI is exhausted) 	<p align="center"><u>CommonHealth</u></p> <p align="center"><u>CommonHealth XXI</u></p>	CommonHealth	The CommonHealth program existed prior to the separate XXI Children’s Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI state plan and as authorized under this 1115 demonstration. Certain children derive eligibility from both the authority granted under this demonstration <u>and</u> the separate XXI program.
Higher income children with disabilities ages 0 through 18	Above 300%	Title XIX	<u>CommonHealth</u>	CommonHealth	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL

Higher income adults with disabilities ages 19 through 64	Above 133% Above 150% for 19- and 20-year olds)	Title XIX	<u>CommonHealth</u>	CommonHealth ("working")	Such individuals are subject to a one-time only deductible except that there is no deductible for individuals who work 40 hours or more per month. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.
Higher income adults with disabilities who are 65 and older	Net income above 100% FPL and/or Assets > \$2,000	Title XIX	<u>CommonHealth</u>	CommonHealth (65+)	Such individuals are subject to a deductible and asset test under the State Plan except there is no deductible or asset test for individuals who have paid employment for 40 hours or more per month. Individuals who met the deductible and asset test under the State plan receive MassHealth Standard. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

Table A. MassHealth Demonstration Expansion Populations (See Section X for terminology)

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

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

Populations Made Eligible through the Demonstration	Federal Poverty Level (FPL) and other qualifying criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	Massachusetts Demonstration Program	Additional comments
Individuals with HIV not otherwise eligible for medical assistance with income above 133% through 200% FPL.	Above 133 to 200%	Title XIX	<u>e-HIV/FA</u>	Family Assistance	Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.
Individuals who receive Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children	N/A	Title XIX	<u>TANF/EAEDC</u>	MassHealth	Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not an income determination.
Provisional Eligibility	Self-Attested income level to qualify for other group, pending verification	Title XIX	<u>Provisional Eligibility</u>	MassHealth	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority in accordance with STC 25.
End of Month Coverage Beneficiaries determined eligible for subsidized Qualified Health Plan (QHP) coverage through the Massachusetts Health Connector but not enrolled in a QHP	Ineligible for MassHealth and Eligible for QHP up to 400% FPL	Title XIX	<u>End of Month Coverage</u>	N/A	Effective January 1, 2014, expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP, during the period specified in STC 30.

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

V. DEMONSTRATION PROGRAMS AND BENEFITS

30. **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.
31. **Demonstration Program Benefits.** Massachusetts provides health care benefits through the following specific benefit programs. The benefit program for which an individual is eligible is based on the criteria outlined in section IV of the STCs. Table B in section IV, provides a side-by-side analysis of the benefits offered through these MassHealth programs.
32. **MassHealth Standard.** Individuals enrolled in MassHealth Standard receive state plan services including for individuals under age 21, Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. In addition, individuals enrolled in Standard receive additional demonstration benefits specifically authorized in demonstration expenditure authorities.

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

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

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

33. **MassHealth CarePlus.** MassHealth's CarePlus ABP is for individuals in the New Adult Group ages 21-64 who are not otherwise eligible for MassHealth Standard ABP. CarePlus provides medical and behavioral health services, including diversionary behavioral health service and non-emergency medical transportation, but does not include long term services and supports. Benefits are provided either through direct coverage, cost effective premium assistance, or a combination of

both (benefits wrap). Premium assistance will be furnished in coordination with section V.

34. **MassHealth Breast and Cervical Cancer Demonstration Program (BCCDP).** The BCCDP is a health insurance 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.
35. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under Standard; individuals under age 21 receive EPSDT services as well. In addition, individuals enrolled in CommonHealth receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished in coordination with section V. In addition, for CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth will also pay the cost of the monthly Medicare Part B premium. These benefits shall begin on the first day of the month following the date of the MassHealth eligibility determination. The Commonwealth may establish eligibility for this coverage without applying an asset test.
36. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under Standard. Among other things, individuals enrolled in Family Assistance receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. The Commonwealth may waive its requirement for children with access to ESI to enroll in ESI if the Commonwealth determines it is more cost effective to provide benefits under direct Family Assistance coverage than to provide premium assistance. For individuals who derive their Family Assistance benefits via the 1115 demonstration and who are on Direct Coverage, premium assistance will be furnished in coordination with STC 45. There are two separate categories of eligibility under Family Assistance:
 - a) **Family Assistance-HIV/AIDS.** As referenced in table A above, for persons with HIV/AIDS whose income is above 133 percent less than or equal to 200 percent of the FPL. Unlike other coverage types, persons with HIV who have access to ESI do not have to enroll in available ESI; however, if they choose to receive premium assistance, the Commonwealth will provide covered services that are not available from the ESI plan on a fee-for-service (FFS) basis.
 - b) **Family Assistance-Children.** As referenced in table A above, children can be enrolled in Family Assistance if their family's income is above 150 percent and less than or equal to 300 percent FPL. Benefits are provided either through direct coverage or cost effective premium assistance. Direct coverage Family Assistance under the title XXI program is provided through an MCO 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 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.

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

38. **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 CFR. 440.255.

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

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

Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
EPSDT	X	X		
Inpatient Acute Hospital	X	X	X	X
Adult Day Health	X	X		
Adult Foster Care**	X	X		
Ambulance (emergency)	X	X	X	X
Audiologist Services	X	X	X	X
Behavioral Health Services (mental health and substance abuse)	X	X	X	X
Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
Chapter 766 Home Assessment***	X	X	X	
Chiropractic Care	X	X	X	

Chronic Disease and Rehabilitation Hospital Inpatient	X	X	X	X
Chronic Disease and Rehabilitation Hospital Outpatient	X	X	X	X
Community Health Center (includes FQHC and RHC services)	X	X	X	X
Day Habilitation****	X	X		
Dental Services	X	X	X	X
Diversionsary Behavioral Health Services	X	X	X	X
Durable Medical Equipment and Supplies	X	X	X	X
Early Intervention	X	X	X	
Family Planning	X	X	X	X
Group Adult Foster Care	X	X		
Hearing Aids	X	X	X	X
Home Health	X	X	X	X
Hospice	X	X	X	X
Laboratory/X-ray/Imaging	X	X	X	X
Medically Necessary Non-emergency 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
Skilled Nursing Facility	X	X	Limited	Limited
Speech and Hearing Services	X	X	X	X
Targeted Case Management	X	X		
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X
Vision Care	X	X	X	X

Chart Notes

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

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

****** Day Habilitation Services** – These services are state plan services and the definition of these services may vary contingent upon the approved state plan. In general, the services are assistance with skill acquisition in the

following developmental need areas: self-help, sensorimotor, communication, independent living, affective, behavior, socialization and adaptive skills. Services are provided in non-residential settings or Skilled Nursing Facilities when recommended through the PASRR process. Services include nursing, therapy and developmental skills training in environments designed to foster skill acquisition and greater independence. A day habilitation plan sets forth measurable goals and objectives, and prescribes an integrated program of developmental skills training and therapies necessary to reach the stated goals and objectives.

40. Diversionary Behavioral Health Services. Diversionary behavioral health services are home and community-based mental health and substance use disorder services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and substance use disorder services in more community-based, less structured environments. Diversionary services are also provided to support an individual’s return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. 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. Some of the 24 hour service providers of Diversionary Behavioral Health Services meet the definition of an Institution for Mental Diseases (IMD).

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. Any MassHealth member under the demonstration who is enrolled in managed care may be eligible to receive diversionary services. Managed care entities and the Prepaid Inpatient Health Plan (PIHP) for behavioral health services identify appropriate individuals to receive diversionary services. Managed care entities maintain a network of diversionary services and arrange, coordinate, and oversee the provision of medically necessary diversionary services, as described in Table C.

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

<u>Diversionary</u>	<u>Setting</u>	<u>Definition of Service</u>
Community Crisis Stabilization	24-hour facility	Services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.

Community Support Program (CSP)	Non-24-hour facility	An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services
<u>Diversionsary</u>	<u>Setting</u>	<u>Definition of Service</u>
		to Covered Individuals with a long-standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.
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.

<p>Acute Treatment Services for Substance Abuse</p>	<p>24-hour facility, Including IMDs</p>	<p>24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co- occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs</p>
<p>Clinical Support Services for Substance Abuse</p>	<p>24-hour facility, including IMDs</p>	<p>24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.</p>

<p>Transitional Care Unit Services addressing the needs of children and adolescents, under age 19, in the custody of the Department of Children and Families (DCF), who need group care or foster care and no longer meet the</p>	<p>24-hour facility, including IMDs</p>	<p>A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu**, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.</p>
<p>Psychiatric Day Treatment*</p>	<p>Non-24-hour facility</p>	<p>Services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.</p>
<p>Intensive Outpatient Program</p>	<p>Non-24-hour</p>	<p>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.</p>
<p><u>Diversions</u></p>	<p><u>Setting</u></p>	<p><u>Definition of Service</u></p>

<p>Structured Outpatient Addiction Program</p>	<p>Non-24-hour facility</p>	<p>Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.</p>
<p>Program of Assertive Community Treatment</p>	<p>Non-24-hour facility</p>	<p>A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community.</p> <p>Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.</p>

Emergency Services Program*	Non-24-hour facility	Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.
Community Based Acute Treatment for Children and Adolescents	24-hour facility	Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (which is defined as one- on-one therapeutic monitoring as needed for individuals who may be at immediate risk for suicide or other self-harming behavior); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.

Chart Notes:

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

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

<u>Diversions</u>	<u>Setting</u>	<u>Definition of Service</u>
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		<p>to Covered Individuals with a long- standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting.</p> <p>Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.</p>
Partial Hospitalization*	Non-24-hour facility	<p>An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.</p>

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

<u>Diversions Behavioral Health Service</u>	<u>Setting</u>	<u>Definition of Service</u>
	facility	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	Non-24-hour facility	Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.

<p>Program of Assertive Community Treatment</p>	<p>Non-24-hour facility</p>	<p>A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and</p>
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Diversionary Behavioral Health Service	Setting	Definition of Service
		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 a day, seven days a week, 365 days a year.
Emergency Services Program*	Non-24-hour facility	Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.
Community Based Acute Treatment for Children and Adolescents	24-hour facility	Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (which is defined as one-on-one therapeutic monitoring as needed for individuals who may be at immediate risk for suicide or other self harming behavior); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.
<u>Chart Notes:</u>		
* This service is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment.		
** In this context, “therapeutic milieu” refers to a structured, sub-acute setting, in which clinical services (therapies) are provided at both the individual and group level, and in which the common social/interpersonal interactions between each patient, and all others who are present in the setting, are incorporated into the treatment approach.		

41. Substance Use Disorder Services Substance Use Disorder Services.

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

As is currently the case, the Department of Public Health, Bureau of Substance Abuse 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 D. Additional SUD Authorized Services

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

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

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

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

These methodologies are subject to CMS approval of the pilot program protocol. The CMS approved protocol is Attachment F to these STCs. The state must evaluate the degree to which such a payment and flexible use of funds enhances the effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower costs.

a) Eligibility. The state must limit the pilot program to demonstration eligible children, age 2

through 18 at the time of enrollment in the pilot, who are enrolled in the Primary Care Clinician Plan panel of a participating practice site, and who have high-risk asthma. Children with high-risk asthma are those children who have, in the last 12 months prior to enrollment in the pilot, had an asthma-related inpatient hospitalization, observation stay, or emergency department visit or an oral corticosteroid prescription for asthma. The state must utilize Medicaid claims data to identify eligible children.

- b) Benefits. The benefits within a payment such as a PMPM may vary over the course of the pilot. Prior to enrolling beneficiaries in the Pediatric Asthma Program, CMS must approve the benefit package and any changes proposed to the benefit package over the course of the pilot through the protocol process outlined in subparagraph (g). For example, services include for Phase 1: non-traditional services and supplies to mitigate environmental triggers of asthma and home visitation and care coordination services conducted by qualified Community Health Workers. In Phase II, the payment structure such as a PMPM, bundled, global, or episodic payment may be expanded to also include certain Medicaid State plan services with utilization that is particularly sensitive to uncontrolled asthma (i.e. treatment provided by physicians, nurse practitioners and hospitals, medical equipment such as a nebulizer, spacer, peak flow meter, etc.).
- c) Delivery System. Provider Participation in the pilot must be limited to primary care clinician sites that participate or enroll in the Primary Care Clinician Plan (PCCP). The practices must be responsible for supervision and coordination of the medical team, including Community Health Workers; delivery of asthma-related services paid for by the PMPM payment; as well as the PMPM cost of each beneficiary enrolled.

Provider participation in the pilot must be determined through a Request for Proposal (RFP) process. The state must prioritize participation by qualified practices that serve a high number of patients with high-risk asthma enrolled in PCCP and have the capacity to manage asthma in a coordinated manner. In addition, the state must seek to include qualified practices that are geographically dispersed across the state and represent a range of provider types, such as physician group practices, community health centers, and hospital outpatient departments, in order to explore a variety of infrastructure challenges.

- d) Infrastructure Support for Participating Provider Sites. To defray the costs of implementing the financial, legal and information technology system infrastructure required to manage a payment such as PMPM and coordination of patient care, participating provider sites are eligible for up to \$10,000 per practice site for the sole purpose of infrastructure changes and interventions related to this Pediatric Asthma Pilot only. The amount of infrastructure support is variable up to this maximum depending on the provider's readiness, the state's review and finding of such readiness, and CMS' concurrence on the use of the proposed funding for the practice as per the protocol process outlined in subparagraph (g) and (h).
- e) Pilot Expansion. Following initial implementation and evaluation of programmatic outcomes, and subsequent CMS approval, the state may request CMS approval to

implement a payment such as a PMPM, bundled, global or episodic payment and/or shared savings methodology component to the Pediatric Asthma Pilot. Examples of favorable outcomes include the prevention of asthma-related emergency department utilization, and asthma-related hospitalizations and improved patient outcomes.

- f) Extent of FFP in the Pilot. FFP for this pilot program is subject to compliance with the protocols attached as Appendix F, as such protocols may be amended pursuant to subparagraph (g) below. The infrastructure support described in subparagraph (d) above must be provided through the Infrastructure and Capacity-Building fund as part of the Safety Net Care Pool outlined in section VIII CMS will provide FFP at the applicable Federal Medical Assistance Percentage for services and supplies outlined in the approved benefit package pursuant to subparagraph (g)(1), subject to reimbursement amounts identified in the payment methodology outlined in subparagraph (g)(5), demonstration budget neutrality limits and any applicable SNCP limits.
- g) Required Protocols Prior to Claiming FFP. The state has met the following milestones which required CMS preapproval in order to enroll beneficiaries and claim FFP under this pilot program. These protocols/milestones are found in Attachment F.
- 1) A description and listing of the program specific asthma-related benefit package that will be provided to the pilot participants with rationale for the inclusion of each benefit;
 - 2) Eligibility, qualifications and selection criteria for participating providers, including the RFP for preapproval;
 - 3) A plan outlining how this pilot may interact with other federal grants, such as for related research (e.g. NIH, HUD, etc.) and programmatic work (e.g. CHIPRA grant related to pediatric health care practices in multi-payer medical homes, etc.). This plan should ensure no duplication of federal funds and outline the state's coordination activities across the various federal supports for related programmatic activities to address potential overlap in practice site selection, patient population, etc.
 - 4) A plan for the purchase and dissemination of supplies within the pilot specific benefit package, including procurement methods by the state and/or providers including volume discounts, etc.;
 - 5) A payment rate setting methodology outlining the PMPM payment for the pilot services and supplies, consideration of risk adjustment and the estimated/expected cost of the pilot;
 - 6) A payment methodology outlining cost and reconciliation for the infrastructure payments to participating provider sites, and the eligibility and reporting requirements associated with the infrastructure payments; and
 - 7) An approved evaluation design for the pilot that is incorporated into the evaluation design required per section XII. The objective of the evaluation is to determine the benefits and savings of the pilot as well as design viability and inform broader implementation of the design. The evaluation design must include an evaluation of programmatic outcomes for purposes of subparagraph (e). As part of the evaluation, the state at a minimum must include the following requirements:

- i) Collect baseline and post-intervention data on the service utilization and cost savings achieved through reduction in hospital services and related provider services for the population enrolled in the pilot. This data collection should include the quality measure on annual asthma-related emergency room visits outlined in the initial core set of children’s health care quality measures authorized by the Children’s Health Insurance Program Reauthorization Act (CHIPRA) beginning with a baseline set at the onset of the pilot, adjusted for the age range enrolled in the pilot program;
 - ii) A detailed analysis of how the pilot program affects the utilization of acute health services, such as asthma-related emergency department visits and hospitalizations by high risk pediatric asthma patients, and how the pilot program reduces or shifts Medicaid costs associated with treatment and management of pediatric asthma;
 - iii) An assessment of whether the cost projections for the provider payment were appropriate given the actual cost of rendering the benefits through the pilot program; and
 - iv) A detailed analysis of how the effects of the pilot interact with other related initiatives occurring in the state.

- h) Changes to the Pediatric Asthma Program and/or Amendments to the Protocols. If the state proposes to amend the pilot benefits, payment structure, delivery system or other issues pursuant to the protocols it must seek CMS approval to amend its protocols as outlined in subparagraph (g) and (i). An amendment to protocols is not subject to STC 7 regarding demonstration amendments. Should the state choose to design and plan for payments such as bundled, global or episodic payments or shared savings to participating providers, methodology documents must be preapproved by CMS prior to contract changes or implementation of the changes; any shared savings or payment methodologies must be consistent with CMS policy and guidelines, including any quality reporting guidelines.

- i) Reporting. The state must provide status updates on the pilot program within the quarterly and annual reports as required by section VI. At a minimum, reporting for the pilot program must provide an update on all pilot program related activities including:
 - 1) Current and future state activities related to the required deliverables as described in subparagraph (g), including anticipated changes to the benefit package, delivery system or payment methodology;
 - 2) Services and supplies provided to beneficiaries, community outreach activities, increases and decreases in beneficiary enrollment or provider enrollment, and any complaints regarding quality or service delivery;
 - 3) Pediatric asthma pilot program payments to participating providers that occurred in the quarter. Infrastructure payments made to providers under this pilot will be reported pursuant to section VIII;
 - 4) Expenditure projections reflecting the expected pace of future provider payments; and
 - 5) Progress on the evaluation of the pilot program as required in subparagraph (g),

including a summary of the baseline and pilot outcome data from Medicaid claims data associated with enrollee utilization and associated cost of treatment, including prescriptions, and primary care, emergency department and hospitalization visits.

VI. DELIVERY SYSTEM

The MassHealth section 1115 demonstration provides benefits through multiple delivery systems and programs. A fundamental philosophy of MassHealth is that the Commonwealth will enable beneficiaries to take advantage of available and qualified employer-sponsored or student health insurance if cost effective. These circumstances include the availability of private health insurance, 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.

43. **Direct Coverage.** MassHealth benefits provided through direct coverage are delivered both on a fee for service (FFS) and capitated basis under the demonstration. As described below in Table D, MassHealth may require beneficiaries eligible for direct coverage under Standard, Standard ABP, Family Assistance, CommonHealth, or CarePlus to enroll in managed care. Generally, these individuals can elect to receive services either through the statewide Primary Care Clinician (PCC) Plan or from a MassHealth-contracted managed care organization (MCO). Managed care enrollment is mandatory for CommonHealth members with no third party liability.

In addition, children who are clients of the Departments of Children and Families (DCF) or Youth Services (DYS) who do not choose a managed care plan are required to enroll with the behavioral health contractor for behavioral health services and may choose to receive medical services on a fee-for-service basis.

Children eligible under TEFRA section 134 (Kaileigh Mulligan) and children receiving title IV-E adoption assistance may opt to enroll in managed care or receive health services via fee-for-service. Children who choose managed care may choose a managed care organization (MCO) or a PCC plan. Children who choose an MCO will receive their behavioral health services through the MCO. Children who choose the PCC Plan will receive their behavioral health services through the behavioral health contractor. 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.

44. **Managed Care Arrangements.** MassHealth may implement, maintain, or modify (without amendment to the demonstration), and any managed care arrangements authorized under section 1932(a) of the Act or 42 CFR 438 et seq., including:

a) The PCC Plan. The PCC Plan is a primary care case management program administered by

MassHealth. In the PCC Plan, members enroll with a PCC who provides most primary and preventive care and who is responsible for providing referrals for most specialty services. Members can access specialty services from any MassHealth provider, subject to PCC referral and other utilization management requirements. Members enrolled in the PCC Plan receive mental health and substance abuse services through a single Behavioral Health Program (BHP) contractor, which is a Prepaid Inpatient Health Plan (PIHP). PCC Plan members may receive family planning services from any provider without consulting their PCC or obtaining prior approval from MassHealth.

- i. Enhanced Primary Care Clinician Payments. In accordance with 42 C.F.R. section 438.6(c)(5)(iv), MassHealth may establish enhanced fee-for-service rate payments or capitated rate payments to Primary Care Clinicians for coordination of the care delivered to their enrolled PCC plan members. MassHealth may also establish pay-for-performance incentives using capitated or other payment arrangements for achieving certain quality of care benchmarks, for demonstrating certain levels of improvement for selected Healthcare Effectiveness Data and Information Set (HEDIS) or other quality indicators, and for implementing practice infrastructure designed to support the delivery of high-quality health care services to enrolled members.
 - ii. In state fiscal years 2017 and 2018, MassHealth will contract with ACOs (“Pilot ACOs”) for an ACO Pilot within the PCC Plan; the ACO Pilot is not a separate delivery system or an enrollment option for members. Members in the PCC Plan will not experience fixed enrollment periods for the ACO Pilot, and members will still have access to all PCC Plan benefits and network of providers. Pilot ACOs consist of provider-led entities such as health systems or groups of health care providers that contract with MassHealth to provide care coordination and management and to take financial accountability for cost and quality of care for certain attributed PCC Plan members. Members enrolled in the PCC Plan who are assigned to PCCs that participate with Pilot ACOs will be considered attributed to these Pilot ACOs. MassHealth may establish Referral Circles for Pilot ACOs; Referral Circles are groups of providers within MassHealth’s FFS network, for which MassHealth will eliminate the need for otherwise-required primary care referrals for ACO-attributed members, in order to facilitate increased access and coordinated care. MassHealth will hold Pilot ACOs financially accountable for cost and quality of care through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses). MassHealth will contract with Pilot ACOs selectively. Pilot ACOs are not managed care entities under 42 CFR 438. See Attachment L for additional detail on the ACO Pilot.
- b) Patient Centered Medical Home Initiative (PCMHI). The PCMHI is a multi-payer initiative to transform selected primary care practice sites into PCMHs by 2015. MassHealth is a dominant public payer in the PCMHI and is assuming the same responsibilities as other participating payers both for enrollees in its PCC Plan and those in Medicaid contracted MCOs. The PCMHI practices must meet reporting requirements on clinical and operational

measures, in addition to certain benchmarks to indicated continued progress towards medical home transformation, such as obtaining National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medicaid Home (PPC®-PCMHI™) Level One recognition. Any infrastructure support provided to Primary Care Clinicians who participate as PCMHI providers must be funded by the infrastructure and capacity-building component of the SNCP as referenced in STC 50(c). A formal evaluation of the PCMHI is also being conducted and should be included as relevant to the demonstration in draft evaluation design as per STC 90.

- c) **MCOs.** MassHealth contracts with MCOs that provide comprehensive health coverage including behavioral health services to enrollees. MCO enrollees may receive family planning services from any provider without consulting their PCP or MCO and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in the MCO network, MassHealth reimburses the provider on a FFS basis and recoups the funds from the MCO.

45. Exclusions from Managed Care Enrollment. The following individuals may be excluded from enrollment in a MassHealth-contracted managed care plan:

- a) Individuals for whom MassHealth is a secondary payer (i.e., a member with other health insurance). For purposes of exclusion from managed care, “other health insurance” is defined as any medical coverage plan available to the member, including, but not limited to Medicare, CHAMPUS, or a private health plan. However, MassHealth requires children eligible for MassHealth Standard/Standard ABP and CommonHealth, for whom MassHealth is a secondary payer, to enroll with the behavioral health contractor for behavioral health services;
- b) Individuals 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) Individuals receiving Limited coverage;
- d) Individuals receiving hospice care, or who are terminally ill as documented with a medical prognosis of a life expectancy of 6 months or less; and
- e) Participants in a Home and Community-Based Services Waiver who are 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 on a fee-for-service basis.

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.

46. Contracts.

- a) Managed Care Contracts. All contracts and modifications of existing contracts between the Commonwealth and MCOs must be prior approved by CMS. The Commonwealth will provide CMS with a minimum of 30 days to review and approve changes.
- b) Public Contracts. Contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index), unless the contractual payment rate is set at the same rate for both public and private providers. This requirement does not apply to contracts under the SNCP as outlined in section VIII.
- c) Selective Contracting. Procurement processes and the subsequent final contracts developed to implement selective contracting by the Commonwealth with any provider group shall be subject to CMS approval prior to implementation, except for contracts authorized pursuant to 42 C.F.R. section 431.54(d).
- d) Patient Centered Medical Home Initiative (PCMHI). Details regarding the PCHMI may be found in the Commonwealth's PCC and MCO contracts.

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

If available and cost effective, the Commonwealth will provide premium assistance on behalf of individuals eligible for Standard (including ABP 1), CarePlus or CommonHealth coverage, to assist them in the purchase of private health insurance coverage. The state will also provide coverage for additional services required to ensure that such individuals are receiving no less than the benefits they would receive through direct coverage under the state plan. This coverage will be furnished, at the state option, on either a FFS basis or through managed care arrangements. These individuals are not required to contribute more towards the cost of their

private health insurance than they would otherwise pay for MassHealth Standard (including ABP 1), CarePlus or CommonHealth coverage. Cooperation with the Commonwealth to obtain or maintain available health insurance will be treated as a condition of eligibility for all of those in the family group, except those who are under the age of 21, or pregnant.

48. **Student Health Insurance (SHIP) Plans.** For individuals with access to SHIP, the Commonwealth may require enrollment in such plan as a condition of receiving benefits. Once the individual enrolls in the SHIP, premium and cost sharing assistance will be provided for the entire plan year or the duration of the SHIP enrollment, if less than one year. The state will also ensure individuals receive comparable benefits to those offered in Medicaid programs the individual is eligible for receiving, for the duration of the individual’s enrollment in SHIP. In addition, for those individuals enrolled in SHIP with premium assistance, the Commonwealth will provide continuous eligibility that will coincide with the SHIP year, or the duration of the SHIP enrollment, if less than one year, for which premium assistance is provided.
49. **Overview of Delivery System and Coverage for MassHealth Administered Programs.** The following chart provides further detail on the delivery system utilized for the MassHealth administered programs and the related start date for coverage:

Table E. Delivery System and Coverage for MassHealth Demonstration Programs

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
<u>Standard/Standard ABP</u>					

Individuals with no third party liability (TPL)	MCO or PCC Plan**	x			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
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 are offered via MCO, PCC Plan, or FFS.		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
Medically complex children in the care/custody of the DCF	Special Kids Special Care MCO		x		Start date of state custody

<p>Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF</p>	<p>All services are offered via MCO, PCC Plan, or FFS, with the exception of behavioral health which is provided via mandatory enrollment in BHP PIHP unless a child enrolls in an MCO or Accountable Care Partnership Plan.</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>Start date of state custody</p>
<p>Coverage Type</p>	<p>Delivery System Type</p>	<p>Mandatory</p>	<p>Voluntary</p>	<p>FFS Only</p>	<p>Start Date of Coverage****</p>
	<p>Is enrolled in an MCO (in which case, behavioral health is provided through the MCO or Accountable Care Partnership Plan).</p>				
<p>Provisionally eligible pregnant women and children, for an up to 90-day period, before self-attested family income is verified</p>	<p>FFS</p>			<p>x</p>	<p>10 days prior to date of application if citizenship/immigration status is verified</p>

Individuals in the Breast and Cervical Cancer Treatment Program	MCO or PCC Plan	X			10 days prior to date of application
<u>CommonHealth*</u>					
Individuals with no TPL	MCO or PCC Plan **	X			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for HIV/AIDS*</u>					

Individuals with no TPL	MCO or PCC Plan**	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for Children***</u>					
Individuals with no TPL	MCO or PCC Plan**	X			10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>CarePlus</u>					
Individuals with no TPL	MCO only (if there are two MCOs in the area)	X			10 days prior to date of application

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

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
*TPL wrap could include premium payments					
** FFS until member selects or is auto-assigned to MCO or PCC Plan; if fewer than two MCOs are available in a CarePlus member's service area, the member must enroll in the PCC Plan or MCO					
***Presumptive and time-limited during health insurance investigation					
****All retroactive eligibility is made on a FFS basis					

50. Pilot Accountable Care Organizations. MassHealth is transitioning from fee-for-service to integrated accountable care, as providers form accountable care organizations (ACOs). ACOs are provider-led organizations that are held contractually responsible for the quality, coordination and total cost of members' care. This shift to accountable, total cost of care models at the provider level is central to the Commonwealth's goal of a sustainable MassHealth program.

As a first step, MassHealth will contract with Pilot ACOs, provider -led entities such as health systems or groups of health care providers which contract with MassHealth to provide care coordination and management and to take financial accountability for cost and quality of care for certain PCC Plan members. MassHealth may establish Referral Circles for Pilot ACOs; Referral Circles are groups of providers within the network, for which MassHealth will eliminate the need for otherwise-required primary care referrals for ACO-attributed members, in order to facilitate increased access and coordinated care. MassHealth will hold these ACOs financially accountable for cost and quality of care through shared savings and shared losses (i.e., downside risk). The following elements will be documented in Protocol XXX: whether or not the Pilot ACOs will be reimbursed using asymmetric risk (i.e., potential shared savings exceed potential shared losses), and whether selective MassHealth contracting will be geographically limited. Pilot ACOs are not managed care entities and are not subject to 42 C.F.R 438.

- a) **Responsibilities:** Pilot ACOs are responsible for coordinating and managing care for attributed members as described in each Pilot ACO's Total Cost of Care and Quality Management Model. The Total Cost of Care and Quality Management Model is submitted by each Pilot ACO for MassHealth approval and describes components such as:
 - i. The ACO's care management programs;
 - ii. The ACO's care coordination and integration, including clinical partners and proposals for using interdisciplinary, team-based models of care;
 - iii. The ACO's assessment of members' needs for culturally and linguistically accessible services;
 - iv. The ACO's member outreach and engagement efforts;
 - v. The ACO's approach to distributing funds among providers participating with the ACO;
 - vi. The ACO's approach to risk stratification and high-risk medical management; and
 - vii. The ACO's performance management and quality improvement strategy.

- b) **Payment:** Pilot ACOs will be eligible to receive shared savings based on total cost of care for attributed members. Pilot ACOs will also be at risk for shared losses.

- c) **Quality Payments:** Pilot ACOs must report on clinical quality measures in order to be eligible for shared savings, and will be evaluated on a range of quality measures including claims-based measures and a member experience survey. The ACO Pilot does not include additional quality incentive payments.
- d) **Qualifications.** Each Pilot ACO must apply for Risk-Bearing Provider Organization certification from the Massachusetts Division of Insurance, must maintain a governing board that is 75% provider-controlled and includes a consumer or advocate representative, must include a Quality Committee and a Patient and Family Advisory Committee in the broader governance structure, must contract with an exclusive group of participating primary care providers, must provide members with required member protections including member rights and grievance procedures, and must implement a MassHealth-approved Total Cost of Care and Quality Management Model.
- e) **Access Requirements:** Members attributed to a Pilot ACO may receive services from the same MassHealth Provider network available to PCC Plan enrollees, including from MassHealth’s managed behavioral health vendor. The state will ensure that members attributed to Pilot ACOs can access covered services, and that such services are delivered in a culturally competent manner, in accordance with MassHealth’s access and availability standards, as with other members in the MassHealth PCC Plan
- f) **Provider Payments:** Providers who deliver services to Members attributed to a Pilot ACO will continue to be paid in the same manner as providers who deliver services to PCC Plan enrollees, including from MassHealth’s managed behavioral health vendor. Pilot ACOs will be accountable for total cost of care through a retrospective reconciliation process, as further detailed in Attachment L.
- g) **Enrollment:** Members attributed to Pilot ACOs will be members enrolled in MassHealth’s PCC Plan who are enrolled with PCCs participating in the ACO Pilot. MassHealth will attribute these members to ACOs based on these PCC enrollments. Members may switch PCC enrollments at any time, subject to the normal PCC Plan rules, and may also enroll in MCOs at any time, subject to MassHealth’s normal MCO enrollment rules
- h) **Notice to beneficiary:** The state will notify members whose PCCs participate in the ACO Pilot of their attribution to a Pilot ACO. Pilot ACOs may not request member dis-enrollment
- i) **Member rights and protections:** Members attributed to Pilot ACOs will have

access to MassHealth/Board of Hearings appeals processes and to their ACOs' grievance proceedings. ACOs will also be required to ensure members receive care in accordance with a member bill of rights.

- j) **Beneficiary choice:** Members may switch PCCs, including to a PCC not participating in the ACO Pilot, at any time, subject to normal PCC enrollment rules
- k) **Limited capacity:** Because ACO attribution will be based on members' enrollments with PCCs, MassHealth will ensure ACO capacity through MassHealth's normal PCC Plan rules for limiting PCC panel size.

VII. COST SHARING

51. **Overview.** Cost-sharing imposed upon individuals enrolled in the demonstration and eligible under the state plan or in a "hypothetical" eligibility group is consistent with the provisions of the approved state plan except where expressly made not applicable in the demonstration expenditure authorities. Cost sharing for individuals eligible only through the demonstration varies across demonstration programs and by FPL, except that no co-payments are charged for any benefits rendered to children under age 19, individuals ages 19 or 20 or pregnant women. Additionally, no premium payments are required for any individual enrolled in the Demonstration whose gross income is less than 150 percent FPL. Please see Attachment B for a full description of cost-sharing under the demonstration for MassHealth-administered programs. The Commonwealth has the authority to change cost-sharing for the Small Business Employee Premium Assistance programs without amendment. Updates to the cost-sharing will be provided upon request and in the annual reports.

VIII. THE SAFETY NET CARE POOL (SNCP)

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

53. SNCP Operational Authority and Effective Date.

- a) **Coordination of funding with Temporary Extension period.** For the period operating under temporary extension from July 1, 2014, through the period prior to the date of the approval letter, all SNCP expenditures were authorized up to the amount of the DSH allotment for SFY 2015, with the exception of Commonwealth Care Orderly Closeout and

Temporary Coverage DSHPs which were funded through budget neutrality savings. The aggregate SNCP cap must be reduced by Commonwealth Care Orderly Closeout and Temporary Coverage DSHP expenditures for the temporary extension period to reflect this exception.

b) **Operation through June 30, 2017.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, the Commonwealth is currently only authorized to operate the SNCP through June 30, 2017, with the exception of the Health Connector Subsidies which are authorized through June 30, 2019. All STCs, waivers and expenditure authorities relating to the SNCP are effective for dates of service beginning on the date of the approval letter through June 30, 2017 unless otherwise provided in these STCs and reflected in Attachment E.

54. **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 51, 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) Designated State Health Programs

(1) Specified State-Funded Programs. The Commonwealth may claim as allowable expenditures under the demonstration expenditures for designated programs that provide or support the provision of health services and initiatives that promote cost containment and that are otherwise state funded, as specified in Attachment E of the STCs, for dates of service beginning as of the date of the approval letter through June 30, 2017. Allowable expenditures under this program will be subject to the DSHP limit described in section VIII.

(2) Health Connector Subsidies. For dates of service beginning as of the date of the approval letter, the Commonwealth may claim as allowable expenditures under the demonstration Health Connector subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for individuals with incomes at or below 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; and (2) whose income is at or below 300 percent of the FPL. Federal financial participation for the premium assistance and cost sharing portions of Health Connector subsidies for citizens and eligible qualified non-citizens will be provided through the Designated State Health Programs authority under the SNCP pursuant to this STC. Allowable expenditures for Health Connector subsidies will not be subject to the DSHP cap and aggregate SNCP limit described in section VIII.

- b) Providers. For dates of service beginning July 1, 2014, as described in Attachment E, the Commonwealth may claim as an allowable expenditure under the demonstration to the extent permitted under the SNCP limits under STC 51, 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, Medicaid managed care, and low-income uninsured individuals. The Commonwealth may also claim as an allowable expenditure payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD). The Commonwealth may also claim a portion of One Care Demonstration capitation payments for dental services provided to One Care members that in the absence of One Care would otherwise be reimbursed through the Health Safety Net as a Dental Wrap service.
- c) Infrastructure and capacity-building. The Commonwealth may claim as allowable expenditures under the demonstration to the extent permitted under the SNCP limits under section VIII expenditures that support capacity-building and infrastructure for the improvement or continuation of health care services that benefit the uninsured, underinsured, MassHealth, demonstration and SNCP populations. Infrastructure and capacity-building funding may also support the improvement of health care services that benefit the demonstration populations as outlined in section V, and to support pilot ACOs (in addition to hospitals generally and community health centers) with infrastructure and care coordination expenses during the ACO pilot period. Activities related to Delivery System Transformation Initiatives are prohibited from also being claimed as infrastructure and capacity-building. In the annual report as required by section XII, the Commonwealth must provide the actual amount, purpose and the entity each associated payment was made to for this component of the SNCP.
- d) Delivery System Transformation Initiatives (DSTI). The Commonwealth may claim as allowable expenditures under the demonstration, to the extent permitted under the SNCP limits under STC 51, incentive payments to providers for the development, implementation, and improvement of programs that support hospitals' efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and build the capacity to participate in payment reform strategies and models. Massachusetts must use an independent assessor to evaluate DSTI hospital Semi-Annual and Annual reports and determine whether the state and hospitals have achieved the specified metrics and measures. FFP at the administrative match rate is available for the independent assessor.
- i. Eligibility. The program of activity funded by the DSTI shall be based in public and private acute hospitals, with a high, documented Medicaid patient volume, that are directly responsive to the needs and characteristics of the populations and communities. Therefore, providers eligible for incentive payments are defined as public or private acute hospitals with a high Medicaid payer mix and a low commercial payer mix based on the 2009 cost report data. The hospitals eligible for

incentive payments, over this demonstration period, based on this criterion, are listed in Attachment I.

- ii. Master DSTI Plan. The Commonwealth must submit to CMS for approval a “master” DSTI plan (future attachment J). The master plan must:
 - i. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by hospitals;
 - ii. Specify the DSTI categories consistent with subparagraph (4) below, and detail the associated projects, population-focused objectives and evaluation metrics from which each eligible hospital will select to create its own plan;
 - iii. Detail the requirements of the hospital-specific plans discussed in subparagraph (3) and STC 52; and
 - iv. Specify all requirements for the DSTI plans and funding protocol pursuant to STC 52.

- iii. Hospital-specific Plans. Upon CMS approval of the Commonwealth’s master DSTI plan, each participating hospital must submit an individual DSTI plan approved by the state and CMS that identifies the projects, population-focused objectives, and specific metrics adopted from the master DSTI plan and meets all requirements pursuant to STC 52. CMS shall approve each hospital’s DSTI plan following the state review process pursuant to STC 52(a)(6), provided that the plan(s) meet all requirements of the approved master DSTI plan outlined in STC 50 and STC 52 in addition the requirements outlined for the hospital specific DSTI plans pursuant to STC 52(b) and the approved DSTI payment and funding protocol pursuant to STC 52 (c).

Participating hospitals must implement new, or significantly enhance existing health care initiatives. The hospital-specific DSTI plans must address all four categories, as outlined in subparagraph (4) below, but each hospital is not required to select all projects within a given category. Each individual hospital DSTI plan must include a minimum number of projects selected within each category as outlined in the master DSTI plan and report on progress to receive DSTI funding. Eligibility for DSTI payments will be based on successfully meeting metrics associated with approved projects as outlined in subparagraph (8) and the submission of required progress reports outlined in STC 53(d)(1).

- iv. DSTI Categories and Projects. Each participating hospital must select a minimum number of projects from each category as outlined in the master DSTI plan. Additionally, the projects must be consistent with the overarching approach of improving health care through the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The selected projects will be detailed in the hospital-specific plans described in subparagraph (3) and STC 52. Each project, depending on the purpose and scope of the project, may include a mix of process-oriented metrics to measure progress in the development and implementation of infrastructure and outcome metrics

to measure the impact of the investment. Metrics are further discussed in subparagraph (5) and STC 52.

There are four categories for which funding authority is available under the DSTI, each of which has explicit connection to the achievement of the Three Part Aim mentioned in the preceding paragraph:

Category 1: Development of a fully integrated delivery system: This category includes investments in projects that are the foundation of delivery system change to encompass the concepts of the patient-centered medical home (PCMH) model to increase delivery system efficiency and capacity. Examples include:

- i. Investments in communication systems to improve data exchange with medical home sites
- ii. Integration of physical and behavioral health care
- iii. Development of integrated care networks across the continuum of care
- iv. Investment in patient care redesign efforts, such as patient navigators, alternative delivery sites, alternative office hours, etc.

Category 2: Improved Health Outcomes and Quality: This category includes development, implementation and expansion of innovative care models which have the potential to make significant demonstrated improvements in patient experience, cost and care management. Examples include:

- i. Implementation of Enterprise-wide Care Management or Chronic Care Management initiatives, which may include implementation and use of disease management registries
- ii. Improvement of care transitions, and coordination of care across inpatient, outpatient, post-acute care, and home care settings
- iii. Adoption of Process Improvement Methodologies to improve safety, quality, and efficiency

Category 3: Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments that promote system sustainability. Examples include:

- i. Enhancement of Performance Improvement and Reporting Capabilities
- ii. Development of enhanced infrastructure and operating and systems capabilities that would support new integrated care networks and alternative payment models to manage within new delivery and payment models
- iii. Development of risk stratification capabilities/functionalities

Category 4: Population-Focused Improvements. This category involves evaluating the investments and system changes described in categories 1, 2 and 3 through population-focused objectives. Metrics must evaluate the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers. Metrics must also evaluate the impact of the payment

redesign and infrastructure investments to improve areas such as cost efficiency, systems of care, and coordination of care in community settings. All hospitals must report on metrics selected from a nationally validated or where applicable, a state validated common set of metrics defined in the master DSTI plan.

- v. DSTI Metrics and Evaluation. Each eligible provider must develop process- oriented and outcome metrics for each of the Categories 1, 2 and 3 that demonstrate clear project goals and objectives to achieve systematic progress. Examples of such project metrics may include: identification and purchase of system, programming of system, going live on a system, contracting with a payer using a bundled payment system, enrollment of a defined percentage of patients to a Medical Home model, increase by a defined amount the number of primary care clinics using a Care Management model, improve by a defined percentage patients with self- management goals, increase by a defined amount the number of patients that have an assigned care manager team, etc.

Metrics related to Category 4 shall recognize that the population-focused objectives/projects do not guarantee outcomes, but may impact outcomes. The objectives/projects must result in learning, adaptation and progress toward the desired outcome. These metrics must quantitatively measure the impact of the projects in Categories 1, 2, and 3 (e.g. disease measurements, ER admissions, cost management, etc.) on each participating provider's patient population. _

- vi. Funding At Risk for Outcomes and Quality Improvement: The percentage of DSTI funding at risk for improved performance on validated outcome or quality measures will gradually increase from 0 percent in SFY 2015 to 10 percent in SFY 2016 to 20 percent in SFY 2017 (averaging to 10 percent total over the three year period). This accountability structure is on a provider-specific basis. In addition, CMS will retain the existing "pass/fail" funding accountability for metrics associated with project activities (structural and process). Outcome measures focus on assessing progress on health outcomes that result from the structural and process modifications or improvements. Examples include impacts on morbidity, mortality, or readmissions. The specific outcome and quality measures will be defined in the approved Master DSTI Plan and hospital-specific plans described in STC 52. Examples of approvable metrics for outcome measures include but are not limited to:
- i. Agency for Healthcare Research and Quality (AHRQ) inpatient quality indicators and pediatric quality indicators
 - ii. National Quality Forum
 - iii. CMS Adult or Child Core Measures
 - iv. CMS Inpatient Quality Reporting (CMS-IQR)/Joint Commission
 - v. The U.S. Preventive Services Task Force (USPSTF) Preventive Measures
 - vi. AHRQ Preventive Quality Indicators
 - vii. National Quality Forum (NQF) 0028 – Preventive Care and Screening
 - viii. NQF 0712 - Screening for clinical depression

- ix. Transition of Care Measure CTM-3
- x. NQF 0554: Medication Reconciliation Post-Discharge (MRP)
- xi. NQF 0441 – Assessed for rehabilitation
- xii. NQF 1604 – Total Cost of Care Population Based PMPM Index
- xiii. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- xiv. National Committee for Quality Assurance (NCQA)
- xv. Massachusetts Patient-Centered Medical Home Initiative Measures

vii. Aggregate DSTI Outcome and Quality Improvement Accountability. Overall DSTI project funding is available up to the amounts specified in the special terms and conditions and Attachment E. As a general matter, DSTI funding is subject to the provider meeting the specific metric in the approved Master DSTI Plan. In addition, pool wide achievement of performance goals and targets must be achieved or maintained for full access to the funding level specified in the STCs, Attachment E and the DSTI Master Plan. Performance goals and targets for the DSTI providers will be defined in the Master DSTI Plan. The performance goals and targets will be based on the four domains described above. In DY 20 (SFY 2017) (the third year of the renewal period), the DSTI hospitals must show improvement relative to DY 18 (SFY 2015) performance baselines. If the DSTI providers do not meet the required aggregate performance goals as specified by the DSTI Master Plan by the end of year three, the DSTI pool will be subject to a five percent reduction in available funding. In other words, if the DSTI hospitals do not demonstrate the aggregate performance improvements as specified in the DSTI Master Plan, five percent of the DY 20 DSTI funding will be withheld.

This reduction, if applicable, will be taken at the end of the three year period.

The five percent reduction is an aggregate pool wide penalty based on three years of performance. It is not an additional penalty imposed on an individual provider for not meeting a specific metric. CMS will work with the Commonwealth to assure that any reduction penalty is equitable.

viii. DSTI Payments. DSTI payments for each participating provider are contingent on that provider meeting project metrics as defined in the approved hospital-specific plans. As further discussed in subparagraph (9) below, the master DSTI plan and payment and funding protocol, as required by STC 52, includes an incentive payment formula. Payment cycles to providers are described in the DSTI funding protocol and will be made at a minimum on a semi-annual basis contingent upon providers meeting the associated metrics. The actual metrics for incentive payments and the amount of incentive payments disbursed in a given year will be outlined pursuant to the approved master DSTI plan, hospital-specific plans and funding protocol requirements outlined in STC 52 and the reporting requirements outlined in STC 53. In DY18, approval of the hospital-specific plans will be considered an appropriate metric for the first incentive payment, and will equal up to 25 percent of the DY 18

total annual amount of DSTI funding a hospital is eligible for based upon incentive payments.

DSTI payments are not direct reimbursement for expenditures or payments for services. DSTI payments are intended to support and reward hospital systems for improvements in their delivery systems and payment models that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The payments are not direct reimbursement for expenditures incurred by hospitals in implementing reforms. The DSTI payments are not reimbursement for health care services that are recognized under these STCs or under the state plan.

DSTI payments should not be considered patient care revenue and will not be offset against other Medicaid reimbursements to hospital systems, including payments funded through approved intergovernmental transfers, or approved certified public expenditures incurred by government owned or operated hospital systems and their affiliated government entity providers for health care services, infrastructure and capacity-building, administrative activities, or other non-DSTI payment types authorized under these STCs and/or under the state plan.

- ix. Distribution of DSTI Funds among Hospitals: Attachment I specifies the hospitals eligible for DSTI over the demonstration approval period and outlines available DSTI funds for participating providers to earn through DSTI incentive payments for SFY 2015 - 2017.

The master DSTI plan, and payment and funding protocol, as outlined in STC 52, must specify the DSTI incentive payment formula and denote the total annual amount of DSTI incentive payments each participating hospital may be eligible for based upon the projects and metrics it selects. The incentive payment formula must identify per metric the following: (1) the annual base amount of funding per metric associated with the each category pursuant to STC 50(d)(4); (2) increases to that base amount associated with a hospital's proportional annual DSTI allowance; and (3) a rationale for any percentage adjustments made to a hospitals calculated DSTI allowance to account for factors such as differences in quality infrastructure, differences in external supports for improvements, and differences in patient populations to be identified in the master DSTI plan.

- x. FFP. FFP is available for DSTI payments to a participating provider in accordance with the CMS-approved DSTI master plan, the individual provider's plan and the funding protocol outlined in STC 52 as approved by CMS. DSTI payments to a particular provider are contingent upon whether that participating provider meets project metrics as defined in its hospital-specific plan, and are subject to legislative appropriation and availability of funds. FFP is available only for DSTI payments that are made in accordance with the master DSTI plan and the applicable hospital-specific plan.

- e) Cambridge Health Alliance (CHA) Public Hospital Transformation and Incentive Initiatives. CHA is the Commonwealth's only public acute hospital and has among the highest concentration of patients participating in MassHealth demonstration programs of any acute hospital in the Commonwealth. Through June 30, 2017, CHA will implement behavioral health integration initiatives as well as other approved initiatives. CHA identified that integrating primary care and behavioral health will help address the significant health disparities, and additional initiatives will support CHA's ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety-net populations it serves. Details regarding the Metrics and Evaluation of the initiatives are found in Attachment K. Unless otherwise noted in Attachment K, CHA's Public Hospital Transformation and Incentive Initiatives must comply with DSTI requirements, including carry-forward and reclamation provisions, as outlined in STC 52. Reflecting the size of the federal commitment to CHA and CHA's emphasis on short-term delivery system transformation, the percentage of CHA Public Hospital Incentive Initiative specific funding at risk for outcome measures goes from 0 percent in SFY 2015 to 15 percent in SFY 2016 to 30 percent in SFY 2017 (averaging 15 percent over the three year period). In DY18, CMS approval of CHA's initiatives will be considered an appropriate metric for the first incentive payment, and will equal up to 25 percent of the DY 18 total annual amount of Public Hospital Transformation and Incentive Initiatives funding that CHA is eligible for based upon incentive payments. Attachment E specifies the total allotment for CHA's Public Hospital Transformation and Incentive Initiatives.

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

Intended Funding Source: The non-federal share of PHTII payments will be provided through permissible intergovernmental transfer provided by CHA (from funds that are not federal funds or are federal funds authorized by federal law to be used to match other federal funds in accordance with 1903(w) of the Act and implementing regulations).

55. Expenditure Limits under the SNCP.

- a) Aggregate SNCP Cap. From the date of the approval letter through June 30, 2019, (SNCP extension period), the SNCP will be subject to an aggregate cap of \$4.970 billion, as well as the overall budget neutrality limit established in section XI of the STCs, provided, however, that allowable expenditures for Health Connector subsidies will not be subject to the aggregate SNCP cap or DSHP cap. Because the aggregate SNCP cap is based in part on an amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment, any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate SNCP cap, and a corresponding change to the provider cap as

described in subparagraph (c). Such a change shall be reflected in section VIII, and shall not require a demonstration amendment. The aggregate SNCP cap of \$4.970 billion is based on an annual DSH allotment of \$659,573,317 (total computable), the Commonwealth's projected DSH allotment for SFY15, and budget neutrality savings. With the exception of Health Connector Subsidies DSHP authority, the SNCP is extended for DYs 18-20 while CMS and the state transform the structure of the SNCP. The SNCP authority for Health Connector Subsidies DSHP extends through DY22.

- b) For the period operating under temporary extension from July 1, 2014, through the period prior to the date of the approval letter, all SNCP expenditures were authorized up to the amount of the DSH allotment for SFY 2015, with the exception of Commonwealth Care Orderly Closeout and Temporary Coverage DSHPs which were funded through budget neutrality savings. The aggregate SNCP cap must be reduced by Commonwealth Care Orderly Closeout and Temporary Coverage expenditures for the temporary extension period to reflect this exception.
- c) Infrastructure Cap. The Commonwealth may expend an amount equal to no more than five percent of the aggregate SNCP cap over the SNCP extension period for infrastructure and capacity building, as described in section VIII. No FFP will be available to reimburse the Commonwealth for infrastructure and capacity-building until the Commonwealth notifies CMS and obtains subsequent CMS approval, of the specific activities that will be undertaken to improve the delivery of health care to the uninsured, underinsured, MassHealth, demonstration or SNCP populations. No demonstration amendment is required for CMS approval of the specific activities for infrastructure and capacity-building. The Commonwealth must update Attachment E to reflect these activities; no demonstration amendment is required. Progress reports on all such activities must be included in the quarterly and annual reports outlined in section X and section XI, respectively. Infrastructure projects for which FFP is claimed under this expenditure authority are not eligible for DSTI incentive payments.
- d) Provider Cap. The Commonwealth may expend an amount for purposes specified in section VIII 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 provider cap. Such change shall not require a demonstration amendment. The provider cap is based on an annual DSH allotment of \$659,573,317 (total computable), the Commonwealth's projected annual DSH allotment for SFY 2015.
- e) DSHP Cap. Expenditure authority for DSHP is limited to \$385 million for SFY 2015, \$257 million for SFY 2016 and \$129 million for SFY 2017 through June 30, 2017. These limits do not apply to expenditure authority for the Commonwealth Care Orderly Closeout and Temporary Coverage DSHPs, as further described in Attachment E, chart A. Health Connector Subsidies are not subject to the DSHP cap. Prior CMS approval is required to make changes to Chart C of Attachment E. No demonstration amendment is

required for CMS approval of updates to Chart C of Attachment E to include additional DSHP programs.

- f) Budget Neutrality Reconciliation. The Commonwealth is bound by the budget neutrality agreement described in section XI 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 XI.

- g) Cost for Uncompensated Care Effective July 1, 2014. The SNCP payments pursuant to section VIII support providers for furnishing uncompensated care. Prior to July 1, 2014, these payments were not limited to the documented cost of providing such care. During the 2011-2014 extension period, CMS and the Commonwealth worked to develop a cost limit protocol, approved by CMS on December 17, 2013 and included as Attachment H to the STCs. The Uncompensated Care Cost Limit Protocol (Attachment G) ensures that beginning on July 1, 2014 all provider payments for uncompensated care pursuant to STC 50(b) will be limited on a provider-specific basis to the cost of providing Medicaid state plan services and any other additional allowable uncompensated costs of care provided to Medicaid eligible individuals and uninsured individuals, less payment received by or on behalf of such individuals for such services. Notwithstanding the generality of the foregoing, Critical Access Hospitals may receive 101% of the cost of providing Medicaid services, and 100% of uncompensated care costs as specified by the provisions of Section 1923(g) of the Act as implemented by 447.295(d). The DSH audit rule definition of allowable inpatient and outpatient services and allowable uninsured costs and revenues served as the initial framework for discussions on the cost protocol. Any additional costs to be included as allowable as uncompensated were identified and included in the resulting approved cost limit protocol.

56. DSTI Plan and Funding Protocol. The state must meet the following milestones before it can claim FFP for DSTI funding:

- a) Commonwealth Master DSTI Plan. The Commonwealth must have an overarching master DSTI plan in place that has been approved by CMS. The master plan is affixed to the STCs in Attachment J. The master plan must at a minimum include:
 - 1) Identification of community needs, health care challenges, the delivery system, payment reform, and population-focused improvements that DSTI will address in addition to baseline data to justify assumptions;
 - 2) Identification of the projects and objectives that fall within the four categories, as outlined in section VIII, from which each participating hospital will develop its hospital-specific DSTI plan, and identify the minimum level of projects and population-focused objectives that each hospital must select;

- 3) In coordination with subparagraph (a)(2) above, identification of the metrics and data sources for specific projects and population-focused objectives that each participating hospital will utilize in developing a hospital-specific DSTI plan to ensure that all hospitals adhere to a uniform progress reporting requirement;
 - 4) With regard to Category 3, the state must also identify its actions and timelines for driving payment reform;
 - 5) Guidelines requiring hospitals to develop individual hospital DSTI plans as outlined in section VIII.
 - 6) A state review process and criteria to evaluate each hospital's individual DSTI plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
 - 7) A reporting protocol outlining the requirements, process and timeline for a hospital to submit its interim progress on DSTI plan metrics and for the state to provide CMS with information documenting progress;
 - 8) A state review process and timeline to evaluate hospital progress on its DSTI plan metrics and assure a hospital has met its approved metrics prior to the release of associated DSTI funds;
 - 9) A process that allows for hospital plan modification and an identification of under what circumstances a modification plan may be considered including for carry-forward/reclamation, pending state and CMS approval; and
 - 10) A state process of developing an evaluation of DSTI as a component of the draft evaluation design as required by section XII. When developing the master DSTI plan, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XII of the STCs. The state must select a preferred research plan for the applicable research question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, DSTI master plan must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating provider chooses not to undertake that project. The intent of this data set is to enable cross provider comparison even if the provider did not elect the intervention.
- b) Hospital DSTI Plans. At a minimum, the individual hospital DSTI plans should include the following, in addition to the requirements pursuant to section XII .

- 1) A background section on the hospital system(s) covered by the DSTI plan that includes an overview of the patients served by the hospital;
- 2) An executive summary for the DSTI plan that summarizes the high-level challenges the DSTI plan is intended to address and the target goals and objectives included in the plan for the demonstration approval period including an explanation of the hospital's achievements and challenges in the SFY 2012- 2014 demonstration approval period;
- 3) Sections on each of the four categories as specified in section VIII and include:
 - A. For Categories 1, 2 and 3 –
 - i. Each hospital must select a minimum number of projects, with associated metrics, milestones and data sources in accordance with the master DSTI plan.
 - ii. For each project selected, the hospital at a minimum must include:
 - (1) A description of the goal(s) of the project, which describes the challenges of the hospital system and the major delivery or payment redesign system solution identified to address those challenges by implementing the particular project;
 - (2) A description of the target goal over the demonstration approval period and metrics associated with the project and the significance of that goal to the hospital system and its patients;
 - (3) A narrative on the hospital's rationale for selecting the project, milestones, and metrics based on relevancy to the hospital system's population and circumstances, community need, and hospital system priority and starting point with baseline data;
 - (4) A narrative describing how this project supports, reinforces, enables and is related to other projects and interventions within the hospital system plan; and
 - (5) Any other hospital reporting guidelines stipulated in the master DSTI Plan.
 - B. In addition to requirements addressed in the above subparagraph (i), Category 2 must also include:
 - i. A description of how the selected project can refine innovations, test new ways of meeting the needs of target populations and disseminate findings in order to spread promising practices.
 - C. Category 4 – Population-Focused Improvements
 - i. Projects within this category must focus on evaluation of the population-focused improvements associated with Categories 1, 2 and 3 projects and associated incentive payments. Each hospital must select a minimum number of projects in accordance with in the master DSTI plan. All hospitals will select metrics from a common set defined in the master DSTI plan.

- c) DSTI Payment and Funding Protocol. The state must develop and submit in conjunction or as part of the master DSTI plan, an incentive payment methodology for each of the four categories to determine an annual maximum budget for each participating provider. The state also must identify an allowable non-federal share for the DSTI pool, which must be approved by CMS. The following principles must also be incorporated into the funding protocol contained in Attachment J:
- 1) Each hospital will be individually responsible for progress towards and achievement of its metrics to receive its potential incentive funding related to any metric from DSTI.
 - 2) In order to receive incentive funding related to any metric, the hospital must submit all required reporting as described in section IX.
 - 3) **Funding Allocation Guidelines.** The master DSTI plan must specify a formula for determining incentive payment amounts. Hospital-specific DSTI plan submissions must use this formula to specify the hospital-specific incentive payment amounts associated with the achievement of approved transformation metrics for approval by the Commonwealth and CMS pursuant to section VIII. Category metrics will have a base value. Each category may have a different base value but metrics within categories will be based on a starting dollar point. Given the varied nature of the projects and hospital systems, the total incentive payment amounts available to an individual hospital for each category depend upon the size of the hospital, total projects and metrics selected in the hospital specific DSTI. The submission must describe how the factors affect each hospital's maximum allowable payment.
 - 4) **Carry-Forward/Reclamation.** The master plan/protocol must describe the ability of a hospital to earn payment for any missed metric within a defined time period. Carry-forward/reclamation of incentive payments is only available to the hospital associated with a given incentive payment and is not available for redistribution to other hospitals. Carry-forward/reclamation is limited to this demonstration approval period ending June 30, 2017.
 - i. If a participating hospital system does not fully achieve a metric that was specified in its plan for completion in a particular year, the payment associated with that metric may be rolled over for 12 months and be available if the hospital meets the missed metric in addition to the metric associated with the year in which the payment is made.
 - ii. In the case of a participating hospital that is close to meeting a metric in a particular year, the hospital may be granted a grace period to the reporting deadline set for a particular payment cycle by which to meet a metric associated with the incentive payment if it has an approved plan modification pursuant to section VIII. The allowable time period for such a grace period may vary based on the type and scope of the project associated

with such metric and may be up to 180 days. The plan modification must be approved by the Commonwealth and CMS 30 days prior to the deadline of the incentive payment reporting pursuant to section X. The plan modification must outline how the hospital plans to meet the metric within the given grace period. The process for hospital plan modification, including the modification requirements, deadline by which a hospital must submit a requested modification and the Commonwealth and CMS approval process will be outlined within the master DSTI plan pursuant to section VIII.

iii. Projects that focus primarily on infrastructure will have further limited rollover ability as defined in the master DSTI plan.

d) CMS Approval of DSTI Funding Protocols and Master and Hospital-Specific Plans. CMS and the state agree to the targeted approval period of 90 calendar days after the date of the approval letter. However, if CMS determines that a protocol or plan is not ready for approval on the target date, CMS will notify the state of its determination.

57. SNCP Additional Reporting Requirements. All SNCP expenditures must be reported as specified in section X. 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) 2015-2017, and where applicable for SFY 2018-2019 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 section VIII.

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 section VIII. 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 section VIII of these STC.

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 section VIII of these STC.

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

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

- a) DSHP. The Commonwealth must submit to CMS for approval a table of projected DSHP spending for specified state-funded health program expenditures authorized pursuant to section VIII, by approved program, no later than 45 business days after enactment of the state budget for each SFY. CMS must approve the Commonwealth's projected DSHP expenditures within 30 business days of the Commonwealth's submission of the update, provided that all DSHP projections are within the applicable SNCP limits specified in section VIII.

The Commonwealth must submit to CMS for approval an update to the table of projected DSHP spending that reflects actual DSHP expenditures for each SFY, within 180 calendar days after the close of the SFY. CMS must approve the Commonwealth's actual DSHP expenditures within 45 business days of the Commonwealth's submission of the update, provided that all DSHP expenditures are within applicable limits.

The Commonwealth may submit to CMS for approval further updates to the table of projected DSHP spending by approved program at such other times as may be required to reflect projected or actual changes in DSHP expenditures. CMS must approve the Commonwealth's updated charts within 45 business days of the Commonwealth's submission of the update, provided that all DSHP expenditures are within applicable limits.

No demonstration amendment is required to update the table of projected DSHP spending by approved program within the expenditure limits specified in section VIII. Prior CMS approval is required to make changes to Chart C of Attachment E. No demonstration amendment is required in order to add to the list of DSHP programs in Chart C of Attachment E as long as the additional programs are approved by CMS and are within the expenditure limits for that demonstration year.

- b) Additional DSHP Reporting for Connector Care. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 62. This data must, at a minimum, include:
- 1) The number of individuals served by the program;
 - 2) The size of the subsidies; and
 - 3) A comparison of projected costs with actual costs.
- c) DSTI Reporting. The participating providers and the state must report the following:
- 1) Hospital Reporting. The reporting protocol within the master DSTI plan outlines the hospitals' reporting requirements, process and timelines and must be consistent with the following principles:
 - i. Hospital Reporting for Payment. Participating providers seeking payment under DSTI must submit reports to the state demonstrating progress, measured by Category specific metrics. The reports must include the incentive payment amount being requested for the progress achieved in accordance with the payment mechanisms outlined in the master DSTI plan. The required hospital reporting requirements, process and timeline are pursuant to the reporting protocol, state review process and funding protocol as outlined in section VIII and must be consistent with the following principles:
 1. The hospital reports must be submitted using the standardized reporting form approved by the state and CMS;
 2. The state must use this documentation in support of DSTI claims made on the MBES/CBES 64.9 Waiver form.
 - ii. Hospital System Annual Report. Hospital systems must submit an annual report, based on the timeline approved in the reporting protocol component of the master DSTI plan. The reports must at a minimum:
 1. Be submitted using a standardized reporting form approved by the state and CMS;
 2. Provide information included in the semi-annual reports, including data on the progress made for all milestones; and
 3. Provide a narrative description of the progress made, lessons learned, challenges faced and other pertinent findings.
 - iii. Documentation. The hospital system must have available for review by the state or CMS, upon request, all supporting data and back-up documentation.
 - 2) Commonwealth Reporting. Section VIII requires DSTI reporting as a component of the quarterly operational reports and annual reports. The DSTI reporting must at a minimum include:
 - i. All DSTI payments made to specific hospitals that occurred in the quarter;
 - ii. Expenditure projections reflecting the expected pace of future

- disbursements for each participating hospital;
 - iii. An assessment by summarizing each hospital's DSTI activities during the given period; and
 - iv. Evaluation activities and interim findings of the evaluation design pursuant to section XII.
- d) **ICB Reporting.** Section VIII requires ICB reporting as a component of the quarterly operational reports and annual reports. The ICB reporting must at a minimum include:
- 1) The applicant organization, project type, and funding awarded to the organization under ICB;
 - 2) Description of project activities and outcomes that occurred during the reporting period for each applicant organization;
 - 3) The amount of ICB payments that were made to the eligible hospital organization during the reporting period;
 - 4) Evaluation activities and interim findings of the evaluation design pursuant to section XII.

IX. GENERAL REPORTING REQUIREMENTS

58. **General Financial Reporting Requirements.** The state must comply with all general financial requirements under title XIX of the Social Security Act in section X of the STCs.
59. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 C.F.R section 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.
60. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section XI of the STCs, including the submission of corrected budget neutrality data upon request.
61. **Bi-Monthly Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit packages, activities related to the Safety Net Care Pool, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes to payment rates, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the State is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

62. **Quarterly Operational Reports.** The Commonwealth must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the Commonwealth's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

- a) Updated budget neutrality monitoring spreadsheets;
- b) Events occurring during the quarter or anticipated to occur in the near future that effect health care delivery including approval and contracting with new plans, benefits, enrollment, grievances, quality of care, access, proposed changes to payment rates, health plan financial performance that is relevant to the demonstration, payment reform initiatives or delivery system reforms impacting demonstration population and/or undertaken in relation to the SNCP including ICB grant programs, updates on activities related to the pediatric bundled payment pilot program, pertinent legislative activity, and other operational issues;
- c) Action plans for addressing any policy and administrative issues identified;
- d) Quarterly enrollment reports that include the member months for each demonstration population;
- e) Updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act;
- f) Activities and planning related to payments made under the Safety Net Care Pool pursuant to reporting requirements outlined in section VIII of the STCs;
- g) Updates on data related to the provisional eligibility authority.
 - 1) Total number of Medicaid/CHIP applicants for the specified quarter
 - 2) Total number Medicaid/CHIP applicants with identified income inconsistencies for the specified quarter
 - 3) Average number of days to resolve inconsistency
 - 4) Number of Medicaid CHIP applicants disenrolled due to income ineligibility identified
 - 5) Basis for ineligibility
 - 6) Quality of initial data
 - 7) Expenditures for ineligible individuals
- h) Evaluation activities and interim findings.

63. **Annual Report.** The Commonwealth must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must

also contain a discussion of the items that must be included in the quarterly operational reports required under section VIII in addition to the annual HCBS report as stipulated in section VI. The Commonwealth must submit the draft annual report no later than October 1st of each year. Within 60 business days of receipt of comments from CMS, a final annual report shall be submitted.

64. **Final Report.** Within 120 calendar days following the end of the demonstration, the Commonwealth must submit a draft final report to CMS for comments. The Commonwealth must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

65. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section XI of the STCs.

66. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00030/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.
- b) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- c) Pharmacy Rebates. When claiming these expenditures the Commonwealth may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24->

[2014.pdf](#)). The Commonwealth must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

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

- d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the Commonwealth under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64Narr by demonstration year.
- e) Demonstration year reporting. Notwithstanding the two-year filing rule, the Commonwealth may report adjustments to particular demonstration years as described below:
 - i. Beginning July 1, 2005 (SFY 2006/ DY, 9) all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, and separate schedules will be completed for demonstration years 6, 7, 8, and 9.
 - ii. Beginning July 1, 2006 (SFY 2007/ DY 10), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-7 will be reported as demonstration year 7, and separate schedules will be completed for demonstration years 8, 9, and 10.
 - iii. Beginning July 1, 2007 (SFY 2008/ DY 11), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, and separate schedules will be completed for demonstration years 9, 10, and 11.
 - iv. Beginning July 1, 2008 (SFY 2009/ DY 12), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-10 will be reported as demonstration year 10, and separate schedules will be completed for demonstration

years 11 and 12. Demonstration year 12 includes dates of service from July 1, 2008, through June 30, 2009.

- v. Beginning July 1, 2009 (SFY 2010/ DY 13), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration year 11, and separate schedules will be completed for demonstration years 12 and 13 and 14. Demonstration year 13 includes dates of service from July 1, 2009, through June 30, 2010.

Beginning July 1, 2010 (SFY 2011/ DY 14), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration year 11, and separate schedules will be completed for demonstration years 12 and 13 and 14. Demonstration year 14 includes dates of service from July 1, 2010, through June 30, 2011.

- vi. Beginning July 1, 2011 (SFY 2012/ DY 15), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration 11, all expenditures and adjustments for demonstration years 12-14 will be reported as demonstration year 14 and separate schedules will be completed for demonstration years 15 and 16 and 17. All expenditures and adjustments for dates of service beginning July 1, 2011, will be reported on separate schedules corresponding with the appropriate demonstration year.
- vii. Beginning October 1, 2013, all expenditures and adjustments for demonstration years 1-11 previously reported in sections i.-vi. will be reported as demonstration year 11. All expenditures and adjustments for demonstration years 12-14 will be reported so that quarters with the same American Recovery and Reinvestment Act reimbursement rates are consolidated; e.g., reports QE 09/09 through QE 12/10, all of which have the ARRA rate of 11.59 percent, will be consolidated into one report. For the quarters ending 6/09, 3/11 and 6/11 that have ARRA rates that are not the same as another quarter, they will continue to be reported on separate schedules. Separate schedules will be completed for dates of service after July 1, 2011 for expenditures and adjustments for demonstration years 15, 16, and 17.

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

below.

- 1) **Base Families:** Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only)
- 2) **Base Disabled:** Eligible individuals with disabilities enrolled in Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only)
- 3) **1902(r)(2) Children:** Medicaid expansion children and pregnant women who are enrolled in MassHealth Standard, as well as eligible children and pregnant women enrolled in MassHealth Limited (emergency services only)
- 4) **1902(r)(2) Disabled:** Eligible individuals with disabilities enrolled in Standard with income between 114.1 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency services only)
- 5) **BCCDP:** Individuals eligible under the Breast and Cervical Cancer demonstration Program who are enrolled in Standard
- 6) **CommonHealth:** Higher income working adults and children with disabilities enrolled in CommonHealth
- 7) **e-Family Assistance:** Eligible children receiving premium assistance or direct coverage through 200 percent of the FPL enrolled in Family Assistance.
- 8) **Base Fam XXI RO:** Title XXI-eligible AFDC children enrolled in Standard after allotment is exhausted
- 9) **1902 (r)(2) XXI RO:** Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted
- 10) **CommonHealth XXI:** Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted
- 11) **Fam Assist XXI:** Title XXI-eligible children through 200 percent of the FPL eligible for Family Assistance under the demonstration after the allotment is exhausted

- 12) **e-HIV/FA:** Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance
- 13) **SBE:** Subsidies or reimbursement for ESI made to eligible individuals
- 14) **SNCP-HSNTF:** Expenditures authorized under the demonstration for payments held to the provider sub-cap to support uncompensated care
- 15) **SNCP-DSHP:** Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP)
- 16) **SNCP-DSTI:** Expenditures authorized under the demonstration for Delivery System Transformation Initiatives (DSTI)
- 17) **SNCP-OTHER:** All other expenditures authorized under the SNCP
- 18) **Asthma:** All expenditures authorized through the pediatric asthma bundled pilot program
- 19) **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
- 20) **Health Connector Subsidy:** Expenditures for subsidies described in section VIII
- 21) **Provisional Eligibility:** Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority
- 22) **TANF/EAEDC:** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children.
- 23) **End of Month Coverage:** Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.
- 24) **Continuous Eligibility:** Expenditures for individuals enrolled in the Student Health Plan Insurance Program (SHIP) for a continuous period up to 12 months, who may otherwise have been deemed

ineligible during such period.

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

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

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

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

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
 - b) The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each

contribute 2 eligible member months to the total, for a total of 4 eligible member months.

73. Cost Settlement.

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

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

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

- a) Administrative costs, including those associated with the administration of the demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c) Net medical assistance expenditures and prior period adjustments made under section

1115 demonstration authority with dates of service during the demonstration extension period, including expenditures under the Safety Net Care Pool.

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

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

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

- a) Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
- b) To the extent, the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies as allowable under 42 C.F.R. § 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;
- d) The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from state or local monies and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care

providers must be made in an amount not to exceed the non-federal share of title XIX payments.

- e) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the Commonwealth any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

78. **Monitoring the Demonstration.** The Commonwealth will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

79. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

80. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning July 1, 2014.

81. **Limit on Title XIX Funding.** Massachusetts will be subject to a limit on the amount of federal title XIX funding that the Commonwealth may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual DSH allotment that would have applied to the Commonwealth absent the demonstration (DSH allotment). Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the Commonwealth using the procedures described in section X. The data supplied by the Commonwealth to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Commonwealth's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

82. **Risk.** Massachusetts shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Massachusetts will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Massachusetts at risk for the per capita costs for demonstration enrollees, CMS assures that the

federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

83. Expenditures Excluded From Budget Neutrality Test. Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

- a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on behalf of enrollees under age 65 who are institutionalized in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded, or a state psychiatric hospital for other than a short-term rehabilitative stay;
- b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient, and home and community-based waiver services, except pursuant to section IV;
 - i. *Exception.* Hospice services provided to individuals in the MassHealth Basic and Essential programs are subject to the budget neutrality test.
- c) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement; and
- d) Allowable administrative expenditures.

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

- a) Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the Commonwealth under section X for each EG, including the hypothetical populations, times the appropriate estimated per member/per month (PMPM) costs from the table in subparagraph (v) below;
 - ii. Starting in SFY 2006, actual expenditures for the CommonHealth EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline CommonHealth costs, or actual CommonHealth per member per most cost experience for SFYs 2015- 2017;
 - iii. The amount of actual expenditures included will be the lower of the trended baseline costs, or actual per member per most cost experience for each eligibility

group in SFYs 2015-2017;

- iv. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior demonstration periods are provided in Attachment D; and
- v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Group (EG)	Trend Rate	DY 18 PMPM (SFY 2015)	DY 19 PMPM (SFY 2016)	DY 20 PMPM (SFY 2017)	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)
Mandatory and Optional State Plan Groups						
<u>Base Families</u>	5.2 percent	\$655.57	\$689.66	\$725.53	\$763.25	\$802.94
<u>Base Disabled</u>	4.8 percent	\$1,442.34	\$1,511.57	\$1,584.13	\$1,660.17	\$1,739.86
<u>BCCDP</u>	5.3 percent	\$4,290.46	\$4,517.85	\$4,757.30	\$5,009.44	\$5,274.94
<u>1902(r)2 Children</u>	4.6 percent	\$526.70	\$550.93	\$576.27	\$602.78	\$630.51
<u>1902(r)2 Disabled</u>	4.8 percent	\$1,129.30	\$1,183.51	\$1,240.32	\$1,299.85	\$1,362.25
Hypothetical Populations*						
<u>CommonHealth</u>	4.8 percent	\$671.10	\$711.36	\$754.04	\$799.29	\$847.24

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

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

Eligibility Group (EG)	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM
<u>New Adult Group</u>	5.3 percent	\$485.67	\$511.42	\$538.52	\$567.06	\$597.12

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

- c. The Supplemental Budget Neutrality Test is calculated by taking the PMPM cost projection for the New Adult Group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap is obtained by multiplying total computable Supplemental Cap by the Composite Federal Share described in section XI.
- d. The Supplemental Budget Neutrality Test is a comparison between the federal share of the Supplemental Cap and total FFP reported by the State for the New Adult Group.
- e. If total FFP for the New Adult Group should exceed the federal share of the Supplemental Budget Neutrality Test after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in section XI.
- f. The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure limits. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the Commonwealth may receive for expenditures on behalf of demonstration populations as well as demonstration services described in Table B in section IV during the demonstration period.
- g. Limit B. The Commonwealth's annual DSH allotment.
- h. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) adjustment:
- i. The Commonwealth must present to CMS for approval a draft evaluation plan outlining the methodology to track the following:
 - 1) Baseline measurement of EPSDT service utilization prior to the EPSDT court-ordered remedial plan in *Rosie D. v Romney* (the Order) final judgment and final remedial plan established on July 16, 2007;
 - 2) Increase, following entry of the Order, in utilization of :
 - a) EPSDT screenings;
 - b) Standardized behavioral health assessments utilizing the Child and Adolescent Needs and Strengths (CANS), or other standardized assessment tool in accordance with the Order; and
 - c) State plan services available prior to the entry of the Court Order.

- 3) Cost and utilization of services contained in State Plan amendments submitted by the Commonwealth in accordance with the Order and approved by CMS; and
 - 4) Methodology for tracking and identifying new EPSDT services for purposes of budget monitoring.
- ii. The draft evaluation plan with an appropriate methodology to track new EPSDT expenditures must be approved by CMS through the amendment process described in STC 7. Once an appropriate methodology to track new EPSDT expenditures is approved by CMS, these projected expenditures will be included in the expenditure limit for the Commonwealth, with an effective date beginning with the start of the new EPSDT expenditures, and reconciled to actual expenditure experience.

86. 1115A Duals Demonstration Savings. When Massachusetts' section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the Duals Demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the Duals Demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal. This evaluation of estimated and certified amounts of actual title XIX savings will reflect addendums and amendments to the 1115A Duals Demonstration contract and adjustment to the MassHealth Component of the capitation rate, including interim and final risk corridor settlements.

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

2014 April to Dec. 2014/ DY 1			PMPM			1,000 = \$10,000=
CCY 2015/ DY 2	\$1,000 PMPM	1.5%	\$15 PMPM	1,000	\$10,000	\$15 PMPM * 1,000 = \$= 5,000
CCY 2016/ DY 3	\$1,000 PMPM	>4% (Per the Duals Demonstra Tion contract, the savings percentage applied to	\$40 PMPM	1,000		[\$40 PMPM * 1,000 = =

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

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

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

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

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

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

The Commonwealth must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A Duals

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

87. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the Commonwealth on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C. with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.
88. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the demonstration as adjusted July 1, 2008, rather than on an annual basis. However, if the Commonwealth exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the Commonwealth must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
DY 18	Cumulative budget neutrality limit plus:	2.0percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 18 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 18 through 21	Cumulative budget neutrality limit plus:	.5 percent
DY 18 through 22	Cumulative budget neutrality limit plus:	0 percent

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

89. **Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in section XI, composite federal share ratio. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

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

XII. EVALUATION OF THE DEMONSTRATION

92. **Submission of a Draft Evaluation Design Update.** The Commonwealth must submit to CMS for approval a draft evaluation design update no later than 120 calendar days after CMS' approval date of the renewal. The draft evaluation design update must build and improve upon the evaluation design that was approved by CMS for demonstration period ending on June 30, 2014.

At a minimum, the draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire health care reform demonstration set forth in section II of these STCs. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population, specific testable hypothesis, including those that focus on target populations for the demonstration and more generally on beneficiaries, providers, plans, market areas and public expenditures. The updated design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. It must discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the Commonwealth. The draft design must identify whether the Commonwealth will conduct the evaluation, or select an outside contractor for the evaluation.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results. Information from the external quality review organization (EQRO) may be considered for the purposes of evaluation, as appropriate.

The updated design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.
 - 1) The number of uninsured in the Commonwealth;
 - 2) The number of demonstration eligibles accessing ESI;
 - 3) Growth in the Commonwealth Care Program;

- 4) Decrease in uncompensated care and supplemental payments to hospitals;
- 5) Substance Use Disorder
- 6) The number of individuals accessing the Health Safety Net Trust Fund;
- 7) The impact of DSTI payments to participating providers on the Commonwealth's goals and objectives outlined in its master plan including:
 - i. Were the participating hospitals able to show statistically significant improvements on measures within Categories 1-3 related to the goals of the three-part aim
 - ii. Were the participating hospitals able to show improvements on measures within Category 4 related to the goals of the three-part aim
 - iii. What is the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers?
 - iv. What is the impact of the payment redesign and infrastructure investments to improve cost efficiency?
 - v. What is the impact of DSTI on managing short and long term per-capita costs of health care?
 - vi. How did the amount paid in incentives compare with the amount of improvement achieved?
- 8) The benefits, savings, and design viability of the Pediatric Asthma Pilot Program;
- 9) The benefits, cost and savings of providing early intervention services for demonstration eligible children with autism;
- 10) The impact of utilization of Express Lane Eligibility procedures for parents and caretakers and childless adults; and
- 11) Availability of access to primary care providers.
- 12) The impact of the ICB grants that allow participating providers to advance the Commonwealth's goals in the following areas or other areas of focus where applicable:
 - i. Readiness for global payments;
 - ii. Medical Home Transformation ;
 - iii. Improving health outcomes and quality, e.g., redirecting ED use to CHCs and implementing improvements in care transition; and
 - iv. Outreach and Enrollment.
- 13) The impact of SNCP funding and recommendations for reforms or alternatives to the Massachusetts' Medicaid financing system that sustains funding through regular provider payments. The impact of the Health Connector subsidy program on QHP enrollment trends addressing the following, at a minimum;
 - i. How many individuals with incomes between 133 and 300 percent of the FPL have taken up QHP coverage with the assistance of the Health Connector subsidy program?

b. Evaluation Design Process: Addressing the research questions listed above will require a

qualitative and, where applicable, quantitative research methodologies. When developing the master DSTI plan, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XII of the STCs. From these domains of focus, the state must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option research plan in response to each research question considered:

- i. Quantitative or qualitative outcome measures;
 - ii. Proposed baseline and/or control comparisons;
 - iii. Proposed process and improvement outcome measures and specifications;
 - iv. Data sources and collection frequency;
 - v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
 - vi. Cost estimates;
 - vii. Timelines for deliverables.
- c. Sources of Measures. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).
- d. The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state.
- e. Levels of Analysis: The evaluation designs proposed for each research question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

93. Interim Evaluation Reports. In the event the Commonwealth requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the Commonwealth must submit an interim evaluation report as part of its request for each subsequent renewal.

94. Final Evaluation Design and Implementation. CMS must provide comments on the draft evaluation design described in section XII within 60 business days of receipt, and the

Commonwealth shall submit a final design within 60 business days after receipt of CMS comments. The Commonwealth must implement the evaluation design and submit progress of the programs described therein in the quarterly and annual progress reports. The Commonwealth must submit to CMS a draft of the evaluation report within 120 calendar days after expiration of the demonstration. CMS must provide comments within 60 business days after receipt of the report. The Commonwealth must submit the final evaluation report within 60 days after receipt of CMS comments.

95. **Final Evaluation Report.** The state must submit to CMS a draft of the evaluation final report within 60 business days after receipt of CMS comments in accordance with section XII. The final report must include the following:

- a. An executive summary;
- b. A description of the demonstration, including programmatic goals, interventions implemented and resulting impact of these interventions;
- c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
- d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
- e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
- f. Successes, challenges, and lessons learned.

96. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the Commonwealth must fully cooperate with federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

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

Date – Specific	Deliverable	STC Reference
Within 180 days after the expiration of the demonstration	Final Report	Section IX
Annually		
October 1 st	Draft Annual Report	Section IX, 62 Section V
30 days of the receipt of CMS comments	Final Annual Report, including DSTI reporting, ICB report	Section IX, Section VIII, Section V
No later than 45 days after enactment of the state budget for each SFY	Updates to Charts A-B of Attachment E that reflect projected annual SNCP expenditures and identify the non-Federal share for each line item	Section VIII
No later than 45 days after enactment of the state budget for each SFY	Projected annual DSHP expenditures	Section VIII
180 days after the close of the SFY (December 31 st)	Updates to Charts A-B of Attachment E that reflect actual SNCP payments and expenditures	Section VIII
At Least Semi-Annually		
	DSTI Hospital Reporting, ICB Reporting	Section VIII
Quarterly		
60 days following the end of the quarter	Quarterly Operational Reports, including DSTI reporting, ICB reporting and eligible member months	Section IX, Section VIII, Section X

	Quarterly Expenditure Reports	Section X
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**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

	Federal Poverty Level (FPL) and/or Other qualifying	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility	Demonstration Program	Comments
Unborn Targeted Low Income Child	0 through 200%	Uninsured	No (through December 31, 2013) Yes (effective January 1, 2014)	Separate XXI		Healthy Start (through December 31, 2013) Standard (effective January 1, 2014)	
	AFDC-Poverty Level Infants	Any	Yes	XIX via Medicaid state plan	<u>Base Families</u> <i>Without Waiver</i>	Standard	
		Insured	Yes	XIX via Medicaid state plan	<u>1902(r)(2) Children</u> <i>Without Waiver</i>	Standard	

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

Newborn Children Under age 1	185.1 through 200%	Uninsured at the time of applicatio n	Yes (if XXI is exhausted)	XXI Medicaid Expansion (via Medicaid state plan and XXI state plan)	<u>1902(r)(2) XXI RO</u> <i>Without Waiver</i> (member months and expenditures for these children are only reported)	Standard	
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**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
	200.1 through 300%	Insured	Yes	XIX via demonstration authority only	E-Family Assistance	Family Assistance Premium Assistance	No additional wraparound benefit is provided
		Uninsured at the time of application	Yes	Separate XXI		Family Assistance	

This chart is provided for informational purposes only.

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
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**ATTACHMENT A
OVERVIEW OF CHILDREN’S ELIGIBILITY IN MASSHEALTH**

Newborn Children Under Age 1 and Disabled	200.1-300%	Insured	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance with wraparound to direct coverage CommonHealth	
		Uninsured at the time of application	Yes (if XXI is exhausted)	Separate XXI Funded through XIX if XXI is exhausted via demonstration authority	<u>CommonHealth XXI</u> <i>Hypothetical</i> (member months and expenditures for these children are only reported if XXI)	CommonHealth	The CommonHealth program was in existence prior to the separate XXI Children’s Health Insurance Program and was not affected by the maintenance of effort date. The

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

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

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

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

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

	Age 6 through 17: 0 through 114% Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets						
	AFDC-Poverty Level Children	Insured	Yes	XIX	<u>Base Families</u> <i>Without waiver</i>	Standard	
	Age 6 through 17: 114.1% through 133% Age 18: 0 through 133%	Uninsured	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	<u>Base Fam XXI</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	
Population	Federal Poverty Level (FPL) and/or Other qualifying	Insuranc e Status upon applicati on	Part of MassHealth Demonstratio n?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility	Demonstratio n Program	Comments

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

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

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

	All children Age 1 through 18: 150.1 through 200%	Insured	Yes	XIX via demonstration authority only	<u>E-Family Assistance</u>	Family Assistance Premium Assistance Direct Coverage	No additional wraparound is provided to ESI
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Population	Federal Poverty Level (FPL) and/or Other qualifying	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EC)	Demonstration Program	Comments
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**ATTACHMENT A
OVERVIEW OF CHILDREN’S ELIGIBILITY IN MASSHEALTH**

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

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

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

Children Aged 1 through 18 and Disabled	150.1 through 300%	Insured	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance With wrap to direct	
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**ATTACHMENT A
OVERVIEW OF CHILDREN’S ELIGIBILITY IN MASSHEALTH**

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

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

Children Aged 1 through 18 and Disabled	Above 300%	Any	Yes	XXI via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance With wraparound to	
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**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

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

**ATTACHMENT B
COST SHARING**

Cost-sharing imposed upon individuals enrolled in the demonstration varies across coverage types and by FPL. However, in general, no co-payments are charged for any benefits rendered to individuals under age 21 or pregnant women. Additionally, no premiums are charged to any individual enrolled in the demonstration whose gross income is less than 150 percent of the FPL. In the event a family group contains at least two members who are eligible for different coverage types and who would otherwise be assessed two different premiums, the family shall be assessed only the highest applicable premium. Family group will be determined using MassHealth rules for the purposes of assessing premiums as described in section IV of the STC.

Demonstration Program	Premiums (only for persons with family income above 150 percent of the FPL)	Co-payments
MassHealth Standard/Standard ABP	\$0	All co-payments and co-payment caps are specified in the Medicaid state plan.
MassHealth CarePlus	\$0	MassHealth Standard co-payments apply.
MassHealth Breast and Cervical Cancer Treatment Program	\$15-\$72 depending on income	MassHealth Standard co-payments apply.
MassHealth CommonHealth	\$15 and above depending on income and family group size	MassHealth Standard co-payments apply.
CommonHealth Children through 300% FPL Children with income above 300% FPL adhere to the regular CommonHealth schedule	\$12-\$84 depending on income and family group size	MassHealth Standard co-payments apply.
MassHealth Family Assistance: HIV/AIDS	\$15-\$35 depending on income	MassHealth Standard co-payments apply.
MassHealth Family Assistance: Premium Assistance	\$12 per child, \$36 max per family group	Member is responsible for all co-payments required under private insurance with a cost sharing limit of 5 percent of family income

**ATTACHMENT B
COST SHARING**

MassHealth Family Assistance: Direct Coverage	\$12 per child, \$36 max per family group	Children only-no copayments.
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Breast and Cervical Cancer Demonstration Program Premium Schedule	
Percent of FPL	Premium Cost
Above 150 to 160	\$15
Above 160 to 170	\$20
Above 170 to 180	\$25
Above 180 to 190	\$30
Above 190 to 200	\$35
Above 200 to 210	\$40
Above 210 to 220	\$48
Above 220 to 230	\$56
Above 230 to 240	\$64
Above 240 to 250	\$72

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

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

**ATTACHMENT B
COST SHARING**

CommonHealth Supplemental Premium Schedule	
% of FPL	Premium requirement
Above 150% to 200%	60% of full premium per listed premium costs above
Above 200% to 400%	65% per above
Above 400% to 600%	70% per above
Above 600% to 800%	75% per above

**ATTACHMENT B
COST SHARING**

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

**ATTACHMENT B
COST SHARING**

Small Business Employee Premium Assistance* (effective January 1, 2014)	% of FPL	Premium Requirement for Individual	Premium Requirement for Couples
Small Business Employee Premium Assistance* provides premium assistance to certain employees who work for a small employer	Above 150% to 200%	\$40.00	\$80.00
	Above 200% to 250%	\$78.00	\$156.00
	Above 250% to 300%	\$118.00	\$236.00

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

ATTACHMENT C
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

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

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

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

NARRATIVE REPORT FORMAT:

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

Demonstration/Quarter Reporting Period:

Example:
 Demonstration Year: 18 (7/1/2014 – 6/30/2015)
 Quarter 1: (7/14 – 09/14)

Introduction

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

Enrollment Information

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

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

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

ATTACHMENT C
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

Base Childless Adults (CarePlus)	
BCCDP	

**ATTACHMENT C
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT**

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

* For temporary coverage, the Commonwealth must report how many individuals were found to have income above 400 percent of the FPL.

Enrollment in Managed Care Organizations and Primary Care Clinician Plan

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

Delivery System for MassHealth-Administered Demonstration Populations

Plan Type	June 30, 2008	September 30, 2008	Difference
MCO			
PCC (non Pilot ACO)			
MBHP			
FFS			
PA			
Pilot ACO			

Enrollment in Premium Assistance and Small Business Employee Premium Assistance

Outreach/Innovative Activities

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

Safety Net Care Pool

Provide updates on any activities or planning related to payment reform initiatives or delivery system reforms affecting demonstration population and/or undertaken in relation to the SNCP. As per section VIII, include projected or actual changes in SNCP payments and expenditures within the quarterly report. Please note that the annual report must also include SNCP reporting as required by section VIII

Operational/Issues

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

Policy Developments/Issues

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

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

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

1902(r)(2) Disabled				
New Adult Group				
BCCDP				
CommonHealth				

TANF/EAEDC				
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B. For Informational Purposes Only

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

Consumer Issues

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

Quality Assurance/Monitoring Activity

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

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS

**ATTACHMENT D
 MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS**

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

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

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

DY	Time Period	Families		Disabled		MCB		1902(r)(2) Children		1902(r)(2)	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
1	SFY 1998	\$199.06	7.71%	\$491.04	5.83%	\$438.39	5.83%	\$177.02	5.33%	\$471.87	4.40%
2	SFY 1999	\$214.41	7.71%	\$519.67	5.83%	\$463.95	5.83%	\$186.49	5.35%	\$497.12	4.80%
3	SFY 2000	\$230.94	7.71%	\$549.97	5.83%	\$491.00	5.83%	\$196.93	5.60%	\$524.96	5.50%
4	SFY 2001	\$248.74	7.71%	\$582.03	5.83%	\$519.62	5.83%	\$208.16	5.70%	\$554.88	5.30%
5	SFY 2002	\$267.92	7.71%	\$615.96	5.83%	\$549.91	5.83%	\$220.02	5.70%	\$586.51	5.70%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCDP	
		PMPM	Trend	PMPM	Trend	PMPM	Trend	PMPM	Trend	PMPM	Trend
6	SFY 2003	\$288.58	7.71%	\$677.56	10.0%	\$236.98	7.71%	\$645.16	10.0%	\$1,891.62	10.0%
7	SFY 2004	\$310.83	7.71%	\$745.32	10.0%	\$255.26	7.71%	\$709.67	10.0%	\$2,080.78	10.0%
8	SFY 2005	\$334.79	7.71%	\$819.85	10.0%	\$274.94	7.71%	\$780.64	10.0%	\$2,288.86	10.0%
9	SFY 2006	\$359.23	7.30%	\$824.79	7.00%	\$295.01	7.30%	\$718.13	7.00%	\$2,449.08	7.00%
10	SFY 2007	\$385.46	7.30%	\$834.71	7.00%	\$316.54	7.30%	\$660.60	7.00%	\$2,620.52	7.00%
11	SFY 2008	\$413.60	7.30%	\$901.39	7.00%	\$339.65	7.30%	\$724.31	7.00%	\$2,803.95	7.00%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCDP	
		PMPM	Trend	PMPM	Trend	PMPM	Trend	PMPM	Trend	PMPM	Trend

ATTACHMENT D
MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS

12	SFY 2009	\$466.84	6.95%	\$1,011.95	6.86%	\$382.45	6.95%	\$791.46	6.86%	\$3,052.78	6.86%
13	SFY 2010	\$499.05	6.95%	\$1,081.37	6.86%	\$407.87	6.95%	\$846.68	6.86%	\$3,265.69	6.86%
14	SFY 2011	\$533.73	6.95%	\$1,115.55	6.86%	\$436.22	6.95%	\$904.76	6.86%	\$3,489.72	6.86%

**ATTACHMENT D
 MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS**

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

ATTACHMENT D
MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART A

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

Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 54 (projected and rounded in millions).

#	Type	Applicable caps	State law or regulation	Eligible providers	Total SNCP Payments per SFY					Total for SFY15-17*	Applicable footnotes
					SFY 2015	SFY 2016	SFY 2017	SFY 2018**	SFY 2019**		
1	Public Service Hospital Safety Net Care Payment	Provider		Cambridge Health Alliance	\$ 88.0	\$88.0	\$88.0	TBD	TBD	\$264.0	(1)
				Boston Medical Center Cambridge Health Alliance	\$52.0	\$52.0	\$52.0	TBD	TBD	\$156.00	(1)
2	Health Safety Net Trust Fund Safety Net Care Payment	Provider	101CMR 613.00, 614.00	All acute hospitals	\$156.3	\$156.3	\$156.3	TBD	TBD	\$468.90	(2)
3	Institutions for Mental Disease (IMD)	Provider	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	\$24.0	\$24.0	\$24.0	TBD	TBD	\$72.00	(3)
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	Provider		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	\$45.0	\$45.0	\$45.0	TBD	TBD	\$135.00	(4)
5	State-Owned	Provider		Cape Cod and Islands	\$77	\$77	\$77	TBD	TBD	\$231.00	

	Non-Acute Hospitals Operated by the Department of Mental Health			Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital							
6	Delivery System Transformation Initiatives	n/a		Eligible hospitals outlined in Attachment I	\$230.3	\$230.3	\$230.3	TBD	TBD	\$690.8	(5)
7	Public Hospital Transformation and Incentive Initiative	n/a		Cambridge Health Alliance	\$220.0	\$220.0	\$220.0	TBD	TBD	\$660.0	(6)
8	DSHP-Specified State Funded Programs	DSHP		n/a	\$385.0	\$257.0	\$129.0	TBD	TBD	\$771.0	(7)
9	DSHP - Health Connector subsidies*	n/a		n/a	\$41.8	\$75.2	\$188.0	\$198.0	\$208.0	\$711.0	(8)
10	Designated State Health Programs – CommCare Transitional Coverage	n/a		n/a	\$175.4	n/a	n/a	n/a	n/a	\$175.4	(9)
11	Designated State Health Programs – Temporary Coverage	n/a		n/a	\$560.2	n/a	n/a	n/a	n/a	\$560.2	(10)

12	Infrastructure and Capacity-Building	Infrastructu re		Hospitals and CHCs	\$ 30.0	\$30.0	\$30.0	TBD	TBD	\$90.0	(11)
	Total				\$2,085	\$1,255	\$1,243			\$4,991	

*The amount included in the Total includes DSHP Health Connector Subsidies for SFY 18-19.

**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) for DY 18-20, and has provided in the STCs that Massachusetts will not make such DSH payments in DY 18-20, but instead will make provider support payments under the SNCP. In DYs 21 and 22 Massachusetts is not currently authorized to make SNCP provider payments. Massachusetts and CMS will collaborate to reach agreement on a redesigned SNCP structure for DYs 21 and 22. If an amendment to the demonstration for restructured SNCP provider payments for DYs 21 and 22 is not approved, Massachusetts will resume making DSH payments in accordance with an approved State plan pursuant to section 1902(a)(13)(A)(iv) of the Social Security Act.

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

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

Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in section VIII (projected and rounded in millions).

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

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

Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in section VIII (projected and rounded in millions).

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

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

Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in section VIII (projected and rounded in millions).



The following notes are incorporated by reference into chart A

- (1) 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.
- (2) 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.
- (3) IMD claiming is 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. Three payment types make up the IMD category; inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification centers.
- (4) Expenditures for items #4-5 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.

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

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

Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in section VIII (projected and rounded in millions).

(5) Delivery System Transformation Initiative funds will be distributed to participating hospitals pursuant to STCs 50 and 52.

(6) Public Hospital Transformation and Incentive Initiative Funding will be distributed to Cambridge Health Alliance pursuant to section VIII.

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

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

Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in section VIII (projected and rounded in millions).

(7) DSHP specified state funded programs are described in Chart C with dates of service beginning as of date of approval letter through June 30, 2017.

(8) Expenditures for DSHP Health Connector Subsidies are approved beginning January 1, 2014 and based on actual enrollment and premium assistance costs. Consequently, the amount of total expenditures may vary. The Health Connector Subsidies are authorized for five additional years, SFYs 2015-2019. Beginning November 4, 2016, the Health Connector Subsidies will include expenditures for point of service cost-sharing subsidies in addition to the existing premium assistance subsidies. The Health Connector Subsidies are not subject to the overall SNCP cap or the DSHP cap. Here are the projected totals (in millions) during the renewal period for the Health Connector Subsidies by SFY.

SFY 2015:	\$41.8
SFY 2016:	\$75.2
SFY 2017:	\$188.0
SFY 2018:	\$198.0
SFY 2019	\$208.0

(9) Expenditures for DSHP – CommCare Transitional Coverage are provided effective January 1, 2014 through February 28, 2015, and are based on actual enrollment. Consequently, the amount may vary. These expenditures are not subject to the DSHP cap.

(10) Expenditures for DSHP –Temporary Coverage are approved effective January 1, 2014 through February 28, 2015, and are based on actual enrollment. Consequently, the amount may vary. These expenditures are not subject to the DSHP cap.

(11) Infrastructure and Capacity-Building (ICB) funds support Commonwealth-defined health systems improvement projects, and are approved by

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

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

Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in section VIII (projected and rounded in millions).

CMS pursuant to section VIII. Participating providers (including hospitals, community health centers, primary care practices and physicians) and ACOs as well as provider-specific amounts are determined based on a formal request for responses (RFR) process. Spending for ICB is subject to the limit described in section VIII.

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

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

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50 (projected and rounded)

#	Type	State law or regulation	Eligible providers	Total SNCP payments per SFY									
				SFY 2015	Source of Non-federal share	SFY 2016	Source of Non-federal share	SFY 2017	Source of Non-federal share	SFY 2018*	Source of Non-federal share	SFY 2019*	Source of Non-federal share
1	Public Service Hospital Safety Net Care Payment		Boston Medical Center Cambridge	\$140.0		\$140.0		\$140.0		TBD		TBD	
2	Health Safety Net Trust Fund Safety Net Care Payment	101 CMR 613.00, 614.00	All acute hospitals	\$156.3		\$156.3		\$156.3		TBD		TBD	
3	Institutions for Mental Disease (IMD)	130 CMR 425.408, 101 CMR 346.00	Psychiatric inpatient hospitals Community-based detoxification centers	\$24.0		\$24.0		\$24.0		TBD		TBD	

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

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

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50 (projected and rounded)

4	Special Population State-Owned Non- Acute Hospitals Operated by the Department of Public		Shattuck Hospital Tewksbury Hospital	\$45.0		\$45.0		\$45.0		TBD		TBD	
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center	\$77.0		\$77.0		\$77.0		TBD		TBD	
6	Delivery System Transformation Initiatives		Eligible hospitals outlined in Attachment I	\$230.3		\$230.3		\$230.3		TBD		TBD	
7	Public Hospital Transformation and Incentive Initiative		Cambridge Health Alliance	\$220.0		\$220.0		\$220.0		TBD		TBD	
8	Designated State Health Programs (DSHP) - Specified State-Funded Programs		n/a	\$385		\$257.0		\$129.0		TBD		TBD	

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

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

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50 (projected and rounded)

9	DSHP – Health Connector Premium Assistance & Cost Sharing Subsidies		n/a	\$41.8		\$75.2		\$165.7		\$172.5		\$180.9	
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10	DSHP – Commonwealth Care Orderly Closeout		n/a	175.4		n/a		n/a		n/a		n/a	
11	DSHP-Temporary Coverage (AA Population)		n/a	\$560.2		n/a		n/a		n/a		n/a	
12	Infrastructure and Capacity-Building for Hospitals and Community Health Centers		Hospitals and, community health centers, primary care practices and physicians, Accountable Care Organization Pilots	\$30.0		\$30.0		\$30.0		TBD		TBD	
	Total			\$2,085		\$1,258		\$1,220		TBD		TBD	

Designated State Health Programs (DSHP). The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and the applicable Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. No demonstration amendment is required for CMS approval of updates to Chart C of Attachment E to include additional DSHP programs. This chart shall be updated pursuant to the process described in section VIII.

Chart C: Approved Designated State Health Programs (DSHP)

Dates of Service from the date of the approval letter through June 30, 2017

This DSHP is subject to the overall DSHP cap and the overall SNCP cap.

Agency	Program Name
	<u>Previously Authorized Programs</u>
DMH	Homeless support services
DMH	Individual and family flexible support
DMH	Comprehensive psychiatric services
DMH	Day services
DMH	Child/adolescent respite care services
DMH	Community rehabilitative support
DMH	Adult respite care services
DMH	Department of Corrections – DPH/Shattuck Hospital Services
DPH	SANE Program
DPH	Growth and nutrition program
DPH	Multiple Sclerosis
DPH	Universal Immunization Program
DPH	Pediatric Palliative Care
EHS	Children’s Medical Security Plan
ELD	Prescription Advantage

ELD	Enhanced Community Options*
ELD	Home Care Services*
ELD	Home Care Case Management and Admin
ELD	Grants to Councils on Aging
HCF	Community Health Center Uncompensated Care Payments
HCF	Fisherman's Partnership
MCB	Turning 22 Program – respite
MCB	Turning 22 Program – training
MCB	Turning 22 Program – co-op funding
MCB	Turning 22 Program – mobility
MCB	Turning 22 Program – homemaker
MCB	Turning 22 Program – client supplies
MCB	Turning 22 Program – vision aids

MRC	Turning 22 Services
MRC	Head Injured Programs
VET	Veteran's Benefits
<u>New Authorized Programs</u>	
DMH	Prescription Monitoring Program
DMH	Substance Abuse Trust Fund
DMH	Naloxone Project
DMH	MA Child Psychiatric Access Project
DMH	Clubhouse Services
DMH	Program of Assertive Community Treatment
DMH	Peer Services Recovery and Learning Community
DMH	Mental Health Jail Diversion Programs and Comprehensive Community Intervention Team
DMH	Community and School Therapeutic Support
HPC	CHART Grants
DPH	Domestic Violence Prevention
DPH	Suicide Prevention and Intervention Program
DPH	Prevention and Wellness Grant Program
DPH	Postpartum CHW Pilot Program
DCF	Domestic Violence Prevention – Residential
DCF	Family Resource Centers
DESE	Substance Abuse Counselors
DDS	Oral Healthcare for Developmentally Disabled

*These items are inclusive of amounts included in capitation payments to One Care plans for One Care enrollees for “Home Care Services” as specified in Appendix B, Exhibit 4: New Community-based Services in the One Care Three-Way Contract.

Dates of service July 1, 2014 through June 30, 2019

This DSHP is not subject to the aggregate SNCP cap or the DSHP cap.

Agency	Program Name
HealthConnector	Health Connector Premium Assistance and Cost Sharing Subsidies

Attachment I

The hospitals listed below are the providers who are eligible to participate in DSTI for the term of this Demonstration approval period, and are eligible to earn incentive payments based on a proportional allotment indicated in the master DSTI plan. This is not a guarantee of funding for DSTI providers, but an allocation and actual funding will be based upon incentive payments as outlined in an approved master DSTI plan and approved hospital specific DSTI plans pursuant to section VIII.

Participating Hospital	Proportional Allotment Participating Hospitals Maybe Eligible to Earn through Incentive Payments		
	DY 18	DY 19	DY 20
<u>Public Acute Hospital:</u>			
Cambridge Health Alliance	\$49,338,666.67	\$49,338,666.67	\$49,338,666.67
<u>Private Acute Hospitals:</u>			
Boston Medical Center	\$113,908,666.67	\$113,908,666.67	\$113,908,666.67
Holyoke Medical Center	\$8,968,666.67	\$8,968,666.67	\$8,968,666.67
Lawrence General Hospital	\$15,876,666.67	\$15,876,666.67	\$15,876,666.67
Mercy Medical Center	\$16,734,666.67	\$16,734,666.67	\$16,734,666.67
Signature Healthcare Brockton Hospital	\$18,384,666.67	\$18,384,666.67	\$18,384,666.67
Steward Carney Hospital	\$7,054,666.67	\$7,054,666.67	\$7,054,666.67

Attachment P

Historical Background on MassHealth Demonstration

The implementation of mandatory managed care enrollment under MassHealth changed the way health care was delivered resulting in a new focus on primary care, rather than institutional care. In order to aid this transition to managed care, the demonstration authorized financial support in the form of supplemental payments for two managed care organizations (MCOs) operated by safety net hospital providers in the Commonwealth to ensure continued access to care for Medicaid enrollees. These payments ended in 2006.

In the 2005 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars to further expand coverage directly to the uninsured, funded in part by redirecting certain public funds that were dedicated to institutional reimbursement for uncompensated care to coverage programs under an insurance-based model. This agreement led to the creation of the Safety Net Care Pool (SNCP). This restructuring laid the groundwork for health care reform in Massachusetts, because the SNCP allowed the Commonwealth to develop innovative Medicaid reform efforts by supporting a new insurance program.

Massachusetts' health care reform legislation passed in April 2006. On July 26, 2006, CMS approved an amendment to the MassHealth demonstration to incorporate those health reform changes, which expanded coverage to childless adults, and used an insurance connector (Marketplace) and virtual gateway system to facilitate enrollment into the appropriate program. This amendment included:

- the authority to establish the Commonwealth Care program under the SNCP to provide sliding scale premium subsidies for the purchase of commercial health plan coverage for uninsured persons at or below 300 percent of the FPL;
- the development of payment methodologies for approved expenditures from the SNCP;
- an expansion of employee income eligibility to 300 percent of the FPL under the Insurance Partnership; and
- increased enrollment caps for MassHealth Essential and the HIV/Family Assistance Program.

At this time, there was also an eligibility expansion in the Commonwealth's separate title XXI program for optional targeted low-income children between 200 percent and 300 percent of the FPL, which enabled parallel coverage for children in households where adults are covered by Commonwealth Care. This expansion ensured that coverage is equally available to all members of low-income families.

In the 2008 extension of the demonstration, CMS and the Commonwealth agreed to reclassify three eligibility groups (those aged 19 and 20 under the Essential and Commonwealth Care programs and custodial parents and caretakers in the Commonwealth Care program) with a categorical link to the title XIX program as "hypotheticals" for budget neutrality purposes as the populations could be covered under the state plan. As part of the renewal, the SNCP was also restructured to allow expenditure flexibility through a 3-year aggregate spending limit rather than annual limits; a gradual phase out of federal support for the Designated State Health Programs; and a prioritization in the SNCP to support the Commonwealth Care Program.

Three amendments were approved in 2010 and 2011 to allow for additional flexibility in the Demonstration. On September 30, 2010, CMS approved an amendment to allow Massachusetts to

(1) increase the MassHealth pharmacy co-payment from \$2 to \$3 for generic prescription drugs; (2) provide relief payments to Cambridge Health Alliance totaling approximately \$216 million; and (3) provide relief payments to private acute hospitals in the Commonwealth totaling approximately \$270 million.

On January 19, 2011, CMS approved an amendment to: (1) increase authorization for Designated State Health Programs for state fiscal year 2011 to \$385 million; (2) reclassify Commonwealth Care adults without dependent children with income up to and including 133 percent of the federal poverty level (FPL) as a “hypothetical” population for purposes of budget neutrality as the population could be covered under the state plan; and (3) allow the following populations to be enrolled into managed care: (a) participants in a Home and Community-Based Services Waiver; (b) Katie Beckett/ Kaileigh Mulligan children; and (c) children receiving title IV-E adoption assistance.

Additionally, on August 17, 2011, CMS approved an amendment to authorize expenditure authority for a maximum of \$125.5 million for state fiscal year (SFY) 2012 for Cambridge Health Alliance through the SNCP for uncompensated care costs. This funding was approved with the condition that it be counted toward a budget neutrality limit eventually approved for SFY 2012 as part of the 2011 extension.

In the 2011 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars for the following purposes:

- support a Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children with high-risk asthma;
- offer early intervention services for children with autism who are not otherwise eligible through the Commonwealth’s currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
- utilize Express Lane eligibility methodologies to conduct renewals for parents and caretakers to coincide with the Commonwealth’s intent to utilize Express Lane eligibility for children; and
- further, expand the SNCP to provide incentive payments to participating hospitals for Delivery System Transformation Initiatives focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

In the extension granted on December 20, 2011 the Commonwealth’s goals under the demonstration were:

- Maintain near-universal health care coverage for all eligible residents of the Commonwealth and reduce barriers to coverage;
- Continue the redirection of spending from uncompensated care to insurance coverage;
- Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and
- Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

Under the September 2013 amendment, the Commonwealth revised the demonstration and waiver authorities to comply with the provisions of the Affordable Care Act. Additionally, the amendment supported the Commonwealth’s ability to sustain and improve its ability to provide coverage,

affordability and access to health care under the demonstration. The amendment allowed Massachusetts to continue certain programs and realign other programs to comply with the Affordable Care Act provisions that became effective January 1, 2014. For example, the amendment allowed Massachusetts to sunset certain demonstration programs such as MassHealth Basic, MassHealth Essential and the Medical Security Program December 31, 2013. These changes were made to reflect the fact that effective January 1, 2014, the individuals eligible under certain demonstration programs with income up to 133 percent of the federal poverty level (FPL) became eligible under the Medicaid state plan and those with income above 133 percent of the FPL became eligible to purchase insurance through Massachusetts' health insurance Marketplace, the Health Connector. With the combination of previous expansions and the recent health reform efforts, the MassHealth Medicaid section 1115 demonstration now covers approximately 1.8 million individuals.

In the 2014 extension of the demonstration, the Commonwealth continued its commitment to the same goals articulated for the 2011-2014 extension period. In accordance with these goals, CMS and the Commonwealth agreed to:

- Extend the demonstration for a five-year period based upon the authority under Section 1915(h)(2) of the Social Security Act which authorizes five-year renewal terms for states that provide medical services for dual eligible individuals through their demonstration. The five-year renewal period supported the Commonwealth's dual eligibles demonstration as some of the authorities for the duals demonstration are contained in the in the section 1115(a) demonstration.
- Continue authority for the Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children ages 2-18 with high-risk asthma;
- Continue authority to offer intensive early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
- Continue Health Connector Subsidies to provide premium assistance to individuals receiving Qualified Health Plan (QHP) coverage through the Marketplace with incomes up to 300 percent of the FPL;
- Continue and expand the authority for the Commonwealth to conduct streamlined eligibility redeterminations using Supplemental Nutrition Assistance Program (SNAP) verified income data;
- Provide for payment of the cost of the monthly Medicare Part A and Part B premiums and the cost of deductibles and coinsurance under Part A and Part B for Medicare-eligible individuals who have incomes up to 133 percent of the FPL, and pay the costs of the Medicare Part B premium only for CommonHealth members with incomes between 133 and 135 percent FPL; and
- Through June 30, 2017, provide incentive payments to participating hospitals for Delivery System Transformation Initiatives and the Public Hospital Transformation and Incentive Initiatives, and provide support for Infrastructure and Capacity Building investments focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

During the extension period granted in 2014, the goals of the demonstration were:

- Maintain near universal coverage for all residents of the Commonwealth and reduce

barriers to coverage, while ensuring quality healthcare and access to low income individuals;

- Continue the redirection of spending from uncompensated care to insurance coverage, connecting previously low-income uninsured to Medicaid coverage;
- Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements for Medicaid beneficiaries; and
- Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care provided to Medicaid beneficiaries.

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

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

AWARDEE: Massachusetts Executive Office of Health and Human Services

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

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

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

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

I. Demonstration Population Expenditures

1. CommonHealth Adults.

Expenditures for health care-related costs for:

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

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

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

II. Service-Related Expenditures

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

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

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

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

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

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

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

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

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

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

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

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

IV. Streamlined Redeterminations

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

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

V. Delivery System Related Expenditures

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

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

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

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

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

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

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

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

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

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

4. **Reasonable Promptness**

Section 1902(a)(8)

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

5. **Mandatory Services**

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

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

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

6. **Resource Limits**

Section 1902(a)(10)(E)

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

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

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

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**MassHealth 1115 Demonstration
Attachment L: Pilot Accountable Care Organization (ACO) Payment
Methodology**

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 Other sources of information are reviewed, as needed, such as regional and national economic indicators that can provide broad perspectives of industry trends in the United States and in the Northeast.**Error! Bookmark not defined.**

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 MassHealth will account for program changes occurring between the base and performance periods that are expected to affect the TCOC. Data will be adjusted for any known programmatic, benefit, fee, population changes occurring between the base period and the performance period. 3.6. Seasonality 5

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Note: The methodology described in this attachment is wholly distinct from the methodology

used for the full implementation of MassHealth's ACO program rolling out late 2017.

Overview: MassHealth providers will be paid on a fee-for-service basis for care provided to members attributed to Pilot AOCs. For each ACO, MassHealth will track the total costs of care (TCOC) for the ACO's attributed members during the performance period, and will retrospectively compare these costs against an ACO-specific target. Based on the difference between an ACO's TCOC performance and its TCOC target, EOHHS may share savings with the ACO or require the ACO to pay a share of losses. This attachment describes the methodology MassHealth will use to calculate these payments.

The Commonwealth may modify this Attachment with the approval of CMS without amending the STCs.

Section 1.1 Section 1. Eligible and Enrolled Population

1.1. Performance Period

The ACO Pilot performance period will begin December 1, 2016 and end November 30, 2017.

1.2. Member eligibility

MassHealth members must be enrolled in the MassHealth PCC Plan during the performance period in order to be attributed to a Pilot ACO. The eligible population is therefore the same population eligible for the PCC Plan, which includes disabled and non-disabled children and adults under age 65 (i.e., RC I, II, IX, and X). Similarly, MassHealth members who are not eligible for the PCC Plan will not be eligible for the Pilot ACO program, including members who are Medicare dually eligible, limited standard eligible, family planning waiver, women eligible due to pregnancy, Health Safety Net members, and third party liability members. In developing the Pilot ACO TCOC targets, MassHealth is using data for PCC Plan members during the base period.

Rating Category	Description
RC I Child	Temporary Assistance to Needy Families (TANF) less than 21 years of age.
RC I Adult	Temporary Assistance to Needy Families (TANF), ages 21 through 64.
RC II Child	Disabled members, including Supplemental Security Income (SSI) and SSI-related less than 21 years of age.
RC II Adult	Disabled members, including Supplemental Security Income (SSI) and SSI-related, ages 21 through 64.
RC IX	Individuals ages 21 through 64 with incomes up to 133% federal poverty level (FPL), who are not pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage.
RC X	Individuals ages 21 through 64 with incomes up to 133% FPL, who are not pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage, who are also receiving EAEDC through the Massachusetts Department of Transitional Assistance

1.3. Member attribution to ACO

Members in the PCC Plan are each enrolled with a PCC. Each Pilot ACO has a unique, exclusive group of PCCs who have contracted to participate with that ACO; PCC Plan members enrolled with a Pilot ACO's PCCs are considered attributed members for that Pilot ACO.

Section 2. Services included in Total Cost of Care (TCOC)

The services included in TCOC will be broadly consistent with services included in the base capitation for MassHealth's managed care organizations, with some differences. In particular, there are select services (e.g., Hepatitis C drugs) that MassHealth will exclude from the TCOC calculation in order to prevent unpredictable, rare, high-cost events from driving substantial losses for an individual ACO. Additionally, Home Health and LTC services are also excluded from the TCOC, but will be tracked and reported to providers.

2.1. List of covered services

Below is a list of covered service categories under the ACO Pilot program:

Category	Definition
Inpatient PH — Non-maternity	Inpatient services that have not been identified as maternity, behavioral health or LTC. Includes services provided in acute and chronic hospital settings; includes both room and board data and ancillary data billed by the facility during the stay.
Inpatient PH — Maternity	Inpatient PH — Maternity Acute hospital inpatient services related to maternity care and deliveries.
Emergency Room	Emergency room services provided in acute hospital settings; does not include ancillary data associated with the visit if not coded "emergency room" on the claim. Emergency room discharges that result in an admission are not included in this category.
Lab and Radiology — Facility	Laboratory and radiology services provided as outpatient services by acute or chronic care hospitals and freestanding facilities.
Other Outpatient Hospital	Outpatient services provided by acute care hospitals, chronic care hospitals, and ambulatory surgical centers, except those meeting categorization criteria for behavioral health, emergency room, and laboratory and radiology.
Clinics (CHC)	Services provided by Community Health Centers.
Professional Services	PH services provided by medical professionals; including physicians, nurse practitioners, podiatrists, chiropractors, and physical therapists. This category includes professional laboratory services, as well as physician inpatient services billed separately.

Category	Definition
DME & Supplies	DME and medical supplies; including hearing aids, orthotics, prosthetics, and oxygen/respiratory care equipment.
Emergency Transportation	Transportation services provided by emergency transportation providers.
Pharmacy	Retail pharmacy.
Other Medical Services	Speech and hearing services, renal dialysis, dental care, hospice care, and other miscellaneous services.
Inpatient Behavioral Health	Inpatient services related to behavioral health care, provided in acute care hospitals, chronic care hospitals, behavioral health hospitals, or other specialty behavioral health residential facilities.
Outpatient Behavioral Health	Outpatient behavioral health services provided by behavioral health hospitals, mental health clinics, acute care hospitals, physicians, and other appropriate behavioral health service providers. Does not include CBHI services.
Diversionary Behavioral Health	Diversionary behavioral health services are home and community-based mental health and substance use disorder services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and substance use disorder services in more community-based, less structured environments. Diversionary services are also provided to support an individual's return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community.

2.2. Excluded services

MassHealth's current MCO capitation rates include certain high-cost services that are relatively new to the MassHealth program, which may result in a large and unpredictable impact on ACOs' TCOC. Some such services, specifically Hepatitis C drugs, Cystic Fibrosis drugs, and Applied Behavioral Analysis, will therefore be excluded from TCOC calculations.

TCOC will also exclude services that are currently excluded from MCO capitation rates. Long Term Supports & Services (LTSS) will be excluded, as will services rendered by state agencies outside of MassHealth or the health safety net.

Section 3. Calculation of TCOC target

Prior to the start of the performance year, MassHealth will establish a preliminary TCOC target for each Pilot ACO. This section describes how that target will be calculated.

3.1. Base data

The TCOC target will be based on a one-year historical base period of October 1, 2014 through September 30, 2015. MassHealth selected this base period after reviewing the most recent three years of available and reliable data for the ACO-eligible population.

All base data for PCC Plan members and included services will be utilized to inform adjustments such as trend. The base data will consist of MassHealth eligibility records, Primary Care Clinician (PCC) Plan claims and Massachusetts Behavioral Health Partnership (BHP) contractor encounter data for PCC and BHP covered services. Each Pilot ACO's TCOC target will be based on the data for members attributed to that ACO's participating PCCs, specifically, during the base period.

3.2. Risk/acuity adjustment

For each ACO, MassHealth will adjust for any observed changes in acuity between the members attributed during the base period (October 1, 2014 - September 30, 2015) and the ACO performance period (December 1, 2016 to November 30, 2017). Specifically, MassHealth will normalize each ACO's risk score to the overall PCC program during the base period, and again during the performance period.

MassHealth will use a statistically developed risk adjustment tool and standard DxCG grouper to develop individual member-level risk scores; this tool also incorporates independent variables related to social determinants of health.

3.3. Stop-loss adjustment

Consistent with the stop-loss approach described in Section 4.1, MassHealth will adjust the base data in order to mitigate the risk to providers from claims incurred for individual members beyond the stop-loss thresholds (\$50,000 for RC I, \$110,000 for RC II). Expenditures beyond these thresholds will be reduced by 90% in the base data; ACOs are therefore "at risk" for only 10% of these outlier costs.

3.4. Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future time period. As part of the TCOC development process, unit cost and utilization trend factors by RC, region, and service category will be developed.

The primary data sources used in trend development will consist of ACO-eligible members' eligibility records, PCC Plan claims, and BHP encounter data for PCC and BHP covered services. The data reflects a variety of influences, including potential changes in medical management practices, network construction, and population risk. Some of these influences may be accounted for in other aspects of rate setting, such as program changes, and, as such, the data must be considered within the broader context of other assumptions. Any services excluded from TCOC will also be excluded from the trend development.

3.5. Program changes

MassHealth will account for program changes occurring between the base and performance

periods that are expected to affect the TCOC. Data will be adjusted for any known programmatic, benefit, fee, population changes occurring between the base period and the performance period.

Section 4. Calculation of shared savings and losses

4.1. Retrospective calculation of TCOC performance and savings / losses

Within one year from the end of the performance period, MassHealth will calculate each ACO's TCOC performance for the list of covered services described in Section 2.1. Several potential adjustments may be made at that time to account for additional changes between the base and performance periods:

- Shifts in risk: MassHealth will calculate each ACO's benchmark to reflect the actual risk scores of the ACO's covered population, as well as reflect the ACO's final enrollment mix by rating category (i.e., rating category and age group).
- Program changes: To the degree that MassHealth introduces substantial shifts in policy during the performance period that has an effect on TCOC, calculations of performance may be adjusted to reflect the impact of those policy changes
- Stop-loss: In order to appropriately incent ACOs to manage costs, it is important to insulate those ACOs' performance from the impact of unmanageable catastrophic costs incurred by a small number of members. Therefore, MassHealth will count only 10% of claims beyond \$50,000 for individual members in Rating Category I and \$110,000 for individual members in Rating Category II in the calculation of TCOC performance. This approach is consistent with the discounting of those claims from the base data, as described in Section 3. The threshold amounts for each rating category were determined based on Monte Carlo simulations using the distribution in member-level spending and the expected number of attributed lives in the expected Pilot ACOs. By testing the financial impact of different stop-loss thresholds on each ACO's TCOC performance under the assumption that members are randomly assigned to ACOs, MassHealth determined an appropriate threshold that protected ACOs from suffering significant losses due to random variation alone while maintaining a meaningful incentive to manage utilization for high-cost members.

After the adjustments described above, the difference in each ACO's TCOC performance and its target (each expressed as a PMPM) will be calculated on a PMPM basis.

4.2. Determination of shared portion of savings / losses

Once the total savings or losses have been calculated, MassHealth will follow a series of steps that determine the portion of savings or losses retained by the ACO:

- Savings / losses cap: MassHealth will recognize savings or losses for each individual ACO up to a cap of 15% of the ACO's TCOC target. For example, if an ACO's target TCOC is \$500 PMPM, then its cap on recognized savings or losses is $\$500 * 15\% = \75 PMPM. If the ACO achieves TCOC performance of \$400 PMPM, MassHealth would

only recognize \$75 PMPM of the savings. Similarly, if the ACO has a TCOC performance of \$580 PMPM, only \$75 PMPM of losses would be recognized. For the ACO, 100% of savings or losses would be recognized if the ACO performed between \$425 and \$575 PMPM.

- Share of savings: After the determination of savings and losses, MassHealth will pay 50% of recognized savings to ACOs with TCOC performance below target. In the example where an ACO performs at \$400 PMPM on a \$500 PMPM target, MassHealth would therefore pay the ACO $\$75 * 50\% = \37.50 PMPM. Therefore, the maximum financial upside in the ACO Pilot is 7.5% of target.
- Share of losses: MassHealth will recoup 10% of the recognized losses from ACOs with TCOC performance above target. In the example where ACO A performs at \$580 PMPM on a \$500 PMPM target, MassHealth would therefore recoup from ACO A $\$75 * 10\% = \7.50 PMPM. Therefore, the maximum financial upside beyond target TCOC is 1.5% of target.
- Minimum savings / loss ratio: If total savings or losses are less than 2% of the TCOC target, MassHealth will not pay shared savings or recoup shared losses. This approach prevents payments or recoupments from being incurred due to random variation. For example, if an ACO's target TCOC is \$500 PMPM, and its performance is between \$490.01 and \$509.99 PMPM, no savings or losses will be shared. If performance was \$490.00 and below or \$510.00 and above, then the full difference between performance and target would be recognized (per the prior three bullets)

4.3. Impact of quality reporting on shared savings / losses

Pilot ACOs will be required to report on certain clinical quality measures. ACOs that fail to satisfy quality reporting requirements will not be eligible to share in savings.

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

Introduction

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

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

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

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

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

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

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

Determination of Allowable Medicaid and Uninsured Costs

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

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
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and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by acute inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).

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

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
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Early Intervention Services for Children with Autism Spectrum Disorder the Pediatric Asthma Pilot Program payment protocol as specified in STC 40(h).

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

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

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

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

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

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

Worksheet B

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

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

Worksheet C

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

Worksheet D

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

Worksheet D consists of the following five parts:

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

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

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

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

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
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- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

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

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

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

Worksheet E

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

NOTES:

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

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

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

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

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

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

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

Overview

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

NOTES:

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

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

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

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

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

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

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

UCCR Instructions

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

Column 1 – Reported Costs

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

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

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

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

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

Column 3 – Total Costs

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

Column 4 – Charges

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

Column 5 – Hospital Cost-to-Charge Ratios

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

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

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

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

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

Column 7 – MassHealth FFS Inpatient Costs

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

Column 8 – MassHealth Fee-for-Service Outpatient Charges

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

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

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

Column 9 – MassHealth Fee-for-Service Outpatient Costs

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

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

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

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

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

Column 1 – Total Routine Cost Center Inpatient Costs

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

Column 2 – Total Inpatient Days

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

Column 3 – Per Diem

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

Column 4 – MassHealth Fee-for-Service Inpatient Days

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

Column 5 – Total MassHealth FFS Inpatient Costs

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

Column 6 – Medicaid Managed Care Inpatient Days

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

Column 7 – Total Medicaid Managed Care Inpatient Costs

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

Column 8 – HSN and Uninsured Care Inpatient Days

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

Column 9 – Total HSN and Uninsured Care Inpatient Costs

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

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

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For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;

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- Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

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

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

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

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

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

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

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

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

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

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

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

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Column 7 – HSN and Uninsured Care Inpatient Charges

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

Column 8 – HSN and Uninsured Care Inpatient Costs

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

Column 9 – HSN and Uninsured Care Outpatient Charges

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

Column 10 – HSN and Uninsured Care Outpatient Costs

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

Column 11 – Total HSN and Uninsured Care Costs

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

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

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

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

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

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

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

- HSN and Uninsured Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:

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- Individuals with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of a particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

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Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

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Column 12 – Total Massachusetts Medicaid Fee-for-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee-for-service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

Column 1 – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

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Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total

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gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

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Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

III. Reconciliation

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Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552³ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund payments, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation

³ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

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**Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient
Hospital Protocol for Medicaid and Uncompensated Care Cost**

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
 - i. Per STC 50(f), the cost limit protocol will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
 - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid state plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
 - 1. Inpatient chronic disease and rehabilitation hospital services: Inpatient services are routine and ancillary services that are provided to recipients admitted as patients to a chronic disease or rehabilitation hospital. Such services

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- are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
2. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 3. Outpatient chronic disease and rehabilitation hospital services: Rehabilitative and medical services provided to a member in a chronic disease or rehabilitation outpatient setting including but not limited to chronic disease or rehabilitation hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services include, but are not limited to, radiology, laboratory, diagnostic testing, therapy services (i.e., physical, speech, occupational and respiratory) and Day surgery services. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 4. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members eligible for Medicaid through the section 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
 1. Diversionary Behavioral Health Services.
- d. Medicaid Managed Care Costs: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.

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- e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
- f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

I. Certified Public Expenditures – Determination of Allowable Safety Net Care Pool Costs

In accordance with the approved MassHealth Section 1115 demonstration, beginning July 1, 2014, the estimated fiscal year expenditures will be based on the actual fiscal year CMS 2552 and UCCR cost reports.

General Description of Methodology

The certified public expenditures (CPEs) for special population State-Owned Non-Acute hospitals operated by the Department of Public Health (DPH) and Department of Mental Health (DMH) are claimed annually under the Safety Net Care Pool (SNCP) based upon the unreimbursed Medicaid and uninsured. The CPE interim payments made under the SNCP will follow the same methodology as contained in the Commonwealth's Medicaid State Plan.

II. Summary of 2552-10 Cost Report

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

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

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply

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- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

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

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

Worksheet C

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

Worksheet D

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

Worksheet D consists of the following five parts:

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

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53

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(determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

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

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

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

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

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

Worksheet E

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

NOTES:

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

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

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

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The Commonwealth will use the CMS 2552⁴ and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

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

Overview

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

NOTES:

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

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

⁴ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the Medicare 2552 cost report.

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Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

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

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

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

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
associated with physician services who are employees of the hospital billed and received by the hospital								
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and	X	X	X	X	X	X	X	X

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
uninsured patients								
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionsary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

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UCCR Instructions

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

Column 1 – Reported Costs

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

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

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

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

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

Column 3 – Total Costs

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

Column 4 – Charges

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

Column 5 – Hospital Cost-to-Charge Ratios

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

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

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

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

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

Column 7 – MassHealth FFS Inpatient Costs

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

Column 8 – MassHealth Fee-for-Service Outpatient Charges

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

- MassHealth FFS Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;

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

Column 9 – MassHealth Fee-for-Service Outpatient Costs

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

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

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 11. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C.

Column 1 – Total Routine Cost Center Inpatient Costs

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

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Column 2 – Total Inpatient Days

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

Column 3 – Per Diem

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

Column 4 – MassHealth Fee-for-Service Inpatient Days

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

Column 5 – Total MassHealth FFS Inpatient Costs

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

Column 6 – Medicaid Managed Care Inpatient Days

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

Column 7 – Total Medicaid Managed Care Inpatient Costs

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

Column 8 – HSN and Uninsured Care Inpatient Days

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

Column 9 – Total HSN and Uninsured Care Inpatient Costs

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

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

For the purposes of completing Schedule C:

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

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

- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

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- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

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

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

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

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

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

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

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

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

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

Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

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

Column 7 – HSN and Uninsured Care Inpatient Charges

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

Column 8 – HSN and Uninsured Care Inpatient Costs

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

Column 9 – HSN and Uninsured Care Outpatient Charges

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

Column 10 – HSN and Uninsured Care Outpatient Costs

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

Column 11 – Total HSN and Uninsured Care Inpatient and Outpatient Costs

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

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

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

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

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

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

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;

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- Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

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Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians' costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

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Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Total Massachusetts Medicaid Fee For Service Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee for service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

Column 1 – Total SNHCS Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients

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served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay for Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since following payments are not payments for the provision of medical care,

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they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

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Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

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Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

IV. Reconciliation

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552⁵ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not

⁵ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the Medicare cost report(s).

Final Reconciliation

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

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The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

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**Institutions for Mental Diseases – Psychiatric Hospitals and Community Based
Detoxification Centers (CBDCs) Protocol for Medicaid and Uncompensated Care
Cost**

The Commonwealth will use the reports described below to collect data from these providers.

Psychiatric hospitals will fill out the CMS 2552 and UCCR, as required of other hospitals in the cost limit protocol. CBDCs are non-hospital human and social services contractors that do not file a CMS 2552 cost report; therefore, for the purposes of the protocol, the Commonwealth will use only the Massachusetts **Uniform Financial Statements and Independent Auditor’s Report (UFR)** to determine costs and revenues. The UFR is the set of financial statements and schedules required of human and social service contracting with state departments. For the calculation of provider-specific cost limits, psychiatric hospitals and CBDCs will fill out the necessary reports with the information that is relevant to the services they provide to the Medicaid-eligible and HSN and uninsured populations.

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
 - i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable psychiatric hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Pharmacy service costs are separately identified on the CMS 2552 10 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.

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- b. Medicaid State Plan Allowable Costs
 - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by institutions for mental disease. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
 - 1. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - 2. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - 3. Community Based Detoxification Center (CBDC): CBDCs are eligible to receive Safety Net Care Pool payments as Institutions for Mental Diseases (IMDs) under the section 1115 demonstration. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - a. Acute Inpatient Substance Abuse Treatment Services: Short-term medical treatment for substance withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling, and post detoxification referrals provided by an inpatient unit, either freestanding or hospital-based, licensed as an acute inpatient substance abuse treatment service by the Massachusetts Department of Public Health under its regulations at 105 CMR 160.000 and 161.000. These services are delivered in a three-tiered system consisting of Levels III-A through III-C that must conform with the standards and patient placement criteria issued and enforced by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services.
 - b. Substance Abuse Outpatient Counseling Service: An outpatient counseling service that is a

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rehabilitative treatment service for individuals and their families experiencing the dysfunctional effects of the use of substances.

- ii. 1115 Demonstration Population Expenditures: Costs incurred by psychiatric hospitals and CBDCs for providing IMD services to members eligible for Medicaid through the State plan and section 1115 demonstration will be counted as allowable costs. Allowable costs for psychiatric hospital services and CBDC services provided under the 1115 demonstration include service-related expenditures (please note that all services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs). The list of allowable services is contained in the Cost Element table.

1. Diversionary Behavioral Health Services

- c. Medicaid Managed Care Costs: Costs incurred by IMDs for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
- d. Other Allowable Costs, Approved 1915(c) Waivers. The list of allowable services in contained in the Cost Element table.
- e. Additional Allowable Costs – The list of allowable services is contained in the Cost Element table.

I. Summary of 2552-10 Cost Report (Psychiatric Hospitals Only)

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

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

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

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified

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- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

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

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

Worksheet C

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

Worksheet D

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

Worksheet D consists of the following five parts:

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

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

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

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

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

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

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

Worksheet E

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

NOTES:

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

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

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and

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uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth must use the CMS 2552⁶ and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

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

Overview

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

NOTES:

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

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

⁶ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

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

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

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable	X	X	X	X	X	X		

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Medicare cost principles								
Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day		X				X		

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Treatment Program Services								
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

UCCR Instructions

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

Column 1 – Reported Costs

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

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

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

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

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

Column 3 – Total Costs

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

Column 4 – Charges

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

Column 5 – Hospital Cost-to-Charge Ratios

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

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

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

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

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

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

Column 7 – MassHealth FFS Inpatient Costs

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

Column 8 – MassHealth Fee-for-Service Outpatient Charges

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

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

Column 9 – MassHealth Fee-for-Service Outpatient Costs

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

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

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

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

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

Column 1 – Total Routine Cost Center Inpatient Costs

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

Column 2 – Total Inpatient Days

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

Column 3 – Per Diem

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

Column 4 – MassHealth Fee-for-Service Inpatient Days

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

Column 5 – Total MassHealth FFS Inpatient Costs

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

Column 6 – Medicaid Managed Care Inpatient Days

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

Column 7 – Total Medicaid Managed Care Inpatient Costs

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

Column 8 – HSN and Uninsured Care Inpatient Days

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

Column 9 – Total HSN and Uninsured Care Inpatient Costs

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

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

For the purposes of completing Schedule C:

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

- Medicaid Managed Care Charges may not include:

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- Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
 - HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

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

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

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

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

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

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

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

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

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

Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

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

Column 7 – HSN and Uninsured Care Inpatient Charges

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

Column 8 – HSN and Uninsured Care Inpatient Costs

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

Column 9 – HSN and Uninsured Care Outpatient Charges

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

Column 10 – HSN and Uninsured Care Outpatient Costs

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

Column 11 – Total HSN and Uninsured Care Costs

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

Schedule D: Computation of Uncompensated Care Physician Costs

For purposes of completing Schedule D:

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

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

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

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

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

- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

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- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

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Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Total Massachusetts Medicaid Fee-For-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

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Total Massachusetts Medicaid Fee-For-Service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document. .

Column 1 – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

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Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total

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gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

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Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

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III. Uniform Financial Report (UFR)

CBDCs are entities that provide health care services for substance abuse that contract with the MassHealth agency, Medicaid Managed Care Entities and the Bureau of Substance Abuse Services, the latter providing services to the uninsured. Each CBDC is licensed by the Bureau of Substance Abuse Services under the requirements set forth in 105 CMR 164.000. Because CBDCs are not a hospital, they do not fill out the Medicare CMS-2552 cost report and instead fill out the Uniform Financial Report (UFR).

UFR reports are filed with the Massachusetts Operational Services Division (OSD) on an annual basis. This report captures administration and support costs, as defined in 808 CMR 1.00, which includes expenditures for the overall direction of the organization, e.g., general record keeping, budgeting, etc., but also the salaries and expenses of the organization's staff. The report will also capture expenditures for health care services, as defined in M.G.L. c. 118 § 2 (b), the pricing of which is set by the Center for Health Information and Analysis

The CBDCs are required to keep necessary data on file to satisfy the UFR reporting requirements, and books and records must be maintained in accordance with generally accepted accounting principles set forth by the American Institute of Certified Public Accountants (AICPA).

The UFR must be submitted on or before the 15th day of the fifth month after the end of the contractor's fiscal year.

The UFR reports the following data elements:

1. Net Assets
2. Total Current Assets
3. Total Assets
4. Total Current Liabilities
5. Total Liabilities
6. Total Liabilities and Net Assets
7. Total Revenue, Gains, and Other Support
8. Total Expenses and Losses
9. Indirect / Direct Method
10. Cash from Operating Activities
11. Cash from Investing Activities
12. Cash from Financing Activities
13. Total Expenses – Programs
14. Total Expenses – Supporting Services
15. Surplus Percentage
16. Surplus Retention Liability

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The UFR allows for revenue to be reported from Medicaid Direct Payments, Medicaid Massachusetts behavioral Health Partnership (MBHP) Subcontracts, Department of Mental Health, Department of Public Health, and other human and social service agencies.

The CBDC's program expense is broken down by provider type for Psychiatric Day Treatment and Substance Abuse Class Rate Services, including:

1. Psychiatrist
2. N.P., Psych N., N.A., R.N.-Masters
3. R.N.-Non Masters
4. L.P.N.
5. Occupational Therapist
6. Psychologist – Doctorate
7. Clinician (formerly Psych. Masters)
8. Social Worker – L.I.C.S.W.
9. Social Worker – L.C.S.W., L.S.W.
10. Licensed Counselor
11. Cert. Voc. Rehab. Counselor
12. Counselor
13. Case Worker/Manager – Masters
14. Case Worker/Manager
15. Direct Care/Program Staff Supervisor
16. Direct Care/Program Staff

Per unit cost from UFR. The provider will calculate a per unit cost from the UFR for inpatient detoxification programs, who do not submit the Medicare 2552 cost report, by dividing the total reimbursable program expense (Schedule B line 53E) by line 6SS (number of service units delivered). The per diem cost will be reported by the CBDC on the CBDC Protocol Form.

Allowable Costs

- i. From the MMIS paid claims database, the State will obtain the number of units of care, including administrative units, provided to all Medicaid patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS that reports the number of units, days of care, including administrative days, for services provided to Medicaid MCO and other uninsured patients.⁷
- iii. The state will calculate costs by multiplying the per unit cost with the number of MassHealth, Medicaid MCO, and uninsured units described above.

⁷ This is not currently available on the UFR report.

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Payments

- i. From the MMIS paid claims database, the state will obtain payments made to programs for services, including administrative days, provided to MassHealth patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS reporting payments received from all sources for services provided to Medicaid MCO and uninsured patients.

Determination of Provider-Specific SNCP Limit for CBDCs

The State will calculate a provider-specific SNCP limit for each CBDC as by subtracting all applicable payments from the allowable costs

IV. Reconciliation

Interim Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552⁸ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three after months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of

⁸ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

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The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

Interim Reconciliation for UFR Method

Each provider's uncompensated care costs must be computed based on the provider's as-filed Uniform Financial Report (UFR) and for the actual service period. The UFR is filed five months after the close of the cost reporting period. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service period. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The interim reconciliation described above will be performed and completed within twelve months after the filing of the provider's UFR.

Final Reconciliation for the UFR Method

Each provider's uncompensated care costs must be recomputed based on the provider's audited UFR for the actual service period. The UFR is audited and settled by the Commonwealth to determine final allowable costs and reimbursement amounts as recognized by the Commonwealth based on this cost limit protocol. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service

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Uncompensated Care Cost Limit Protocol
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period. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government. Settlement of any over- or underpayment to a provider will be treated as a separate transaction rather an adjustment to the following year's interim payment.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The final reconciliation described above will be performed and completed within twelve months after the audited provider UFR is made available.

ATTACHMENT J
MASTER DELIVERY SYSTEM TRANSFORMATION INCENTIVE PLAN
Approved October 30, 2015

I. PREFACE

1. MassHealth Medicaid Section 1115 Demonstration

This Attachment J, Master DSTI Plan, applies to the extension period of the Centers for Medicare & Medicaid Services (CMS) approved section 1115 demonstration, entitled MassHealth (11-W-00030/1) (demonstration) from July 1, 2014 through June 30, 2019 (DY18 through DY22).

2. Delivery System Transformation Initiatives (DSTI)

STC 50(d) of the Demonstration authorizes the Commonwealth to extend the Delivery System Transformation Initiatives (DSTI) funded through the Safety Net Care Pool (SNCP). These initiatives are designed to provide incentive payments to support investments in eligible safety net health care delivery systems for projects that will advance the triple aims of improving the quality of care, improving the health of populations and enhancing access to health care, and reducing the per-capita costs of health care. In addition, DSTI payments will support initiatives that promote payment reform and the movement away from fee-for-service payments toward alternative payment arrangements that reward high-quality, efficient, and integrated systems of care.

Safety net hospitals (also referred to as “hospital(s)” herein) eligible for DSTI pursuant to STC 50(d)(1) will be required to develop and implement these initiatives and activities in order to receive the incentive payments. Pursuant to STC 50(d)(3), participating hospitals must expand and build upon current initiatives, and may also implement new health care initiatives within their respective health systems, in order to qualify for DSTI incentive payments. In addition, these initiatives may complement or enhance other federal or state initiatives in which a hospital may be participating, but they must not duplicate the exact same activities undertaken by a hospital for which that hospital receives specific funding from the U.S. Department of Health and Human Services or from the Commonwealth. Pursuant to STC 50(d)(8), these incentive payments are intended to support and reward hospitals for improvements in their delivery systems; they are not direct reimbursement or payment for services, should not be considered patient care revenue, will not be offset against other Medicaid reimbursements to a hospital system, and will not be counted as payments when calculating hospital-specific cost limits.

3. Master DSTI Plan

In accordance with STCs 50(d)(2) and 52(a), the master DSTI plan defines the specific initiatives that will align with the following four categories: (1) developing a fully-integrated delivery system, (2) improving health outcomes and quality, (3) developing capabilities to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments that promote system sustainability, and (4) population-focused improvements. Furthermore, the master DSTI plan describes the global context for DSTI in the Commonwealth, describes guidelines for individual hospital DSTI plans, and stipulates the structure and processes governing the DSTI program, pursuant to STCs 50 (d) and 52. The master DSTI plan

also incorporates the required elements of the DSTI payment and funding protocol as described in STC 52(c).

Following approval of the master DSTI plan by CMS and throughout the demonstration renewal period, EOHHS may propose revisions to the master DSTI plan, in collaboration with the respective DSTI hospitals, to reflect modifications to any component of a hospital's final approved plan, including but not limited to projects, measures, metrics, and data sources; or to account for other unforeseen circumstances in the implementation of the DSTI program. CMS shall render a decision on proposed master DSTI plan revisions within 30 business days of submission by EOHHS. Such revisions shall not require a demonstration amendment, provided that they comport with all applicable STC requirements.

4. Hospital Specific DSTI Plans

Each eligible safety net hospital must have a DSTI plan approved by EOHHS and CMS that identifies the projects, population-focused objectives, and specific metrics adopted from the master DSTI plan and meets all requirements pursuant to the STCs. The requirements for hospital-specific DSTI plans are described in STC 52(b) and further detailed in Section IV ("Key Elements of Proposed Hospital Specific Plans") herein.

5. Organization of "Attachment J: Master DSTI Plan"

This document serves as Attachment J to the STCs and contains all required elements that must be included in the Commonwealth's master DSTI plan and DSTI payment and funding protocol, pursuant to STC 52(a) and 52(c). Attachment J is organized into the following sections:

- I. Preface
- II. Commonwealth's Payment & Delivery System Progress and Goals
- III. Community Needs & DSTI Eligibility Criteria
- IV. Key Elements of Proposed Hospital Specific Plans
- V. Non-Federal Share of DSTI Payments
- VI. Reporting & Payments in DY18 through DY20
- VII. Disbursement of DSTI Funds
- VIII. Plan Modification, Grace Periods, and Carry-Forward & Reclamation
- IX. Master DSTI Projects and Metrics
- X. Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects
- XI. Category 4B: Population-Focused Improvements
- XII. Community Based Care Delivery and Integration
- XIII. DSTI Evaluation

II. COMMONWEALTH'S PAYMENT & DELIVERY SYSTEM PROGRESS AND GOALS

6. Global Context

Massachusetts established itself as a leader in health care reform when it became the first state to secure nearly universal health care coverage for its residents. In 2006, the state took a major step forward by enacting Chapter 58 of the Acts of 2006 (Chapter 58), which was the result of a bipartisan effort among state leaders from government, business, the health care industry, community-based groups and consumer advocacy organizations. Chapter 58 aimed to expand access to coverage through a combination of strategies, including the creation of a new marketplace for individuals and small businesses to purchase insurance, an individual mandate to purchase insurance, shared responsibility requirements for employers, and expansions of public health insurance programs. Chapter 58 later served as a model for federal health care reform legislation, the *Patient Protection and Affordable Care Act* of 2010 (ACA), which included many of these same elements.

The goals of Chapter 58, with the support and partnership of CMS, have been largely realized. More than 97% of the Commonwealth's population is insured, including over 98% of children.¹ According to two recent reports by the Blue Cross Blue Shield Foundation of Massachusetts, health reform not only has led to sustained increases in insurance coverage, but reform has also increased access to health care and improved health status among Massachusetts residents. Among the reports' key findings are:

- Massachusetts made sustained gains in access to and use of health care between 2006 and 2012. Nonelderly adults were significantly more likely to have a usual source of health care, more likely to have had a preventive care visit, more likely to have had multiple doctor visits, more likely to have had a specialist visit, and more likely to have had a dental care visit.²
- Emergency departments (ED) visits, a key indicator of gaps in access to regular care, were down nearly four percentage points since 2006. ED use for non-emergency conditions similarly decreased almost four percentage points, and frequent ED use dropped by 2 percentage points.³

¹ Center for Health Information and Analysis, Massachusetts Health Care Coverage: 2012 Estimate (2013). Available at: <http://www.mass.gov/chia/docs/r/pubs/13/2012-mass-insurance-coverage.pdf>.

² Blue Cross Blue Shield Foundation of Massachusetts. *Health Reform in Massachusetts; Expanding Access to Health Insurance; Assessing the Results*, March 2014. <http://bluecrossfoundation.org/publication/updated-health-reform-massachusetts-assessing-results>.

³ Sharon K. Long, Karen Stockley, and Heather Dahlen. *Health Reform in Massachusetts as of Fall 2010: Getting Ready for the Affordable Care Act & Addressing Affordability*. Blue Cross Blue Shield Foundation of Massachusetts, January 2012. Note: the reduction in overall ED use was statistically significant at the .05 level, two tailed test, and the reduction in non-emergent ED use was statistically significant at the .01 level, two tailed test. The reduction in frequent ED use was not statistically significant.

- The share of nonelderly adults in Massachusetts reporting their health status as very good or excellent increased between 2006 and 2010 (from 46.7 percent to 53.2 percent).⁴
- Many of these gains were concentrated among low-income adults, a population that was particularly targeted by health reform initiatives to improve access to and affordability of care.

The Commonwealth's success in insuring nearly all Massachusetts residents highlighted a new set of challenges. Massachusetts, like states around the country, the federal government, the private sector, and individuals, faces rising health care costs and a reimbursement system that too often rewards volume rather than value in the delivery of health care.

In 2012, the Commonwealth set forth a statewide goal to reduce health care costs and move away from fee-for-service payments in another major health care reform law, Chapter 224 of the Acts of 2012 ("Chapter 224"). Chapter 224 outlined a broad vision for health care changes in Massachusetts and created specific mechanisms to enable the state to better assess health care costs with the intention of slowing the growth of such costs in the future. Among other provisions, Chapter 224:

- Established a statewide health care cost growth target;
- Required state programs to lead by example in moving toward alternative payment models;
- Created mechanisms to recognize and facilitate anticipated changes in the health care delivery system, including the adoption of ACO and PCMH models;
- Committed resources to investing in community-based public health initiatives and the health care delivery system; and
- Increased transparency through enhanced reporting and the use of health information technology (HIT).

Between 2012 and 2013, total healthcare expenditures in Massachusetts grew at a rate of 2.3 percent per capita, a rate that is lower than both the statutory benchmark of 3.6 percent and the per-capita economic growth of 2.6 percent in 2013. This lower rate of growth was consistent with relatively low growth nationally in recent years, but may also be related to unique forces within Massachusetts; healthcare spending in the state has grown more slowly than it has in the U.S. for the last two years. The drivers and dynamics contributing to such moderated cost growth are not yet clear.

In 2013, 35 percent of plan members across all public and private payers in Massachusetts were covered under alternative payment methods (APMs), an increase from 29 percent in 2012. Despite this overall increase, there remain significant barriers for further adoption of APMs,

⁴ Ibid.

including penetration of APMs in PPO products, expanding the use of APMs in MassHealth, and exploring bundled payment methods to extend the reach of APMs.

With the recognition that Massachusetts has not yet achieved the scale or pace of reform envisioned in Chapter 224, Massachusetts plans to redouble efforts to move towards alternative payment methods at scale, with the goal of transitioning more than 80 percent of MassHealth members into alternative payment models within 36 months.

7. Commonwealth's Delivery System and Payment Reform Agenda and Timeline

The Commonwealth has and will be undertaking a number of efforts with a single theme: transforming the delivery system to provide integrated care across the continuum, while adopting sustainable alternative payment systems that more directly reward systems for high quality, efficient care. Restructuring health care payment and delivery systems is fundamental to better ensuring consistent quality of care, reducing errors, decreasing health care disparities, and reining in overall health care costs.

A critical component of improving health care quality and curtailing costs is to integrate care to ensure that providers work collaboratively to meet patient care needs and do so in the most appropriate setting. Increased focus on using the right care at the right time in the right place means a significant behavioral change both for providers and for health care consumers, but it is also a pivotal building block in the long-term systemic transformation Massachusetts envisions. In addition, the Commonwealth views delivery system transformation and payment reform as integrally related. In order to align incentives toward more integrated, accountable models of care delivery, the Commonwealth is committed to continuing to reform the way we pay for care, moving from volume based fee-for-service payments to payments based on maintaining access and quality.

One of Massachusetts' key strategies in driving transformation of the care delivery system is for MassHealth, as a public payer covering approximately one in four residents of the Commonwealth, to take a leading role. In 2014, the Primary Care Payment Reform (PCPR) initiative launched with thirty participating provider organizations covering nearly 70,000 MassHealth lives. PCPR provides a capitated payment for primary care services and some behavioral health services, combined with quality incentive payments and shared accountability for the total costs of an attributed patient population. The launch of the PCPR initiative represented a significant step forward for MassHealth in the ability to administer APMs and promote provider practice improvement. Participating organizations have added practice sites to the program for Year 2, increasing the number of lives covered; however, the program remains much smaller than originally anticipated. As a result, the majority of MassHealth business is still operating under fee for service (either through MassHealth's Primary Care Clinician Plan or through contracted managed care organizations).

In order to reach the goal of shifting 80 percent of MassHealth members into accountable care arrangements, the Commonwealth is now undertaking the development and implementation of a comprehensive Massachusetts Accountable Care strategy. The comprehensive strategy will include population-based payment models addressing the needs of distinct segments of MassHealth members (i.e., general population, members with significant behavioral health

needs, members with significant long term care needs) and may also include episode-based payments for certain key conditions. These new payment models linking reimbursement to quality and overall costs will be supported by a holistic approach for transforming the delivery system via infrastructure investments and technical assistance, along with providing transparency and data support to providers to accelerate transformation. We will also work to promote multi-payer alignment on key program design elements in the interest of reducing administrative burden on providers and raising the return on investment for their participation in APMs.

In anticipation of this transformation, MassHealth is committed to a robust and responsive stakeholder process to obtain input and develop a set of models that best serve our unique population. MassHealth will rely on the experience and expertise of consumers and providers across the spectrum of care to collaborate with us, and we plan to work closely with CMS as well as our stakeholders, advocates and other state and federal partners on the path to developing and implementing our Accountable Care Strategy. With input from this stakeholder process, along with intensive internal analysis and program development, MassHealth intends to release specific plans for its new payment models by the end of calendar year 2015 and to launch new models in 2016.

8. Initiatives Supporting Payment & Delivery System Reform

As Massachusetts develops its new Accountable Care Strategy, we will build on the foundation of a variety of ongoing initiatives and infrastructure that have been developed to support payment and delivery system reform, including several that are supported through the 1115 demonstration. In addition to the PCPR initiative described above, ongoing initiatives include:

Electronic Health Record Initiative

The MassHealth Electronic Health Record (EHR) initiative, part of the CMS Medicaid EHR Incentive Program, offers Medicaid health care providers incentive payments to encourage them to adopt, implement, upgrade, or meaningfully use certified EHR technology. Wide adoption and meaningful use of interoperable EHRs are critical building blocks for payment reform, enabling providers to manage their patients' care and costs effectively. Meaningful use of EHRs can improve patient care by simplifying administrative procedures, enhance health care quality by making patient health information available at all points of care, reduce costs through earlier diagnosis and characterization of disease, and increase coordination of information for patients, caregivers, and clinical staff. MassHealth plans to distribute up to \$500 million over the life of the program (through 2021) to eligible health care providers to support transitions to electronic health record systems. To date, 62 hospitals and 5,808 doctors and other providers have been approved to participate in the program, and \$245 million in incentive payments have been disbursed to these providers.

All Payer Claims Database

Massachusetts has developed an All Payer Claims Database (APCD) that aims to provide timely, valid and reliable health care claims data that will allow a broad understanding of cost and utilization across payers, institutions and populations. This dataset is envisioned as a critical tool in informing the development of health care policies in the Commonwealth, as policymakers, payers and providers evaluate different payment methodologies and work to develop performance measures to support integrated health care delivery models. The APCD was first

made available for use by interested parties in the summer of 2012 with private payer data and has since been expanded to include all payers. Potential users apply for data release through an application and governance process.

Pediatric Asthma Pilot Program

The Pediatric Asthma Bundled Payment Demonstration Program is an initiative to pilot bundled payments for high-risk pediatric asthma patients enrolled in selected MassHealth Primary Care Clinician Plan practices. This pilot program aims to improve health outcomes, reduce asthma-related emergency department utilization and asthma-related hospitalizations, and reduce associated Medicaid costs for children with high-risk asthma. The pilot will be conducted in two phases. The first phase will provide a bundled per member per month payment for services not traditionally covered by MassHealth, such as home visits by community health workers and supplies for mitigating environmental asthma triggers in the home. Following initial implementation and evaluation of outcomes from the first phase of the pilot, the Commonwealth plans to implement a bundled payment for ambulatory services required for the most effective treatment and management of pediatric asthma for high-risk patients, with CMS approval. In the fall of 2014 MassHealth received approval from CMS to implement the first phase of the program.

One Care Demonstration Project for Non-Elderly Duals Integration

On August 22, 2012, the Commonwealth entered into a Memorandum of Understanding (MOU) with CMS to establish the Massachusetts Capitated Financial Alignment Demonstration (also known as the Duals Demonstration). The Duals Demonstration aligns payments for Medicare and Medicaid services by creating a single integrated care model delivered by contracted health plans that provide the full spectrum of medical, behavioral health, and long-term services and supports to individuals who have the most complex needs and highest service utilization of any population groups in either the Medicaid or Medicare programs. MassHealth calls its Duals Demonstration program One Care. Enrollment in One Care plans began in October 2013. One Care promotes person-centered models that integrate the full range of care for approximately 18,000 enrolled members between the ages of 21-64 who are eligible for Medicaid and Medicare. One Care is contributing to payment and delivery system reform in the Commonwealth by providing dually eligible MassHealth members with access to an integrated, accountable model of care and support services through global payments.

The Commonwealth will test this model and use experience with One Care to determine how a similar integrated care model can best be expanded to serve more dually eligible members as well as possibly serving Medicaid-only disabled populations as well. Massachusetts plans to incorporate this question into its comprehensive Accountable Care Strategy as we consider how best to serve MassHealth members with significant medical and long term care needs.

III. COMMUNITY NEEDS & DSTI ELIGIBILITY CRITERIA

9. Community Needs

Massachusetts as a state is more affluent, better-educated, and healthier than the nation as a whole. Massachusetts has an overall poverty rate of 15%, below the national rate of 21%, and a median income of \$61,000, above the national median of \$50,000. Of the Commonwealth's

approximately 6.6 million residents, 39% hold a bachelor's or graduate degree, compared to 28% for the nation as a whole.⁵ In addition, Massachusetts has expanded health care coverage while maintaining above-average performance in key health indicators. Life expectancy in Massachusetts is 80.1 years, compared to a national figure of 78.6. The infant mortality rate is 5.6 per thousand, compared to a national rate of 6.8. Obesity and diabetes rates for both children and adults are lower than national rates.⁶

However, the communities that DSTI-eligible safety net providers serve are characterized by lower incomes, more severe socioeconomic challenges, and more adverse health status indicators than the state as a whole. For example, DSTI-eligible hospitals serve the state's largest urban population (the Boston metropolitan area) as well as a rural county with the lowest per-capita income and worst health outcomes in the state (Hampden County).⁷ Populations in these communities have higher risk factors for asthma and diabetes and often face complex medical and behavioral health conditions. Linguistic, cultural, and socio-economic barriers require specialized resources and services to effectively coordinate care and promote health. Prevalence of chronic health care conditions such as diabetes, cardiovascular disease, COPD, and obesity, are higher than in other Massachusetts communities.⁸ These factors create specific challenges in designing effective interventions to coordinate and manage care for safety net populations and simultaneously make the need for delivery system transformation more urgent for safety net providers.

10. Safety Net Health Care Challenges

Safety net hospitals have been important participants in Massachusetts' health reform efforts. The newly insured have continued to rely on safety net hospitals for care, as well as outreach and enrollment, in large numbers. These organizations had long been the site of care for the uninsured; naturally, the newly insured continued to seek health services where they already had a connection. As a result, these hospitals experienced a 30% increase in Medicaid patient care volume during health care reform from 2006 to 2010.⁹ DSTI eligible safety net hospitals have a Medicaid payer mix that is, on average, nearly twice the statewide acute hospital average (27% vs. 14%). The DSTI hospitals' commercial payer mix is, on average, 35% lower than the statewide average (24% vs. 37%). Despite the expansion in health coverage under Chapter 58 reforms, safety net hospitals continue to provide concentrated care to the residual uninsured population.

These factors have limited the capacity of the eligible safety net providers to make investments that position them well for payment reforms. The transformation to new models of care delivery require hospitals and providers to make significant up-front investments in such areas as network development and management; care coordination, quality improvement and utilization

⁵ 2010 American Communities Survey.

⁶ Kaiser Family Foundation. State Health Facts: Massachusetts State Profile. <<http://www.statehealthfacts.org>>

⁷ Massachusetts Community Health Information Profile (MassCHIP), available at <<http://www.mass.gov/eohhs/researcher/community-health/masschip/welcome-to-masschip.html>>

⁸ Ibid.

⁹ Aggregate increase in the annual number of Medicaid and Medicaid Managed Care patient care encounters 2006-2010 for seven safety net hospitals participating in DSTI, derived from Massachusetts Division of Health Care Finance and Policy FY2010 403 Cost Reports.

management; clinical information systems; and data analytics to enhance performance measurement.¹⁰ Many of the eligible safety net hospitals have deferred capital investments (including IT) and operating investments (such as care coordination and management systems enabled by new clinical and financial reporting capabilities) in an effort to manage conservatively and live within their budgets. Choices like these, while necessary in the short term, threaten to undermine the ability of the Commonwealth's safety net providers to transform their delivery systems to meet the Triple Aim goals that the hospitals share with CMS and EOHHS.

Over the past three years, the DSTI program has provided a unique opportunity for the eligible safety net hospitals to begin to overcome these challenges and make meaningful initial progress toward delivery system transformation. Significant work remains to be done, the DSTI program will continue to enable safety net providers' participation in delivery system reform initiatives as the Commonwealth shifts toward widespread adoption of value based payment models.

11. DSTI Eligibility Criteria

STC 50(d) describes the eligibility criteria for the DSTI program. Providers were initially determined eligible to participate in DSTI based on their status as public or private acute hospitals with a Medicaid payer mix more than one standard deviation above the statewide average and a commercial payer mix more than one standard deviation below the statewide average based on FY2009 cost report data. The hospitals listed below are the providers that are eligible to participate in DSTI for the term of this demonstration approval period, and are eligible to earn incentive payments based on an initial proportional allotment indicated in STC 50(d)(9) and Attachment I:

- Cambridge Health Alliance
- Boston Medical Center
- Holyoke Medical Center
- Lawrence General Hospital
- Mercy Medical Center
- Signature Healthcare Brockton Hospital
- Steward Carney Hospital.

In addition to the eligibility criteria described above, DSTI participants must connect to the Mass HIway. A participant that is not currently connected to Mass HIway must submit a plan to sign a Participation Agreement, connect and use the Mass HIway Direct Messaging to exchange patient clinical information as well as a plan to utilize Mass HIway Query and Retrieve services, which are now available. A participant that has already signed a Participation Agreement, but is not connected and does not yet use Mass HIway for Direct Messaging and Mass HIway Query and Retrieve services, which are now available, must submit a plan to connect and utilize the above mentioned services. A participant that is already connected to Mass HIway, and uses Mass HIway Direct Messaging services must provide acknowledgement of the connection and utilization.

¹⁰ Accountable Care Organization Learning Network Toolkit. Engelberg Center for Health Care Reform | The Dartmouth Institute and The Brookings Institution, January 2011.

12. Evolution of the Delivery System Transformation Initiatives

For MassHealth, supporting safety net populations and the safety net providers that provide the majority of their care is a natural place to focus in our efforts to advance delivery system and payment reform. The goal of Delivery System Transformation Initiatives (DSTI) is to leverage incentive payments to advance the transformation of safety net hospitals and their networks into integrated delivery systems characterized by the Triple Aim: improving care for individuals, improving the health of populations, and reducing per-capita costs to make health care affordable for all.

Through DSTI, incentive payments are offered to eligible safety net hospitals that serve a high proportion of Medicaid and uninsured patients to support projects that help them develop more fully integrated delivery systems, improve health outcomes and quality, and advance their capacity to respond to statewide transformation to alternative payment methods. Payments are tied to achieving specific transformation milestones, and increasingly, to demonstrating measurable improvements on health care quality and outcome measures.

When DSTI launched in June 2012, each of the seven participating hospitals established unique DSTI programs that focused on four objectives: development of a fully integrated delivery system; improvement of health outcomes and quality; movement towards value-based purchasing and alternatives to fee-for-service payments; and population-focused improvements.

Semi-annual and annual progress reports for this first phase of DSTI demonstrated the important steps that providers receiving DSTI funding have taken to implement system transformation activities. In the new demonstration renewal period, the participating providers will work to scale promising efforts while undertaking new initiatives to address gaps in care delivery. Some examples include:

Boston Medical Center's Re-Engineered Discharge Process (Project RED). Boston Medical Center's (BMC's) Project RED aims to decrease preventable hospital readmissions and returns to the emergency department by educating patients about their hospital and post-hospital care and ensuring a smooth discharge transition. An initial internal analysis demonstrated that the readmission rate for patients enrolled in the Project RED program at BMC declined 27 percent, while the readmission rate for adult medical Medicaid patients not enrolled in the program declined 15 percent. In the current demonstration period, BMC will expand its Project RED strategies from pilot units to the entire hospital.

Cambridge Health Alliance's (CHA) Patient-Centered Medical Home Initiative. CHA has worked to advance the patient-centered medical home (PCMH) model in its primary care system, as a foundation for improving population health and panel management in alternative payment models consistent with the Triple Aim goals. CHA has achieved NCQA Level 3 recognition for seven primary care sites that together care for 50,000 patients. In the current demonstration period, CHA will expand the medical home model across CHA's entire primary care system with a particular focus on the integration of behavioral health care in the primary care setting.

Holyoke Medical Center's Health Information Exchange (HIE). Holyoke Medical Center (HMC) is advancing the creation of a HIE that integrates both affiliate and independent providers with the goal of providing seamless interoperability and access to patient data between the emergency department and community physicians. This approach will enable health information to follow the patient, support clinical decision-making, improve care coordination, and reduce the duplication of tests. In the current demonstration period, HMC plans to expand connectivity to non-affiliated practices, health centers and hospitals in its service area, as well as initiate a connection to the Massachusetts Health Information Highway (the Mass HIway).

Lawrence General Hospital's Physician Hospital Organization (PHO) Initiative. Lawrence General Hospital (LGH) used DSTI support to bring its disparate, independent physician group practices, solo practitioners, and the independent local health center together under an umbrella entity, the Physician Hospital Organization (PHO). More than 320 physicians joined the PHO and for the first time are working together on clinical integration, engaging in dialogue about referral patterns, preventing "leakage" to higher cost providers, contracts, payment systems and technology initiatives. LGH intends to continue this project to invest in referral systems and data analytics, steps that will enhance the PHO's capacity to enter into contracts with health plans as an entity, and accept alternatives to fee-for-service payments.

Mercy Medical Center's Aligning Systems to Improve Health Outcomes & and Quality. Mercy Medical Center (Mercy) is designing and implementing a patient-centered care coordination and management system called Care Logistics™. This system integrates hospital system workflows to reduce the time to place patients in available beds, treat patients and discharge them safely to the appropriate level of care. Mercy completed a comprehensive assessment of its current care management processes, based on interviews of 261 hospital staff from 39 departments. The hospital is developing a new care coordination model that reconfigures eleven major hospital departments linked by "spokes" into a cohesive "Care Coordination Center" hub. These changes are fostering greater team work, improved patient flow, and enhanced quality. In the current demonstration period, Mercy will continue to develop and refine this new organizational structure.

Signature Healthcare Brockton Hospital's 360° Patient Care Management. Signature Healthcare created a patient care management program for its most seriously ill Medicare managed care population. These patients receive care from a multidisciplinary team, including a physician, nurse practitioner, case manager, pharmacist and physical therapists, as well as community partners such as visiting nurses and hospice. By coordinating the right care delivered in the right place at the right time, the program has resulted in a significant reduction in acute admissions, skilled nursing admissions and the use of long-term care hospitals for this patient population. In the current demonstration period, Signature Healthcare will expand this program to reach significantly more patients, focusing on the Medicaid eligible population.

Steward Carney Hospital's Community Health Worker Initiative. Steward Carney Hospital (Carney) created a new program hiring bilingual community health workers (CHWs) to operate as patient navigators. CHWs interface with patients entering the hospital through the Emergency Department (ED) and serve as navigators for those patients to obtain regular primary and preventive care. Carney's CHWs have connected hundreds of ED patients with regular primary

care practitioners (PCPs) and worked to bridge gaps regarding follow-up care, rescheduled appointments, and changes in insurance. In the current demonstration period, Carney's CHW program will be expanded and integrated within a broader initiative to better coordinate care for ED high utilizers with the aim of improving care for these patients while reducing avoidable ED and inpatient utilization.

Based on the foundational work so far, DSTI work during the current demonstration period will involve a combination of expanding initiatives either in scale, scope, focus, or patient populations, consistent with quality improvement approaches that spread best practices and innovations, and implementing new initiatives. New initiatives will focus on priority areas for the Commonwealth and the federal government such as behavioral health and physical health integration, patient safety, effective care transitions including for high risk populations inclusive of those with behavioral health needs, and substance abuse screening and interventions.

Whereas in the previous demonstration period the DSTI program focused primarily on project implementation activities, this next phase of DSTI shifts the focus increasingly toward measuring and linking payments to improvements in health outcomes and quality. The waiver agreement reflects a portion of payments that are "at-risk" based on performance on a set of approved quality and outcome measures described in this Master Plan. In the second year of the waiver, 10% of total DSTI funding is at risk, and in year 3, 20 percent of DSTI funding is at-risk for each hospital, in addition to five percent of overall funding that is at-risk based on the Commonwealth demonstrating progress across all participating DSTI hospitals.

In order to achieve this at-risk funding, hospitals must do the following:

- In DY19, all hospitals must show impact on **clinical quality** (e.g., diabetes management, behavioral health screening and follow-up) **and system transformation** (e.g., avoidable ED use, care transitions), through measures selected from Category 4A.
- In DY20, all hospitals must demonstrate that they are actively **working with providers across the delivery system to manage care for high utilizers** with goal of reducing ED and inpatient utilization (e.g., through robust care plans, follow-up after hospitalization and data sharing) in order to be eligible for the at-risk payments tied to Category 4A and a portion of Category 4B (equivalent to 15%). Once eligible, hospitals will earn at-risk payments associated with the corresponding measures in Categories 4A and 4B. All hospitals must meet improvement targets for **readmissions**, including overall and/or condition-specific readmissions for the Medicaid population, in order to earn the associated at-risk payments.

;

The Commonwealth has worked with the participating DSTI providers to shape these at-risk measures to focus not only on individual quality measures, but also on measures that reflect the integration of care across the delivery system and the DSTI investments' impact on reducing acute utilization through better care management. For example, the emphasis on readmissions requires coordination with primary and post-acute providers to ensure that patients receive appropriate follow-up care and avoid costly complications. The addition of the requirement for DSTI hospitals to establish structures for partnering with providers across the community to improve care management for high utilizers requires these hospitals to go beyond the boundaries of their own individual systems while placing an explicit focus on high-risk, high-cost patients who can most benefit from better care management. Putting these systems and processes in place will help to strengthen providers' ability to effectively manage the health (and costs) of populations in value based payment models.

During state fiscal years 2015-2017, the Commonwealth will work closely with CMS, participating DSTI providers and other stakeholders to evaluate the Safety Net Care Pool generally and the DSTI program specifically and to redesign these streams of funding to more sustainably support providers and advance statewide system transformation. This phase of DSTI work represents an important step forward in the rapid transition to an accountable care environment.

IV. KEY ELEMENTS OF PROPOSED HOSPITAL SPECIFIC PLANS

13. Hospital Specific DSTI Plans

Each eligible safety net hospital must implement an individual DSTI plan approved by EOHHS and CMS that identifies the projects, population-focused objectives, and specific metrics adopted from Section IX (“Master DSTI Projects and Metrics”) and meets all requirements pursuant to STCs 50(d), 52(a)(2), STC 52(b), and all requirements set forth in Section IV (“Key Elements of Proposed Hospital Specific Plans”).

14. Minimum & Maximum Number of Projects

Hospitals must select a minimum of five projects across Categories 1, 2 and 3 from Section IX (“Master DSTI Projects and Metrics”). The distribution of each hospital’s projects across Categories 1, 2 and 3 must be such that each hospital has at least one project in each of the three categories *and* at least two projects in two of the three categories. Hospitals may implement more than five projects in total for Categories 1, 2 and 3. However, hospitals must not implement more than nine projects in total for Categories 1, 2 and 3.

15. Accountability, Outcome and Quality Improvement Indicators

Hospitals must also report outcomes and improvement measures related to Category 4, which is split into Category 4A and Category 4B, pursuant to STC 50(d) to satisfy accountability requirements in DYs 18-20. The Category 4A measures are at-risk outcomes and improvement measures related to Category 1-3 projects and include a variety of measures that focus on systemic and clinical transformation. All hospitals must choose at least 6 measures from the Category 4A slate, of which two must be outcome measures. By DY 20, all Category 4A measures will be pay-for-performance. More information about Category 4A can be found in Section X (“Category 4: At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects”). The Category 4B measures are population-focused improvements related to readmissions, behavioral health, care transitions and patient safety. All DSTI hospitals must report on all applicable Category 4B measures in DYs 18-20 for which they are eligible, and all hospitals must demonstrate improvement on an established number of the measures in DY20. For all DSTI hospitals, the readmissions measure(s) must shift to pay-for-performance in DY20. Hospitals must report on all applicable population-focused health improvement metrics as described in Section XI (“Category 4B: Population-Focused Improvements”), pursuant to STC 52(a)(3).

In addition to the outcome and quality improvement that must be demonstrated through Categories 4A and 4B, by the end of DY 20 the DSTI participants must demonstrate their progress towards integrating care with local providers and community partners, which will be determined by the Community Based Care Delivery and Integration measures, described in Section XII (“Community Based Care Delivery and Integration”). The Commonwealth has incorporated these measures in recognition that each provider organization seeking to provide high-value, community based care in a payment reform environment will need key structural capabilities to manage the health of populations, and in particular high risk (and usually high cost) patients. The capabilities include: identification of high-risk/high utilizer patients, community high utilizer collaborations, development of integrated care plans, collaboration on care coordination and referrals, data sharing and the use of real-time alerts. As further described

in Section XII (“Community Based Care Delivery and Integration”) hospitals should demonstrate that they have made significant, measureable progress in the development of the structural capacities and processes to manage the health of populations in order to qualify for the at-risk payments tied to Category 4A in DY 20. There is no specific incentive funding that will be paid based on achievement of these metrics; rather, each hospital must demonstrate progress on each of these standards in order to be eligible to receive incentive payments tied to Category 4A in DY20.

16. Organization of Hospital Specific DSTI Plans

Hospital-specific DSTI Plans must include the following sections:

a) Executive Summary

The Executive Summary must provide a summary of the hospital-specific DSTI plan, a summary of the hospital’s vision of delivery system transformation, and a table of the projects included in the plan, including project titles, brief descriptions of the projects, and three year goals. The Executive Summary must also include a description of key challenges facing the hospital and how the three-year DSTI plan supports the hospital’s three-year vision. The Executive Summary should address:

- How the individual projects support the three-year vision;
- How the individual projects reinforce/support each other; and
- How Category 4A and 4B measures are relevant to the hospital’s three-year vision and population/outcomes health improvement;
- Plan to report on aggregate Outcome and Quality Improvement requirements; and
- Challenges and lessons learned from implementation of DSTI plans during DY 15 – 17.

b) Background Section

The background section must include, at a minimum, a summary of the hospital’s community context, a description of the hospital’s patient population, a description of the health system, and a three-year vision of delivery system transformation. The background section also must include a brief description of any initiatives in which the hospital is participating that are funded by the U.S. Department of Health and Human Services and are directly related to any of the hospital’s DSTI projects.

c) Sections on Categories 1, 2, and 3

1) Project Narrative

Pursuant to STC 52(b)(3), each hospital must include a narrative for each project that describes the following elements of the project:

i. Goal(s)

A description of the goal(s) of the project, which describes the challenges of the hospital system and the major delivery or payment redesign system solution identified to address those challenges by implementing the particular project;

ii. Rationale

A narrative on the hospital's rationale for selecting the project, milestones, and metrics based on relevancy to the hospital system's population and circumstances, community need, and hospital system priority and starting point with available baseline data, as well as a description of how the project represents a new initiative for the hospital system or significantly enhances an existing initiative (pursuant to STC 50(d)), including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services;

iii. Expected Results

A description of the target goal over the demonstration approval period and metrics associated with the project and the significance of that goal to the hospital system and its patients. The goals for outcomes and improvement measures can be found in Sections X and XI ("Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects" and "Category 4B: Population-Focused Improvements") ;

iv. Relationship to Other Projects

A narrative describing how this project supports, reinforces, enables and is related to other projects and interventions within the hospital system plan;

v. Description of how Project can Refine Innovations, Test, and Disseminate Findings (Category 2 only)

A description of how the selected project can refine innovations, test new ways of meeting the needs of target populations and disseminate findings in order to spread promising practices.

2) Milestones and Metrics Table

For each project, hospitals must submit milestones and metrics adopted in accordance with Section IX ("Master DSTI Projects and Metrics") and meet the requirements pursuant to STC 50(d)(5) entitled "DSTI Metrics and Evaluation." In a standardized table format, hospitals must indicate by demonstration year, when project metrics will be achieved and indicate the data source. For Categories 4A and 4B measures, reference for the data steward, as applicable, will be included for those outcomes and improvement measures. To ensure clear distinction between the types of measures and consistency in how the measures are applied throughout the plan, the measures for Categories 1-3 projects must be organized by type (structural or process metrics) for each project goal, defined as follows:

- i. Structure Measures (related to Categories 1-3 project metrics) - These measures should focus on delivery system infrastructure issues such as licensure, hiring staff, capital purchase or improvements, planning activities, or initial analysis activities.
- ii. Process Measures (related to Categories 1-3 project metrics) - These measures should focus on implemented activities that are intended to alter the process of delivering care such as workflow modifications, integrating patient care teams, establishing baseline and performance targets, and screening activities. Where possible, these measures should be National Quality Forum-endorsed, and should align with CMS Hospital Quality Initiative Outcome Indicators, and other outcome measures in the CMS Medicaid Adult/Child Core Sets.

d) Section on Category 4A (At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects)

Category 4A measures fulfill the at-risk outcomes and improvement measure requirements related to Categories 1-3 projects.

Category 4A includes improvement measures related to Categories 1, 2 and 3 projects. Each eligible safety net hospital must report on at least 6 metrics pursuant to Section X (“Category 4A: At-Risk Outcomes and Improvement Measures Related to Categories 1-3 Projects”), of which 2 measures must be outcome measures. Each hospital will list its selection of 4A measures that will be pay-for-performance in DY19 and DY20, as designated in the hospital’s plan in accordance with Section X.

e) Section on Category 4B (Population-Focused Improvements)

Category 4B lists a common set of measures that focus on readmissions, behavioral health, care transitions, and patient safety. Hospitals must report on all applicable 4B measures and will demonstrate improvement on a defined number of measures in DY20. Of the measures that are achieved through pay-for-performance, all hospitals must demonstrate improvement on the readmissions measure(s) designated in the hospital’s plan in accordance with Section XI Category 4B: Population-Focused Improvements.

f) Distribution of DSTI Funds

In this section, the hospital must describe how its total potential DSTI funds pursuant to Attachment I will be distributed among the projects and metrics it has selected in its hospital plan. The amount and distribution of funding must be in accordance with the stipulations of STC 50(d)(9), STC 52(c), Attachment I and Section VII (“Disbursement of DSTI Funds”).

V. NON-FEDERAL SHARE OF DSTI PAYMENTS

17. Identification of Allowable Funding Sources

a) Allowable Funding Sources

- 1) Allowable funding sources for the non-federal share of DSTI payments must include all sources authorized under Title XIX and federal regulations promulgated thereunder.
- 2) Except as provided in paragraph 17(a)(3) below, the source of non-federal share of DY 18 – 20 DSTI payments will be state appropriations.
- 3) The source of non-federal share of DYs 18 – 20 DSTI payments to Cambridge Public Health Commission d/b/a Cambridge Health Alliance (CHA) will be an intergovernmental funds transfer. EOHHS will issue a request to CHA for an intergovernmental transfer in the amount of the non-federal share of the applicable incentive payment amounts at least 15 days prior to the scheduled date of payment. CHA will make an intergovernmental transfer of its funds to EOHHS in the amount specified by a mutually agreed timeline determined by EOHHS in consultation with CHA, and in accordance with the terms of an executed payment and funding agreement, and all applicable laws. Upon receipt of the intergovernmental transfer, EOHHS will draw the federal funding and pay both the nonfederal and federal shares of the applicable DY 18 – 20 payment(s) to CHA according to a mutually agreed upon timeline determined by EOHHS in the consultation with CHA, and subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals.

b) CMS Approval of Funding Source

The source of non-federal share for DSTI payments is subject to CMS approval. EOHHS must provide CMS advance notice of a valid source of non-federal share and obtain CMS approval prior to drawing down FFP for DSTI payments, provided that CMS must render a decision on the source of non-federal share within 30 business days of receiving sufficient documentation of the source of non-federal share.

c) Change in Funding Source

If the source of non-federal share of DSTI payments changes during the renewal period, EOHHS must notify CMS and seek CMS' approval of such change prior to claiming FFP for any payment utilizing such funding source. No demonstration amendment is required.

VI. REPORTING AND PAYMENT IN DYs 18 – 20

18. Reporting and Payment in DYs 18 – 20

a) Hospital Reporting for Payment in DYs 18

- 1) Hospital-specific DSTI plan approval will serve as the basis for the transaction of 25% of each hospital's total DY 18 DSTI incentive payment amount. EOHHS will schedule the initial payment transaction for each hospital following approval by CMS of that hospital's plan, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals.
- 2) After CMS approval, each hospital shall submit a report to the Commonwealth demonstrating progress on the achievement of DY 18 metrics through June 30, 2015. The report must be submitted using the standardized reporting form approved by EOHHS and CMS. The report must include the incentive payment amount being requested for the progress achieved on DSTI metrics in accordance with payment mechanics (see section VII "Disbursement of DSTI Funds"). The report must include data on the progress made for all demonstration year metrics, must provide a narrative description of the progress made, and must include the year-end section referenced in paragraph 18(d) below. The hospital must submit, as an attachment to the report form, a copy or list of the data source as identified per metric in the hospital's approved DSTI plan to demonstrate achievement of each DSTI metric for which the hospital is seeking an incentive payment.¹¹ The reports must contain sufficient data and documentation to allow CMS and the state to determine if the hospital has fully met the specified metric. The hospital system must have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation. The report will serve as the basis for authorizing incentive payments to each hospital for achievement of DSTI metrics as approved by CMS in the hospital-specific DSTI plan. The actual payment amounts will be determined by EOHHS based on the achievement of metrics in accordance with the provisions of Section VII ("Disbursement of DSTI Funds").

b) Hospital Reporting for Payment in DY 19-20

Twice per year, each hospital seeking payment under the DSTI must submit reports to the Commonwealth demonstrating progress on DSTI projects, measured by category specific metrics achieved during the reporting period. The Commonwealth must provide such reports to the assigned independent assessor. The reports must be submitted using the standardized reporting form approved by EOHHS and CMS. The reports must include the

¹¹ For non-confidential data sources, the hospital will provide a copy of the data source itself; in the case that a copy of the data itself would compromise confidential patient data, the hospital may alternatively provide a list of the data source(s) used to determine metric achievement.

incentive payment amount being requested for the progress achieved on DSTI metrics in accordance with payment mechanics (see section VII “Disbursement of DSTI Funds”). The report must include data on the progress made for all demonstration year metrics and must provide a narrative description of the progress made; the mid-year report must furthermore provide a narrative explaining how the hospital will achieve the remaining metrics for each project before the end of the year. The hospital must submit, as an attachment to the report form, a copy or list of the data source as identified per metric in the hospital’s approved DSTI plan to demonstrate achievement of each DSTI metric for which the hospital is seeking an incentive payment.¹² In DYs 19 and 20, the second semi-annual report must also include a section which describes the Community Based Care Delivery and Integration measures, as described in Section XII (“Community Based Care Delivery and Integration”), which will be reviewed by EOHHS through a collaborative process with each hospital. The reports must contain sufficient data and documentation to allow CMS, the state and the independent assessor to determine if the hospital has fully met the specified metric. The hospital system must have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

These reports will be due as indicated below after the end of each reporting period:

- 1) Reporting period of July 1 through December 31: the report and request for payment is due January 31.
- 2) Reporting period of January 1 through June 30: the report and request for payment is due July 31. The Commonwealth may permit the reporting for payment of specified readmission outcomes measures as a part of Category 4B subsequent to the July 31, 2016 and July 31, 2017 reports in recognition that additional time may be needed for necessary data to be available.

These reports will serve as the basis for authorizing incentive payments to each hospital for achievement of DSTI metrics. The actual payment amounts will be determined by EOHHS based on the achievement of metrics in accordance with the provisions of Section VII (“Disbursement of DSTI Funds”). EOHHS will schedule the payment transaction for each hospital following EOHHS approval of the hospital report, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals. The state must inform CMS of the funding of all DSTI payments to providers through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter, in accordance with STCs 53(d)(2), 60, 65 and 66.

An independent assessor will review the semi-annual reports, ensure accurate reporting of DSTI hospitals’ achievement, and make recommendations to the state regarding approvals, denials or recommended changes in order to approve payment. However,

¹² For non-confidential data sources, the hospital will provide a copy of the data source itself; in the case that a copy of the data itself would compromise confidential patient data, the hospital may alternatively provide a list of the data source(s) used to determine metric achievement.

EOHHS will review the Community Based Care Delivery and Integration measures, as described in Section XII (“Community Based Care Delivery and Integration”), through a collaborative process with each hospital and make the determination on those requirements. EOHHS will provide final approval of all DSTI payments. DSTI hospitals must be allowed an opportunity to respond to, and correct, any recommendation for denial of payment, for a metric that the hospital believe it achieved, through the resubmission of required clarifications and/or data.

c) Mid-Year Assessment in DY 19 - 20

Following submission of the semi-annual progress report due January 31, each hospital will meet with the Commonwealth for a formal presentation and assessment of progress made on all DSTI projects. This will provide an opportunity for collaboration and intervention as needed to ensure each hospital’s timely progress on DSTI projects. The Commonwealth will submit a written summary of these assessments to CMS as part of the quarterly operational reports as described in paragraph 18(f) below.

d) Hospital System Annual Year-End Report Integrated into Second Semi-Annual Hospital Report for Payment in DY 18-20

Pursuant to STC 53(d), each hospital must submit an annual report integrated into the second hospital report for payment in DY 19 – 20 and single report for payment in DY 18 by July 31 following the end of the demonstration year. This section must be prepared and submitted as a part of the second semi-annual report using the standardized reporting form approved by EOHHS and CMS. The section of the report will provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The hospital system must have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

e) Year-end Payment Reconciliation

Based on its review and verification of each hospital’s second semi-annual report in DY 19 – 20 and single report for payment in DY 18, EOHHS will perform a reconciliation as an additional check to verify that all DSTI payments made to the hospital based on achievement of the applicable metrics were correct. If, after the reconciliation process EOHHS determines that the hospital was overpaid, the overpayment will be properly credited to the Commonwealth and the federal government or will be withheld from the next DSTI payment for the eligible safety net hospital, as determined by EOHHS. If, after the reconciliation process EOHHS determines that the hospital was underpaid, then subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals, EOHHS will schedule necessary payment transaction(s), or will add the additional amount to the next DSTI payment for the eligible safety net hospital, as determined by EOHHS.

f) Commonwealth Reporting to CMS in DY 18 – 20

- 1) Pursuant to STC 53(c), STC 60 and STC 62, DSTI will be a component of the Commonwealth’s quarterly operational reports and annual reports related to the demonstration. These reports will include:
 - i. All DSTI payments made to specific hospitals that occurred in the quarter;
 - ii. Expenditure projections reflecting the expected pace of future disbursements for each participating hospital;
 - iii. An assessment by summarizing each hospital’s DSTI activities during the given period, including a summary of the mid-year assessments of hospital progress when applicable. This must include an excel spreadsheet that includes all project metrics – with a crosswalk by hospital regarding whether that metric is “not applicable”; “in progress”; “completed”; or “to be implemented”; and
 - iv. Evaluation activities and interim findings of the evaluation design pursuant to STC 92.

2) Claiming Federal Financial Participation

The Commonwealth will claim federal financial participation (FFP) for DSTI incentive payments on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set up exclusively for DSTI payments. FFP will be available only for DSTI payments made in accordance with all pertinent STCs and the stipulations of this master DSTI plan, including Section VIII (“Disbursement of DSTI Funds”). The Commonwealth and the hospital system receiving DSTI payment must have available for review by CMS, upon request, all supporting data and back-up documentation. The state may not claim FFP for DSTI payments until both the state and CMS have concluded that the DSTI hospital have met the performance indicated for each payment. FFP will be available only for payments related to activities listed in the approved Master DSTI Plan.

VII. DISBURSEMENT OF DSTI FUNDS

19. DSTI Incentive Payments

a) Eligibility for DSTI Incentive Payments

DSTI payments for each eligible hospital are contingent on that provider meeting project metrics as defined in the approved hospital-specific plans. As outlined in section VI (“Reporting and Payment in DY 18 – 20”) of the master DSTI plan, eligible safety net hospitals will be able to receive DSTI incentive payments related to achievement of their metrics upon submission and approval of the required reports for payment. Once a metric is achieved, the hospital may not continue to receive funds for that same metric in

subsequent funding cycles. DSTI incentive payments to an individual hospital may equal but not exceed the initial proportional allotment outlined in Attachment I.

b) DY 18 DSTI Payments

In DY18, each hospital will receive 25% of its annual proportional DSTI allotment based on CMS approval of its hospital-specific plan, pursuant to STC 50(d)(8) and Attachments E and I. The remaining 75% of the hospital DSTI allotment will be available as incentive payments to each hospital based on successfully achieving metrics associated with approved projects within DSTI Categories 1, 2, 3, and 4A and 4B as described in Sections X and XI (“Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects” and “Category 4B: Population-Focused Improvements”) and in approved hospital-specific plans.

c) DY 19 and DY 20 DSTI Payments

In DY 19, DSTI funds will be available as incentive payments to each hospital based on successfully achieving metrics associated with approved projects within DSTI Categories 1, 2, 3, and 4A and 4B as described in Sections X and XI (“Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects” and “Category 4B: Population-Focused Improvements”) and in approved hospital-specific plans.

In DY20, DSTI funds will be available as incentive payments to each hospital based on successfully achieving metrics associated with approved projects within DSTI Categories 1, 2, 3 and 4A and 4B as described in Section XI (“Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects” and “Category 4B: Population-Focused Improvements”). In order to be eligible for 12.5% at-risk funds associated with Category 4A and 2.5% associated with pay-for-performance measures in Category 4B, each hospital must demonstrate that by the end of DY 20 it has fulfilled the requirements for the Community Based Care Delivery and Integration measures as described in Section XII (“Community Based Care Delivery and Integration”).

d) Funding At Risk for Outcomes and Quality Improvement

The percentage of DSTI funding at risk for improved performance on validated outcome or quality indicators in Categories 4A and 4B will gradually increase from 0 percent in SFY 2015 to 10 percent in SFY 2016 to 20 percent in SFY 2017 (averaging to 10 percent total over the three-year period). This accountability structure is on a provider-specific basis.

e) Hospital Accountability and Funding Limitations

Overall DSTI project funding is available up to the amounts specified in the special terms and conditions and Attachment E. As a general matter, DSTI funding is subject to the provider meeting the specific metric in the approved Master DSTI Plan. In addition, pool wide achievement of performance goals and targets must be achieved or maintained for

full access in DY 20 (SFY 2017) to the funding level specified in the STCs, Attachment E and the DSTI Master Plan. In DY 20 (SFY 2017) (the third year of the renewal period), the DSTI hospitals must show improvement relative to DY 18 (SFY 2015) performance baselines. If the DSTI providers do not meet the required aggregate performance goals as specified by the DSTI Master Plan by the end of year three, the DSTI pool will be subject to a five percent reduction in available funding. In other words, if the DSTI hospitals do not demonstrate the aggregate performance improvements as specified in the DSTI Master Plan, five percent of the DY 20 DSTI funding will be withheld.

This reduction, if applicable, will be taken at the end of the three-year period. The five percent reduction is an aggregate pool wide penalty based on three years of performance. It is not an additional penalty imposed on an individual provider for not meeting a specific metric. CMS will work with the Commonwealth to assure that any reduction penalty is equitable.

The aggregate pool wide penalty will take effect if the DSTI hospitals do not meet two criteria by the end of DY20.

1. Safety Net Hospital performance on delivery system at-risk Category 4A measures.

The set of at-risk measures in Category 4A of Attachment J implemented by hospitals will be assigned a direction for improving or worsening and will be calculated to reflect the performance of all of the safety net hospitals. This milestone will be considered passed in DY20 if more of the at-risk measures in Category 4A for DY19 (SFY 2016) and DY20 (SFY 2017) are improving for all safety net hospitals than are worsening (i.e. the performance level is the same or better, no error bar applied), as compared to initial hospital performance baseline year.

2. Demonstrating successful project implementation for all participating hospitals on Categories 1, 2, and 3 project metrics.

The number of metrics met by each safety net hospital during DYs 18 – 20 (SFYs 2015 – 2017) based on the Categories 1, 2, and 3 project measures specified in their approved DSTI project plan will be added together to determine the success of all DSTI projects. This milestone will be considered passed in DY20 if the number of metrics met by all safety net hospitals in the aggregate is greater than the number of metrics that were not met.

In DY20, in order to be eligible for the 12.5% at-risk payments associated with Category 4A and 2.5% associated with Category 4B, each hospital must demonstrate that it has fulfilled the requirements associated with the Community Based Care Delivery and Integration measures.

20. DSTI Funding Allocation Formula

The following chart depicts the percentage and dollar amount of total DSTI funds available per demonstration year for Categories 1- 4 and the at risk amounts for performance on the Outcome and Quality Indicators in each of the Categories 4A and 4B.

DSTI Funding Allocation

	DY 18/SFY 15		DY 19/SFY 16		DY 20/SFY 17	
Hospital Plans	25%	\$57,566,667	n/a	\$0	n/a	\$0
Categories 1-3	60%	\$138,160,000	80%	\$184,213,333	75%	\$172,700,000
Category 4A	7.5%	\$17,270,000	10%	\$23,026,667	12.5%	28,783,333
Category 4B	7.5%	\$17,270,000	10%	\$23,026,667	12.5%	28,783,333
Total	100%	\$230,266,667	100%	\$230,266,667	100%	\$230,266,666

- a) In DY18, each hospital will receive 25% of its annual proportional DSTI allotment based on CMS approval of its hospital-specific plan, pursuant to STC 50(d)(8) and Attachments E and I. The remaining 75% of the hospital DSTI allotment will be available as incentive payments to each hospital based on successfully achieving metrics associated with approved projects within DSTI Categories 1, 2, 3, and 4A and 4B as described in Sections X and XI (“Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1 – 3 Projects” and “Category 4B: Population-Focused Improvements”) and in approved hospital-specific plans.

b) Funding Allocation Formula for Categories 1-3

- 1) In DY18, after taking into account the payment referenced above in paragraph 20 (a) based on hospital-specific plan approval, 60% of the total remaining DSTI funds (\$138,160,000) are available as incentive payments for successful achievement of metrics for projects in Categories 1-3. In DY 19, 80% of the available DSTI allotment is associated with metrics for Categories 1-3, and in DY 20, the percentage is 75%.
- 3) Projects within Categories 1-3 have an annual base value that is uniform across all projects, except for Project 3.8: Participate in a Learning Collaborative, for which the base value will be one-quarter that of other projects. The annual project base value is calculated by dividing the annual total available amount of DSTI funds by a standard number of projects (6.25). The table below specifies the annual base values for projects in Categories 1-3
 - i. To adjust for the number of projects in the hospital’s final approved hospital plan provided that the number of projects falls between the minimum and maximum number of projects required by Section IV, paragraph 14, if this number varies

from the standard number of projects. This adjustment is calculated by multiplying the proportionally-adjusted annual project base value by the following project ratio: (6.25/# projects in approved hospital-specific plan).

Annual Project Base Values for Categories 1-3		
DY/SFY	Base Value for Projects 1.1 – 3.7, 3.9	Base Value for Project 3.8
DY18/SFY15	\$22,105,600	\$5,526,400
DY19/SFY16	\$29,474,133	\$7,368,533
DY20/SFY17	\$27,632,000	\$6,908,000

- 4) Metrics within Categories 1-3 will have an annual base value that is uniform across all metrics in Categories 1-3, except for metrics for Project 3.8: Participate in a Learning Collaborative, for which the annual metric base value is one-quarter that of metrics associated with other projects. The annual metric base value is calculated by dividing the annual project base value by a standard number of metrics (5). The table below specifies these annual base values for metrics in Categories 1-3.

Annual Metric Base Values for Categories 1-3		
DY/SFY	Base Value for Metrics in Projects 1.1 – 3.7, 3.9	Base Value for Metrics in Project 3.8
DY18/SFY15	\$4,421,120	\$1,105,280
DY19/SFY16	\$5,894,827	\$1,473,707
DY20/SFY17	\$5,526,400	\$1,381,600

- 4) On a hospital specific-basis, adjustments to the annual metric base value will be made:

- i. To reflect the hospital's proportional annual DSTI allotment pursuant to STC 50(d)(9) and Attachment I. Each hospital must multiply the metric base value by its hospital-specific proportional allotment factor:

Hospital-Specific Proportional Allotment Factor	
Eligible Safety Net Hospital	Proportional Allotment Factor
Cambridge Health Alliance	0.2143
Boston Medical Center	0.4947
Holyoke Medical Center	0.0389
Lawrence General Hospital	0.0689
Mercy Medical Center	0.0727

Signature Healthcare Brockton Hospital	0.0798
Steward Carney Hospital	0.0306

- ii. To adjust for the number of metrics for each project in the hospital’s final approved hospital plan, if this number varies from the standard number of metrics. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (5/# metrics for the project).
- iii. An optional factor at the specific hospital’s option to account for factors such as differences in quality infrastructure, differences in external supports for improvements, differences in patient populations, differential levels of metric goals, and differences between process metrics and improvement metrics, pursuant to STC 50(d)(9). In its individual DSTI Plan, if a hospital elects to utilize this adjustment factor, each hospital must provide a rationale for any adjustments made to metric base values. These additional adjustments must be budget neutral for the project, meaning that the total funding allotment for a project may not exceed the total funding allotment derived from the sum of annual metric base values adjusted for i and ii as described above. A metric adjustment (either up or down) may not exceed more than 20% of the metric base value.

b) Funding Allocation Formula for Categories 4A and 4B

- 1) In DY18, after taking into account the payment referenced above in paragraph 20 (a) based on hospital-specific plan approval, funding for Category 4A in DY 18 is 7.5% of the total remaining annual DSTI funding. In DY 19, funding for Category 4A is 10% of the total annual DSTI funding divided evenly across measures. In DY20, Category 4A is 12.5% of the total annual DSTI funding, of which 5% is tied to outcome measures and 7.5% is tied to improvement measures. Payment for Category 4A metrics will be based on hospitals’ performance, which will be demonstrated in each hospital’s approved individual DSTI plan.

Payment for performance on these outcome and improvement measures will be based on an objective demonstration of improvement over a baseline using a valid, standardized method. Category 4A measures have an annual base value that is uniform across all outcome and improvement indicators in DYs 18 and 19. The metric base value is calculated by dividing the total annual at risk amount by the total number of indicators for DYs 18 and 19. In DY 20, 12.5% of total hospital-specific funding will be at-risk based on the

achievement of Category 4A outcomes and improvement measures. Of this 12.5%, 5% is allocated to the Category 4A outcomes indicators and 7.5% is allocated to Category 4A improvement indicators. The tables below specify the annual base value for metrics in Category 4A based on the standard minimum number of measures per hospital in each demonstration year. Hospitals will report on a minimum of 6 Category 4A Outcome and Quality Improvement Indicators.

- i. In DYs 18 and 19, to adjust for the number of metrics in the hospital’s final approved hospital plan, if this number is greater than the minimum number of Category 4A metrics. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (6/ number of metrics for Category 4A).

Annual Metric Base Values for Category 4A Indicators (All) – DY18 and DY19	
DY18/SFY15	\$2,878,333
DY19/SFY16	\$3,837,778
DY20/SFY17	N/A

- ii. In DY 20, to adjust for the number of outcomes metrics in the hospital’s final approved hospital plan, if this number is greater than the minimum number of Category 4A metrics. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (2/ number outcome metrics for Category 4A).

Annual Metric Base Values for Category 4A Outcomes Indicators DY20 Only	
DY18/SFY15	N/A
DY19/SFY16	N/A
DY20/SFY17	\$5,756,667

- iii. In DY 20, to adjust for the number of improvement metrics in the hospital’s final approved hospital plan, if this number is greater than the minimum number of Category 4A metrics. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (4/# number improvement metrics for Category 4A).

Annual Metric Base Values for Category 4A Improvement Indicators DY20 Only	
DY18/SFY15	N/A
DY19/SFY16	N/A
DY20/SFY17	\$4,317,500

More information about Category 4A can be found in Section X (“Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1 – 3 Projects”).

In DY18, after taking into account the payment referenced above in paragraph 20 (a) based on hospital-specific plan approval, funding for Category 4A in DY 18 is 10% of the total remaining annual DSTI funding.

- 2) Funding for Category 4B in DYs 18 is 7.5% and 19 is 10% of the total annual DSTI funding. In DY 20, the 12.5% of total annual DSTI funding allocated to Category 4B, will be allocated with 5% related to pay-for-performance on readmission measure(s), 2.5% related to pay-for-performance on a specified number of metrics, and 5% related to pay-for-reporting, as described in Section XI (“Category 4B: Population-Focused Improvements”).

Category 4B metrics have an annual base value that is uniform across all Category 4B measures in DYs 18 and 19. For the Category 4B pay-for-reporting component, the metric base value is calculated by dividing the total annual available amount of DSTI funding in DYs 18 – 19 for Category 4B by the total number of common measures for Category 4B. In DY 18, all hospitals will report on a minimum of 8 Category 4B measures, with the exception for one measure (SUB-1: Alcohol Use Screening) that is only applicable to hospitals with inpatient psychiatric services. In DYs 19 – 20, all hospitals will report on a minimum of 9 Category 4B measures, with the exception for one measure (SUB-1: Alcohol Use Screening) that is only applicable to hospitals with inpatient psychiatric services. MassHealth will report the readmission measure(s) in DYs 19 – 20. In DY 20, 7.5% of the annual DSTI funding is allotted to Category 4B and is related to pay-for-performance, which is reflected in the corresponding table below. Of which, 5% of the annual DSTI funding is allotted to readmission measure(s) and 2.5% of the annual DSTI funding is allotted to a specified number of pay-for-performance improvement measures (individually payable based on the achievement of 5 measures for hospitals with inpatient psychiatric services and 4 measures for hospitals without inpatient psychiatric services. And 5% of the annual DSTI funding remains pay-for-reporting for the submission of all applicable Category 4B measures (9 for DSTI hospitals with inpatient psychiatric services and 8 for DSTI hospitals without inpatient psychiatric services). The table below specifies the annual base value for metrics in

Category 4B based on the standard minimum number of measures per hospital in each demonstration year.

- i. To adjust for the number of Category 4B pay-for-reporting metrics in the hospital’s final approved hospital plan, if this number varies from the standard number of Category 4B metrics in the instance that a hospital is not required to report measure (SUB-1: Alcohol Use Screening) that is only applicable to hospitals with inpatient psychiatric services. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (8/# metrics for Category 4B for DY18/SFY15; and 9/# metrics for Category 4B for DYs 19 and 20/SFYs 16 and 17).
- ii. In DY 20, to adjust for the number of Category 4B readmission pay-for performance metric(s) in the hospital’s final approved hospital plan, if this number varies from the standard number of Category 4B readmission metric(s). DSTI hospitals may elect to allocate the 5% of DY 20 at-risk funding to either the 30-day all cause readmission measure or split between the 30-day all cause readmission measure and a condition-specific readmission measure and will elect this option in the hospital’s respective January 2016 semi-annual report for payment. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (2/# metrics for Category 4B for DY 20/SFY17).
- iii. In DY 20, to adjust for the number of Category 4B pay-for-performance improvement metrics in the hospital’s final approved hospital plan, if this number varies from the standard number of Category 4B improvement metrics in the instance that a hospital is not required to report measure (SUB-1: Alcohol Use Screening) that is only applicable to hospitals with inpatient psychiatric services. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (5/# metrics for Category 4B for DY 20/SFY17).

Annual Metric Base Values for Category 4B – Pay for Performance on Readmissions Measure(s)	
DY18/SFY15	N/A
DY19/SFY16	N/A
DY20/SFY17	\$5,756,667

Annual Metric Base Values for Category 4B – Pay for Performance on Other Improvement Indicators	
DY18/SFY15	N/A
DY19/SFY16	N/A
DY20/SFY17	\$1,151,333

Annual Metric Base Values for Category 4B – Pay for Reporting	
DY18/SFY15	\$2,158,750
DY19/SFY16	\$2,558,519
DY20/SFY17	\$1,279,259

More information about Category 4B can be found in Section XI (“Category 4B: Population-Focused Improvements”).

- 3) On a hospital specific-basis, adjustments to the annual metric base value will be made:
 - i. To reflect the hospital's proportional annual DSTI allotment pursuant to STC 50(d)(9) and Attachment I. Each hospital must multiply the metric base value by its hospital-specific proportional allotment factor:

Hospital-Specific Proportional DSTI Allotment Factor	
Eligible Safety Net Hospital	Proportional Allotment Factor
Cambridge Health Alliance	0.2143
Boston Medical Center	0.4947
Holyoke Medical Center	0.0389
Lawrence General Hospital	0.0689
Mercy Medical Center	0.0727
Signature Healthcare Brockton Hospital	0.0798
Steward Carney Hospital	0.0306

c) Funding Reallocation Formula for Failing to Meet Accountability Targets

Pursuant to STC 50(d)(7), if the DSTI hospitals do not demonstrate the aggregate performance improvements as specified in the DSTI Master Plan in section VII(19)(e), five percent of the DY 20 DSTI funding will be withheld. This reduction, if applicable, will be taken at the end of the three-year period. The five percent reduction is an aggregate pool wide penalty based on three years of performance. It is not an additional penalty imposed on an individual provider for not meeting a specific metric. CMS will work with the

Commonwealth to assure that any reduction penalty is equitable. The amount of the potential reduction is set a follows:

Potential Reduction in DSTI Funds DY 20/SFY 17
\$11,513,000 (5 Percent)

VIII. PLAN MODIFICATION, GRACE PERIODS, AND CARRY-FORWARD & RECLAMATION

21. Plan Modification Process

- a) Pursuant to STC 52(a)(9) and consistent with the recognized need to provide the hospitals some flexibility to evolve their plans over time and take into account evidence and learning from their own experience and from the field, as well as for unforeseen circumstances or other good cause, a hospital may request modifications to its plan. A hospital must submit a request for modification to EOHHS. Requests for plan modification must be in writing and must describe the basis for the proposed modification. Updates to technical specifications of outcomes and improvement measures in Categories 4A and 4B must be submitted to EOHHS and CMS for review and approval, however shall not require a plan modification.
- b) Plan modifications include proposed changes to or replacement of selected milestones, metrics, and projects in Categories 1-3, as well as changes to or replacement of reporting measures in Categories 4A and 4B. Plan modifications may also address proposed changes in the timeframe for achieving metrics in Categories 1-3. Acceptable reasons to approve a plan modification request are:
 - i. Learning and knowledge acquired from project experience and/or external sources indicate that revising or reorienting project components or metrics would improve and/or enhance the project;
 - ii. Information that was believed to be available to achieve or report on a metric or measure is unavailable or unusable, necessitating a modification to the hospital plan to revise or replace the metric/measure;
 - iii. A hospital identifies superior information to demonstrate achievement of a metric and requests a modification to incorporate that data source;
 - iv. External issues occur outside of the hospital's control that require the hospital to modify or replace a metric, measure, or component of a project;
 - v. New federal or state policies are implemented, or changes in Massachusetts market dynamics occur, that impact a DSTI project and a hospital seeks to update the affected project to reflect the new environment;
 - vi. A hospital encounters an unforeseen operational or budgetary change in circumstances that impacts project components, metrics, and/or timelines;
 - vii. A grace period request that meets the requirements of paragraph 21 below; and
 - viii. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the DSTI program.

c) With the exception of grace period requests, hospitals may request plan modifications during DYs 18 – 20. Plan modification requests must be submitted to EOHHS a minimum of 75 days prior to the end of the demonstration year. EOHHS must take action on the plan modification request and submit recommended requests to CMS for approval within 15 days of receiving a modification request. CMS must take action on the plan modification request within 30 business days of receipt from EOHHS.

d) Plan modifications associated with grace period requests, including EOHHS and CMS review timeframes, are further addressed in paragraph 23 below.

22. Projects Primarily Focused on Infrastructure

Pursuant to STC 52(c)(4)(iii), projects that focus primarily on infrastructure will have further limited rollover ability as defined in the master DSTI plan. For the purposes of the plan modification, grace period, and carry-forward provisions outlined below, projects that focus primarily on infrastructure are defined as those projects where 75% or more of the project metrics over the 3-year period of the demonstration are related to:

- a) Building construction;
- b) Equipment purchases, including hardware and other physical equipment (excluding HIT system software);
- c) Environmental scans to identify frameworks and best practices to be utilized in the implementation of DSTI projects.

23. Grace Periods

a) Pursuant to STC 52(c)(4)(ii), a hospital that needs additional time to achieve a metric beyond the Demonstration year may be granted a grace period for up to 180 days from the end of the Demonstration year if it requests and receives approval for a plan modification as described in paragraph 19 above. However, no grace period is available for DY 20 beyond June 30, 2017. , with the exception of specified readmission outcomes measures where there is state and federal approval for a later reporting date in recognition that the data will not be available for reporting until after the July 31, 2017 report for payment. A hospital must have a valid reason, as determined by the Commonwealth and CMS, why it should be granted a grace period and demonstrate that the hospital is able to achieve the metric within the timeframe specified in the request. Acceptable reasons to approve a grace period request include:

- i. Additional time is needed to collect and prepare data necessary to report on a metric;
- ii. Unexpected delays by third parties outside of hospital's control (e.g., vendors) impact the timing of a metric achievement date;

- iii. A hospital can show that a metric is near completion (e.g., hospital has completed most of the steps building up to a metric achievement, and needs additional time to finalize the last steps);
- iv. An approved plan modification delays the timing for completing an approved metric; and
- v. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the DSTI program.

b) A hospital is required to submit a grace period request in writing to EOHHS accompanied by a proposed plan modification, pursuant to paragraph 21 above. The hospital must submit the request 75 days prior to the end of the demonstration year for which the grace period is being sought. EOHHS must determine its recommended action on a grace period request and plan modification and submit the request to CMS, with its recommendation, within 15 days. CMS must take action on the request within 30 business days of receipt from EOHHS. Pursuant to STC 52(c)(4)(ii), the grace period request and plan modification must be decided by the Commonwealth and CMS 30 business days prior to the end of the demonstration year.

c) A hospital that requests a grace period related to a metric is not precluded from alternatively claiming the incentive payment associated with the same metric under the carry-forward policy described in paragraph 22.

d) If after submitting the grace period request, a hospital achieves the metric before June 30, the hospital may withdraw the grace period request and claim the incentive payment associated with the metric under the regular DSTI reporting process described in Section VI (“Reporting and Payments in DY 18 – 20”).

e) Allowable Time Periods for Grace Period Requests

1) Projects Not Primarily Focused on Infrastructure in Categories 1-3

With respect to incentive payments associated with a project that is not primarily focused on infrastructure as defined in paragraph 21 above, the allowable time period for a grace period is 120 days from June 30 for DY 18 – 19. No grace period is available for DY 20 beyond June 30, 2017.

2) Projects Primarily Focused on Infrastructure in Categories 1-3

With respect to incentive payments associated with a project that is primarily focused on infrastructure as defined in paragraph 20 above, the allowable time period for a grace period is 60 days from the June 30 for DY 18 – 19. No grace period is available for DY 20 beyond June 30, 2017.

3) Category 4A

With respect to incentive payments associated with a measure in Category 4A, the allowable time period for a grace period is 60 days from June 30 for DY 18 – 19. No grace period is available for DY 20 beyond June 30, 2017.

4) Category 4B

With respect to incentive payments associated with a measure in Category 4B, the allowable time period for a grace period is 60 days from June 30 for DY 18 – 19. No grace period is available for DY 20 beyond June 30, 2017. except as expressly described in paragraph 23(a) above.

24. Carry Forward and Reclamation

Hospitals may carry forward unclaimed incentive payments in DY 18 – 19 for up to 12 months from the end of the demonstration year and be eligible to claim reimbursement for the incentive payment according to the rules below for Categories 1- 3 only. No carry-forward is available for DY 20.

a) Projects Not Primarily Focused on Infrastructure in Categories 1-3

With respect to incentive payments associated with projects in Categories 1-3 that are not primarily focused on infrastructure as defined in paragraph 22 above, if a hospital does not achieve a metric that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding associated with that metric for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed metric in addition to the corresponding metric associated with the year in which the payment is made, pursuant to STC 52(c)(4)(i). For purposes of carry-forward in this paragraph, a corresponding metric is a metric that is a continuation of a prior year metric and is readily quantifiable. Examples of corresponding metrics include:

- 1) A metric that shows a number or percentage increase in the same specific activity from the previous year;

If there is no corresponding metric associated with the year in which the payment is made, the hospital will be able to carry forward the available incentive funding associated with the missed metric for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed metric in addition to at least 25 percent of metrics associated with that project in the year in which the payment is made. If at the end of that subsequent demonstration year, an eligible safety net hospital has not fully achieved a metric, it will no longer be able to claim that funding related to its completion of that metric.

b) Projects Primarily Focused on Infrastructure in Categories 1-3

With respect to incentive payments associated with projects in Categories 1-3 that are primarily focused on infrastructure as defined in paragraph 20 above, if an eligible safety

net hospital does not achieve a metric that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding associated with that metric for up to 12 months and be available for full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed metric in addition to at least 50 percent of metrics associated with that project in the year in which the payment is made. If at the end of that additional demonstration year, an eligible safety net hospital has not fully achieved a metric, it will no longer be able to claim that funding related to its completion of that metric.

IX. MASTER DSTI PROJECTS AND METRICS

25. Projects in Categories 1-3

This section presents a menu of Categories 1, 2, and 3 projects from which an eligible safety net hospital may select when designing its individual hospital DSTI plan. Within each project, a hospital may select from an array of structural measures and process measures. In addition to the structure and process measures that are in categories 1-3, hospitals will include at least six associated outcome and improvement measures overall, as defined within Category 4A requirements, outlined in Section X (“Category 4A: At-Risk Outcomes and Improvement Measures Related to Category 1-3 Projects”), reported on over the demonstration period that support the goals of the project, and related metric(s). In general, the Category 4A measures are validated or otherwise supported by national or state entities with a subset of other customized measures reflecting transformation priority areas. Category 4A at-risk outcomes and improvement measures associated with Categories 1 – 3 hospital-specific projects are further described in Section X, paragraph 30. In addition, Category 4B population-focused improvement measures across all hospitals are further described in Section XI, paragraph 31.

During the renewal period, hospitals must report on lessons learned from participation in the mandatory Project 3.9, “Participate in a Learning Collaborate,” as they relate to the hospital’s delivery system transformation goals under DSTI. The report must describe how they have used that information to drive process and outcome improvements to advance the Triple Aim through their DSTI projects.

26. Explanation of Terms for Categories 1-3

- a) **Project Goal:** This component describes the purpose of the project and how it supports the goals of the Category.

- b) **Potential Project Elements:** This component lists example approaches/elements a hospital plan may adopt to implement the project goal. During the renewal period, hospitals may not continue to receive DSTI funding for project elements and metrics completed and/or met during DYs 15-17, nor may they receive funding for similar activities initiated under different project elements that achieve the same objective.

c) **Key Measures:** This component includes the measures from which the eligible safety net hospital may choose:

- 1) **Structural Measures:** These measures focus on delivery system infrastructure issues such as licensure, hiring staff, capital purchase or improvements, planning activities, or initial analysis activities. Progress on these measures will be assessed using a “pass/fail” funding accountability.2)
- 2) **Process Measures:** These measures focus on implemented activities that are intended to alter the process of delivering care such as workflow modifications, integrating patient care teams, establishing baseline and performance targets, and screening activities. Progress on these measures will be assessed using a “pass/fail” funding accountability.

For selected process metrics designated with the notation of an asterisk “ * ” following the selected Category 1 – 3 process metric in Section IX paragraphs 27, 28, and 29 related to the applicability of an incremental target to that metric, the individual DSTI Hospital shall include in their hospital-specific plan, subsequent to establishing a corresponding baseline as appropriate based on the hospital-specific plan, a hospital-specific target for the applicable metric for each applicable demonstration year that shows incremental progress for the process measure, which may be structured as a) a specified target toward which the hospital makes progress utilizing the gap-to-goal methodology or attainment at target; b) a specified percent or number increase over specified baseline; or c) a defined target for achievement. When an individual DSTI hospital utilizes the gap-to-goal methodology for a process measure within a hospital project, the hospital will specify the percentage (such as 10% or 5%) of the gap that will be closed between the performance level and the target. The data source for corresponding metrics will be internal hospital records/documentation.

- 3) **Outcome Measures:** These measures focus on assessing progress on health outcomes that result from represent the process results or other major milestones of the project’s structural and process modifications or improvements. Examples include impacts on morbidity, mortality, or readmissions, etc. Where possible, these measures should align with the approved metrics described in STC 50(d)(6).

Metric: For a measure selected, the hospital plan must incorporate a related metric which clearly states how the measure will be assessed and may be tailored to the hospital plan. For structural and process measures, this will be assessed using a pass/fail methodology. For improvement outcome measures, the methodology requirements for Category 4 measures are articulated in the next Section X

e) **Data Source:** The data source identifies appropriate sources of information that a hospital may use to support and verify the measure/metric. Data sources must align with the measure specifications.

27. Category 1: Development of a Fully Integrated Delivery System

This category includes investments in projects that are the foundation of delivery system change to encompass the concepts of the patient-centered medical home (PCMH) model to increase delivery system efficiency and capacity. Examples include:

- I. Investments in communication systems to improve data exchange with medical home sites;
- II. Integration of physical and behavioral health care;
- III. Development of integrated care networks across the continuum of care;
- IV. Investments in patient care redesign efforts, such as patient navigators, alternative delivery sites, alternative office hours, etc.

Introduction

The fragmentation of the nation's health care delivery system has long been cited as one of the primary obstacles to achieving improved health outcomes while maintaining health care affordability. A 2008 report by the Commonwealth Fund pointed to the "cottage industry" nature of the U.S. health care system—characterized by fragmentation at the national, state, community, and practice levels: “There is no single national entity or set of policies guiding the health care system; states divide their responsibilities among multiple agencies, while providers practicing in the same community and caring for the same patients often work independently from one another.”¹³ Fragmentation hinders providers' ability to deliver high-quality, efficient care, especially for patients obtaining care from multiple providers in a variety of settings. It also leads to waste and duplication. The report specifically observed the following about the nation's current health care system:

- Patients and families navigate unassisted across different providers and care settings, fostering frustrating and dangerous patient experiences;
- Poor communication and lack of clear accountability for a patient among multiple providers lead to medical errors, waste, and duplication;
- The absence of peer accountability, quality improvement infrastructure, and clinical information systems foster poor overall quality of care; and,
- High-cost, intensive medical intervention is rewarded over higher-value primary care, including preventive medicine and the management of chronic illness.

The report recommended policies to promote greater organization of the delivery system to achieve gains in the quality and value of care, including payment reform, investments in health information technology, and government support to facilitate or establish the infrastructure for organized delivery systems, for example through assistance in establishing care coordination networks, care management services, after-hours coverage, health information technology, and performance improvement activities.

¹³Shih A, Davis K, et al. “Organizing the U.S. Health Care Delivery System for High Performance.” *The Commonwealth Fund*. Aug. 2008.

Similarly, the Massachusetts Special Commission on the Health Care Payment System issued a set of payment reform recommendations in 2009 to promote a health care delivery system with features such as:

- Patient-centered care with a strong focus on primary care;
- An emphasis on clinical integration and attention to quality;
- Patient-centered medical home capacity; and,
- Hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need.¹⁴

Additionally, the U.S. Department of Health and Human Services adopted the goal of promoting integrated delivery systems under the “Triple Aim” framework, first articulated by Don Berwick in 2008:

- **Better Care:** improve the overall quality of the US health system by making health care more patient-centered, reliable, accessible, and safe.
- **Better Health:** improve the health of the U.S. population by supporting proven interventions to address behavioral and social determinants of health, and enhancing the quality of care delivered.
- **Lower Costs:** reduce the cost of the improved care delivery for individuals, families, employers, and the government.

A growing body of evidence shows strong support for the kinds of integrated care models being proposed by state and federal policymakers. Research comparing nations, states and regions within the U.S., and specific systems of care has shown that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care.¹⁵ According to a 2006 study by the Commonwealth Fund, when adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The study also found that when primary care physicians effectively manage care in the office setting, patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications, leading to fewer avoidable hospitalizations.¹⁶

Other evidence suggests that integrating mental health care with primary medical care and other services can enhance patients' access to services, improve the quality and effectiveness of their care, and lower overall health care costs.¹⁷ Research studies have increasingly evaluated the interface between physical and mental health, as well as integrated approaches to mental and physical health care that have implications for the future of psychological practice.

¹⁴ “Recommendations of the Massachusetts Special Commission on the Health Care Payment System.” *Massachusetts Special Commission on the Health Care Payment System*. July 16, 2009.

¹⁵Beal AC, Doty MM, et al. “Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey.” *The Commonwealth Fund*. June 2007.

¹⁶ Ibid.

¹⁷ APA Practice Organization. “Research roundup: Integrating physical and behavioral health interventions into psychological service delivery.” *Practice Update*. Apr. 2011.

In recognition of the importance of addressing the problems associated with the fragmented health care delivery system, Category 1 projects encourage greater organization and development of fully integrated delivery systems as a foundational aspect to health care delivery system transformation. It is a critical factor for the eligible safety net hospitals to advance their safety net systems for future success under payment reform. The array of projects within this category reflects differences in local health care environments and varied starting places among the safety net hospitals. Some of the Massachusetts safety net hospitals have more traditional inpatient hospital configurations with affiliated or independent provision of ambulatory care and physician services, while others have the full spectrum of primary care, ambulatory care, and physician services as part of the safety net hospital system's existing structure. As a result, the projects in Category 1 advance integration as appropriate for each individual provider. For example, some hospitals require foundational elements to address current gaps or systems needs to develop an integrated delivery system, while others are focused on expansion of PCMH models within their primary care practices. In addition to PCMH development, Category 1 projects embody other innovations in delivery system integration, such as integration of behavioral and physical health services in primary care practices or emergency departments, the use of culturally competent patient navigators to connect patients with the right care, and the creation of a practice support center to streamline administrative functions and increase access to care for patients. While the eligible safety net hospitals will begin implementing their Category 1 projects from different foundational capacities, they share a vision and commitment toward delivery system integration as a foundation toward transformation and improved health outcomes for safety net populations.

The eligible safety net systems may select from among the projects described below, as specified, for inclusion in their Category 1 DSTI plans.

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Project 1.1: Patient Centered Medical Home

Project Goal

The goal of projects under this heading is to expand or enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a primary care health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care. Federal, state, and DSTI hospitals share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. "PCMHs can be seen as the hub of the integrated care system"¹⁸, and "the medical home model supports fundamental changes in primary care service delivery and payment reforms, with the goal of improving health care quality."¹⁹

PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness.^{20 21} By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly emergency department visits, incur fewer avoidable hospital stays, and report greater patient satisfaction.

These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers. Safety net hospitals' approaches may vary based on the composition of and relationships between providers in the health care delivery system, or they may be tailored to specific patient populations such as those with chronic diseases. Hospitals may pursue a continuum of project elements including PCMH readiness preparations, the establishment or expansion of medical homes which may include gap analyses and eventual application for and/or achievement of PCMH recognition by a nationally or state recognized organization such as NCQA, as well as educating various constituent groups within hospitals and primary care practices about the essential elements of the NCQA medical home standards and facilitating required clinical practice transformation. The development of primary care readiness for implementing patient-centered medical home delivery models may happen within a safety net hospital, or with a hospital in collaboration with affiliated or non-affiliated primary care physician practices.

Areas of focuses may include implementing care plans for a growing number of patients with poorly controlled chronic disease and patient engagement in their health.

¹⁸ "Stage Demonstration to Integrate Care for Dual Eligible Individuals." *Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. Proposal to the Center for Medicare and Medicaid Innovation.* (Dec. 2011) page 7.

¹⁹ "Overview of PCMH." *Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. Massachusetts Patient Centered Medical Home Initiative.* 2012. Available at

<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/>

²⁰ Cosway R et al., "Analysis of Community Care of North Carolina Cost Savings." *Milliman, Inc.* 2011.

²¹ Grumbach K and Grundy P.. "Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States." *Patient-Centered Primary Care Collaborative* Nov. 2010.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements.</i>	Structural	Process
A. Utilize a gap analysis to assess and/or measure PCPs' and primary care practice PCMH transformation readiness according to nationally or state recognized organization such as NCQA.	X	
B. Develop and implement action plans to eliminate gaps identified in medical home readiness assessment.		X
C. Apply for Patient-Centered Medical Home recognition by a nationally recognized organization such as NCQA (or other state or national accrediting body).		X
D. Receive Patient-Centered Medical Home recognition by a nationally recognized organization such as NCQA (or other state or national accrediting body).		X
E. Conduct educational sessions for primary care physician practice offices, medical staff and/or senior leadership on the elements of PCMH and required clinical practice transformation, its rationale and vision.		X
F. Empanel patients who would most benefit from medical homes (as specified in hospital-specific plans) and increase the panel care for in primary care medical homes.		X
G. Improve coordination of care by creating care plans for patients with poorly controlled chronic disease, such as adult diabetes, or other chronic conditions.		X
H. Report on coordination of care improvements for patients with poorly controlled chronic disease, such as adult diabetes, or other chronic conditions.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Conduct a gap analysis against PCMH criteria from a nationally recognized accrediting body (e.g., NCQA or other state or national accrediting body).	1.A. Documentation of a completed, gap analysis required.	<ul style="list-style-type: none"> Internal hospital records/documentation

Key Process Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Sources
1. Implement findings of gap analysis and components of action plan.	1.A. Documentation that identified gap(s) have been closed.	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Apply or reapply for	2.A. Apply or reapply for	<ul style="list-style-type: none"> Documentation of

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Sources
PCMH recognition for selected number of primary care sites (e.g., NCQA or other state or national accrediting body).	medical home recognition from NCQA or other nationally-recognized entity for X number of primary care sites	application to NCQA or other state or nationally-recognized entity
3. Achieve medical home recognition for selected number of primary care sites from a nationally-recognized entity (e.g., NCQA or other state or nationally accrediting body).	3.A. Achieve medical home recognition for X number of primary care sites from NCQA or other state or nationally accrediting body.	<ul style="list-style-type: none"> Documentation of medical home recognition by NCQA or other state or nationally-recognized accrediting body
4. Educate stakeholders including patients, hospital and affiliated practices' leadership, primary care offices, and/or staff members on the elements of PCMH, required clinical practice transformation, rationale and vision.	4.A. Attendance at education program on the elements PCMH, required clinical practice transformation, rationale and vision. Copies of education materials developed and distributed.	<ul style="list-style-type: none"> Internal hospital records/documentation of attendance at educational program(s) and educational materials
5. Report progress on patients empanelled to medical home care teams.	5.A. Report progress on the proportion of primary care patients empanelled to medical home care teams based on team panel size report as of a date certain during the fiscal year. 5. B. Increase the proportion of primary care panel patients empanelled to medical home care teams based on team panel size report (PCMHI 0035).*	<ul style="list-style-type: none"> Internal hospital records/documentation
6. Develop and implement workflows and tools to support patient-centered care planning and documentation for identified high-risk chronic conditions such as diabetes, depression, or pediatric persistent asthma.	6.A. Implement workflows and tools to support patient centered care planning and documentation for primary care patients with identified high-risk chronic conditions.	<ul style="list-style-type: none"> Documentation of EMR tools developed and educational materials provided to care teams regarding workflows and tools to support patient centered care planning

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Sources
7. Report on progress on the percentage of primary care patients 18-75 years of age with diabetes with poorly controlled Hemoglobin HbA1C with a care plan.	7.A. Submission of baseline report on percentage of primary care patients 18-75 years of age with diabetes with poorly controlled Hemoglobin HbA1C who have a care plan. 7.B. Increase percentage of primary care patients 18-75 years of age with diabetes with poorly controlled Hemoglobin HbA1C who have a care plan.*	<ul style="list-style-type: none">• Internal hospital records/documentation

Project 1.2: Integrate Physical Health and Behavioral Health

Project Goal

The goal of projects under this heading is to integrate care delivery models for physical health and behavioral health (BH). In doing so, the goal is to achieve early identification of mental health conditions and unhealthy substance use in primary care; to provide patients with timely access to on site screening for psychological and substance abuse issues and provide brief intervention and referral to treatment that is coordinated with their primary care; and to help patients with mental health conditions to reduce symptoms through evidence-based approaches to diagnosis, tracking and management. This is an especially crucial effort for Medicaid and other populations that have co-occurring chronic health and mental health conditions. Treatments for patients that present with mental health and/or substance abuse concerns are integrated with physical health by focusing on patient-centeredness, and implementing process improvements to further align organizational resources to provide appropriate treatment in the appropriate setting at the appropriate time. This project contemplates that hospitals can design behavioral health-physical health innovations in the acute hospital (emergency and inpatient setting) or in the primary care setting.

According to a recent study released by the Robert Wood Johnson Foundation, only 33% of patients with BH conditions (24% of the adult population) receive adequate treatment.²² Patients with BH issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. These patients often have complex medical and social issues such as multiple chronic health conditions, low income, housing insecurity, social isolation, and social dis-coordination that severely impact their health and social functioning. It is difficult for these patients to receive coordinated care, when behavioral health care is delivered in a separate system and/or location. For example, patients need separate appointments in a new setting, increasing the likelihood of missed appointments, and the lack of coordination with primary care detracts from the quality of care.

This subpopulation typically utilizes a disproportionate share of health care resources, usually without receiving a corresponding benefit in overall health status. Persons with mental illnesses and chronic physical conditions like diabetes, asthma, and hypertension rarely receive care that truly integrated, in a single location. Instead, these patients are forced, by default, to navigate a fragmented healthcare system, often with impaired levels of cognitive functions and/or emotional regulation.

Patients with mental health issues generally experience a higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. These patients often have complex medical and social issues that can severely impact their health status. Caring for this population requires a comprehensive, whole person approach, within an integrated framework, to factor in the physical, behavioral, and social conditions. A target population that is in need of integrated care is identified in Maurer's Quadrant 4.²³ Devising team-based treatment goals for patients with serious mental health illnesses and co-occurring serious physical health illnesses helps patients benefit from truly integrated care delivered in a familiar and welcoming

²² Druss BG, Reisinger Walker E., "Mental Disorders and Medical Co-Morbidity." *Robert Wood Johnson Foundation, The Synthesis Project: Issue 21* (2011).

²³ Maurer, B. (2006). Behavioral health/primary care integration: The four quadrant model and evidence-based practices. *The National Council for Community Behavioral Health*.

Project Goal

place.

Another project focus will develop an evidenced-based, framework for integrating physical and behavioral health care for persons with serious mental illnesses. The framework will be utilized by Providence's leadership and clinical teams to cite evidence-based findings from interpersonal neurobiology, mindfulness practices, biofeedback, nutrition and epigenetics that could provide health benefits for persons struggling with depression, anxiety, addiction and other conditions.^{24 25 26 27 28} The framework will guide the formulation of treatment goals to make use of the latest findings about the myriad and complex interactions of the mind, body and brain. For example, mindfulness interventions have been utilized in clinical settings for decades and meditation has been shown to be effective to reduce several conditions, including stress, anxiety, depression, chronic pain and eating disorders.²⁹

Caring for this population requires a comprehensive, whole person approach within an integrated system prepared to care for the medical, BH, and social conditions faced by safety net patient populations. Milestones include utilizing evidence-based practices to inform the development of guidelines to manage patients with mental health and substance abuse concerns.³⁰ One effective evidence-based strategy that has been shown to improve Triple Aim outcomes in patients with depression, the most prevalent BH disorder, is the DIAMOND/IMPACT model of care, which may serve as a reference for hospitals in developing their physical health and behavioral health integrated, collaborative care models. Among the key elements of these care models: screening for high prevalence mental health conditions, co-location of BH clinicians into primary care settings, collaborative meetings held by primary care and BH team members to discuss cases, training of primary care and BH staff on effective screening and collaborative care, development of standard diagnosis and management workflows, the presence of tracking systems and registries to support effective monitoring of patients, the "Stepped Care" approach for appropriate level of treatment, care

²⁴ Kessler, R., Soukup, J., Davis, R., Foster, D., Wilkey, S., Van Rompay, M., & Eisenberg, D. (2001). The use of complementary and alternative therapies to treat anxiety and depression in the United States. *American Journal of Psychiatry*, 158(20), 289-294.

²⁵ Kabat-Zinn, J., et al. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, 149, 936-943.

²⁶ Siegal, D. (2012-Second Edition). *The developing mind: how relationships and the brain interact to shape who we are*. New York: Guilford Publications, Inc.

²⁷ Siwek, M., et al. (2009). Zinc supplementation augments efficacy of imipramine in treatment resistant patients: a double blind, placebo-controlled study. *Journal of Affective Disorders*, 118(1-3), 187-95. Retrieved March 12, 2014 from <http://www.ncbi.nlm.nih.gov/pubmed/19278731/>

²⁸ McCraty, R., et al. (2001). Analysis of twenty-four hour heart rate variability on patients with panic disorders. *Biological Psychology*, 56 (2), 131-150. Retrieved March 1, 2014 from <http://www.heartmath.org/research/research-library/research-library.html#clinical-research>

²⁹ Hofmann, S., Sawyer, A., Witt, A, Oh, D. (2010). [The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review](#)

³⁰ Knesper, D.J., "Continuity of care for suicide prevention and research: suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatric inpatient unit." *American Association of Suicidology and Suicide Prevention Resource Center*. 2010.

"Emergency Severity Index, Version IX: Implementation Handbook." *Agency for Health Care Research and Quality*. 2012, Available at <https://www.ahrq.gov>.

"Medical evaluation of psychiatric patients," *Emergency Nurses Association*. 2010. Available at <https://www.ena.org>.

"Substance abuse (alcohol and drug) in the emergency care setting," *Emergency Nurses Association*. 2010. Available at <https://www.ena.org>.

Project Goal
management for the highest risk patients with mental health and substance abuse disorders, and relapse prevention, among others. ³¹ Additionally, improvement requires timely access to on-site behavioral health services and, where possible, creating a “warm hand-off” between providers. Over time, projects have the potential to yield improvements in the level of care integration and coordination for patients with co-occurring medical and mental health conditions and ultimately better health and better patient experience of care. Integrating behavioral health care into primary care improves access and coordination, and has been associated with improved outcomes such as reduced depression and anxiety; improved chronic disease outcomes; and reduced health care costs.

Potential Project Elements	Structural	Process
<i>DSTI hospitals undertaking this project may select from among the following project elements:</i>		
A. Better identify patients needing behavioral health care.	X	
B. Conduct an analysis of the system’s behavioral health population.	X	
C. Improve coordination and referral patterns between primary care and behavioral health.		X
D. Train primary care providers in behavioral health care.		X
E. Develop job responsibilities for integrated behavioral health team members and train staff and providers.	X	
F. Develop and implement an integrated, collaborative care model to integrate primary care and behavioral health at primary care sites with co-located behavioral health services.		X
G. Develop and implement plans to integrate physical and behavioral health care for patients with behavioral health and substance abuse issues in the Emergency Department (ED).		X
H. Implement physical-behavioral health integration pilots.		X
I. Implement integrated care models and assess outcomes of the model.		X
J. Link patients with serious mental illnesses to a medical home or another care management program.		X
K. Measure and improve the number of patients engaged in depression care management.		X
L. Improve patient access by measuring the patients who are referred to a licensed integrated behavioral health provider and receive a timely appointment.		X
M. Establish a physical medicine clinic at behavioral health setting.	X	
N. Develop a coordinated plan, with stakeholders, to divert from ED to behavioral health hospital for those patients meeting the criteria for inpatient behavioral health care.	X	
O. Develop integrated physical and behavioral health care partnerships with regional providers.	X	

³¹ Katon W., MD. “The Diamond Model.” (based on Katon’s Collaborative Care Model for depression) and Unutzer J., MD. “IMPACT Study.” (as well as numerous other controlled trials). *Institute for Clinical Systems Improvement and Minnesota Family Health Services*. Presentation to the Institute for HealthCare Improvement Annual Forum, Dec. 2010.

P. Institute home-based, nursing visits for adults discharged from inpatient psychiatric care.		X
Q. Analyze the regional capacities and barriers for providing patients fully integrated care and develop a plan to address gaps.	X	

Key Structural Measures
DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Source(s)</u>
1. Conduct an analysis of the behavioral health population at the hospital.	1.A. Baseline analysis of behavioral health patient population, which may include patient demographics, utilization of emergency room and inpatient services, most common sites of mental health care, most prevalent diagnoses, co-morbidities	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Develop plan and identify care site(s) for integrated physical and behavioral health model of care, including (if necessary) submission to appropriate regulatory bodies.	2.A. Document describing the integrated care model 2.B. Integration plan 2.C. Schedule of operations, policies and procedures 2.D. Signed agreement(s) with primary care site for integrated care 2.E. Copies of regulatory submissions 2.F. Scheduling documentation demonstrating co-location of behavioral health specialist	<ul style="list-style-type: none"> Internal hospital records/documentation
3. Develop recommendations, based on recognized clinical standards, for measures to be used across hospital's primary care sites toward behavioral health integration in primary care, such as screening for high prevalence conditions such as depression or substance abuse disorder.	3.A. Submission of recommended measures to track behavioral health integration in primary care. 3.B. Submission of recommended procedures and screening measures to identify patients with BH concerns.	<ul style="list-style-type: none"> Internal hospital records/documentation, such as minutes for ambulatory department or mental health department
4. Develop a plan to deploy a "psychiatric provider of the day" to the hospital ED	4.A. Plan completed	<ul style="list-style-type: none"> Documentation of plan

<p>5. Determine necessary staffing for integrated behavioral health team members and hire, assign, and/or plan to deploy employees.</p>	<p>5.A. Documentation of job descriptions. 5.B.Documentation of hiring 5.C.Documentation of plan to deploy behavioral health team members. 5.D.Documented outline and detailed structure for integrated care model targeted at behavioral health patients within primary care sites with co-located behavioral health services</p>	<ul style="list-style-type: none"> Internal hospital records/documentation
<p>6. Provide education and training to behavioral health team members on BH integration models, workflows, and interventions. Trainings may be held in subsequent years for additional team members</p>	<p>6.A.Documentation of training tools. 6.B.Documentation of training. 6.C.Documentation of individuals trained.</p>	<ul style="list-style-type: none"> Internal hospital records.
<p>7. Perform gap analysis on existing organizational capacities and gaps for providing high-risk patients’ enhanced access to primary care medicine on site and/or the community for chronic illness care and present report to senior leaders and clinical staff to elicit their feedback and support for an integrated approach.</p>	<p>7.A.Gap Analysis Report 7.B.Gap Analysis Presentation</p>	<ul style="list-style-type: none"> Hospital documentation
<p>8. Assess community resources and/or create community-wide partnership for the advancement of integrated, chronic care for persons with serious mental illness/substance abuse and chronic physical conditions. Perform gap analysis and create plan, with</p>	<p>8.A.Meeting Minutes and Revised Draft of Partnership Purposes and Goals 8.B.Gap Analysis Report 8.C.Plan for Integrated Care for Persons with Serious Mental Illness and/or Substance Abuse and Chronic Physical Health Conditions 8.D. Assessment of community behavioral health resources</p>	<ul style="list-style-type: none"> Hospital documentation Community Partnership Report Behavioral health resource assessment document

<p>participation from the Community Partnership, of region-wide capacities and barriers to provide patients who have serious mental illness/substance abuse and chronic physical conditions with access to primary care medicine, community mental health, disease management, evidence-based complimentary health care and wellness programs.</p>	<p>with regards to access, skill set, geography, and patient payer.</p>	
<p>9. Develop plan to deliver evidence-based, mind/body complementary therapies to psychiatric and substance abuse inpatients.</p>	<p>9.A.Plan for the Delivery of Evidence-Based, Mind/Body Complementary Therapies</p>	<ul style="list-style-type: none"> • Hospital documentation
<p>10. Develop an internal dashboard to identify ED wait times and occupancy for behavioral health</p>	<p>10.A.Complete internal dashboard to identify ED wait times and occupancy for behavioral health</p>	<ul style="list-style-type: none"> • Internal records
<p>11. Identify high-risk behavioral health patients.</p>	<p>11.A.Identification of high-risk patients in specific fiscal year and baseline hemoglobin A1c levels (high risk patients defined as diabetic patients with an hemoglobin A1c greater than 9 that screen positive for depression and are not currently receiving behavioral health treatment)</p>	<ul style="list-style-type: none"> • Internal records
<p>12. Develop patient registry for high-risk patients.</p>	<p>12.A.Documentation of high-risk patient registry</p>	<ul style="list-style-type: none"> • Hospital documentation
<p>13. Develop plan to provide post-discharge home-based nursing visits.</p>	<p>13.A.Post-Discharge Nursing Plan for high-risk patients</p>	<ul style="list-style-type: none"> • Hospital documentation
<p>14. Advance the effectiveness of communication of behavioral health status, assessment and treatment plan</p>	<p>14.A. Develop standardized template for behavioral health providers to communicate to referring provider/ primary care physician</p>	<ul style="list-style-type: none"> • Copy of standardized tool

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Sources
<p>1. Operationalize collaborative, integrated care model with co-located behavioral health services. Hospital may implement integrated model or specific interventions/elements at increasing number of sites, or with increasing number of teams, over the demonstration period.</p>	<p>1.A. Submission of meeting dates documenting collaborative meetings to review patient cases between primary care and mental health staff at the primary care site(s)</p> <p>1.B. Scheduling documentation demonstrating co-location of behavioral health staff at primary care site(s)</p> <p>1.C. Documentation of integrated behavioral health team members.</p> <p>1.D. Documentation of standard diagnosis & management workflows for specific clinical conditions.</p> <p>1.E. Documentation of the number of consultations or visits for BH conditions completed at primary care site by co-located behavioral health clinicians</p> <p>1.F. Documentation of implemented interventions.</p> <p>1.G. Documentation of collaborative care model elements implemented.</p>	<ul style="list-style-type: none"> • Internal hospital records/documentation
<p>2. Assign a “psychiatric provider of the day” to be deployed at the hospital ED</p>	<p>2.A. Provider work schedule</p>	<ul style="list-style-type: none"> • Documentation of provider work schedule
<p>3. Identify and pilot an additional behavioral health intervention</p>	<p>3.A. Documentation of selected intervention and implementation of</p>	<ul style="list-style-type: none"> • Internal records

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Sources
	evidence-based metrics appropriate for selected intervention to assess pilot effectiveness	
4. Measure the number of integrated behavioral health visits that occurred in primary care settings.	4.A. Documentation of the percentage of integrated behavioral health visits. 4.B. Documentation of the number of newly referred patients who had contact with integrated licensed Behavioral Health provider.	<ul style="list-style-type: none"> Internal hospital records/documentation
5. Improve behavioral health screening by implementing standardized approach and/or targeting key chronic conditions.	5.A. Documentation of the percentage of patients screened for depression and substance abuse using specified tool.* 5.B. Report on patients with an active chronic condition screened. 5.C. Documentation of number of patients who screened positive and received referral to appropriate BH follow-up.* 5.D. Perform annual competency to assess staff knowledge in properly applying the PHQ-9 screening tool for X percentage of clinical staff.* 5.E. Report on patients that screen positive that receive brief intervention.*	<ul style="list-style-type: none"> Internal hospital records/documentation.
6. Develop and communicate care plans between mental health and primary care	6.A. Sample documentation of behavioral health care plans	<ul style="list-style-type: none"> Internal hospital records/documentation.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Sources
providers for patients screening positive for depression on PHQ-9.	6.B. Documentation that behavioral health care plan was communicated to primary care provider	
7. Implement plan to deliver evidence-based, mind/body complementary therapies to psychiatric and substance abuse inpatients.	7.A. Schedule of Offerings for Evidence-Based, Mind/Body Complementary Therapies 7.B. Report on Mind/Body Complementary Therapies*	<ul style="list-style-type: none"> Internal hospital records/documentation.
8. Implement plan to provide post-discharge home-based nursing visits.	8.A. Post-Discharge Nursing Visit Documentation for High-Risk Patient*	<ul style="list-style-type: none"> Hospital documentation
9. Implement psychopharmacological consultation service to medical providers at primary care sites providing services.	9.A. Continue to track the number and type of psychopharmacological consultations provided to the primary care providers and provide educational sessions to primary care providers based on needs identified during consultations, as appropriate.	<ul style="list-style-type: none"> Internal hospital records/documentation
10. Assess key performance indicators of physical and behavioral health by addressing concomitant disease and barriers to patient self-management.	10.A. Report on patients with an active current diagnosis of diabetes, CAD, COPD or CHF who had a PHQ-9 score greater than 9 in the first six months of the measurement period, who achieved progress toward depression remission within six months 10.B. Determine baseline	<ul style="list-style-type: none"> Internal documentation and reporting based on EMR

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Sources
	for hemoglobin a1c (Hba1c) control in patients with current active diagnoses of depression and diabetes	
11. Achieve behavioral health occupancy.	11.A. Achieve at least X% behavioral health occupancy for SFY*	<ul style="list-style-type: none"> • Internal records
12. Assess key clinical indicators for depression remission in patients with key chronic conditions	<p>12.A. Develop capacity to report on patients with an active current diagnosis of diabetes, coronary artery disease, chronic obstructive pulmonary disease, and congestive heart failure, using a patient registry to identify patients on a daily basis with a pending appointment</p> <p>12.B. Report progress on patients with an active current diagnosis of diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF), using a patient registry to identify patients on a daily basis with a pending appointment*</p> <p>12.C. Report progress on hemoglobin a1c (Hba1c) control in patients with current active diagnoses of depression and diabetes*</p>	<ul style="list-style-type: none"> • Hospital documentation • Internal documentation and reporting based on EMR •

Project 1.3 Establish Health Data Exchange Capability to Facilitate Integrated Patient Care

Project Goal

The goal of these projects is to establish health data exchange capabilities – including systems, processes, and linkages – to exchange patient health data across providers and to facilitate integrated care across multiple providers. The objective is to expand and exceed meaningful use requirements for the exchange of data by aggregating clinical and/or financial data from the hospital and physician offices, allowing participating physicians to access a longitudinal record through a web-based portal or to directly integrate with the physician practice's Electronic Medical Record (EMR). The tool may utilize the Nationwide Health Information Network (NHIN) along with State, Regional and local HIE network set of standards, services, and policies as a benchmark to address the disparity of information systems across care locations today, while ensuring interoperability and security as the landscape evolves over time. The standards-based solutions will enable patient-centric access to medical records and patient data among multiple health care providers and locations utilizing the Integrating the Healthcare Enterprise (IHE) frameworks among other approaches. The HIE will authenticate and authorize users, verify and validate the identity of patients for whom data is being exchanged, and log all transactions.

Health data exchange capabilities require that the DSTI safety net hospital system establish appropriate systems, processes, and linkages to create and maintain a longitudinal record, repository, and data warehouse of patient health information to more effectively improve data exchange and facilitate integrated patient care across multiple providers, which may include primary care sites, inpatient settings, outpatient and emergency departments, or other care settings. The tool(s) will support proactive care management addressing one or more preventive, primary, routine and chronic care needs. Depending on the design elements of the specific hospital projects, the tools may also be accessible to providers in multiple locations and provide for bi-directional health information data exchange.

Creating dynamic and expansive Health Data Exchange capabilities across communities and affiliated providers will support the achievement of the healthcare Triple Aim of improving the patient experience, reducing costs, and monitoring population health. A robust information systems platform to support HIE is a foundational element in providing the necessary infrastructure to support fluid exchange of pertinent health information across care settings. Information systems help make sure that efforts to deliver health care that is person-centered, effective and focused on improving outcomes, are transparent, accountable and engage all appropriate partners and providers. HIE platforms enhances the electronic, timely notification of primary care providers and other clinicians in the community when one of their patients has visited the Emergency Department (ED) and can go a long way to ensure that there is continuity in the care that is provided to the patient immediately after they leave the ED. Exchanging clinical results, such as lab and radiology, facilitates clinical decision making, appropriate utilization, and appropriate care delivery across settings. Accurate and timely information on outcomes and programs is critical in the journey to a healthy population and a health information technology-driven infrastructure.

Aggregating and warehousing this data is critical as a foundation for an integrated delivery system along with providing the foundational elements of population health and analytics data strategies. Projects under this heading will help address several key healthcare issues such as limited access to clinical patient information, a contributing factor to health care costs and inefficiencies, as well as challenges to improving quality of patient care and the patient care experience.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Establish a sustainable multi-year HIE strategy to integrate the community.	X	
B. Develop provider emergency department notification capabilities.		X
C. Expand lab and radiology results sharing with key provider organizations.		X
D. Develop an integrated clinical data analytics strategy.	X	
E. Explore feasibility of HIE-HIE connectivity with other providers and pilot work.	X	X

Key Structure Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Engage consulting services to perform HIE vendor analysis and work plan development	1.A. Write an RFP to assess and engage consulting services to be hired in 2016 to perform a HIE vendor assessment with work plan and strategy recommendations 1.B. Review proposals and select consulting services for an HIE vendor assessment and recommendations	<ul style="list-style-type: none"> HIE vendor assessment RFP Proposal evaluation summary
2. Engage with consulting services to complete an HIE vendor analysis and develop HIE infrastructure and strategy work plan	2.A. Engage with consulting services selected in Year 1 to complete an HIE vendor assessment 2.B. Reconcile recommendations from consulting services engagement with the current state of HIE industry landscape to create a work plan and timeframes	<ul style="list-style-type: none"> Vendor assessment report HIE Work plan

Key Structure Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
3. Select a consultant to perform analytics vendor analysis and work plan development	3.A. Write an RFP to assess and engage consulting services to be hired in 2017 to perform a clinical analytics vendor assessment with recommendations 3.B. Review proposals and select consulting services for clinical analytics vendor assessment	<ul style="list-style-type: none"> • Clinical analytics vendor assessment RFP • Proposal evaluation summary
4. Initiate implementation of systems and infrastructure to facilitate exchange of health information and explore HIE-to-HIE connectivity	4.A. Implement HIE work plan 4. B. Write an RFP to engage a consultant to perform feasibility study of connecting LGH HIE to a selected HIE 4.C. Review proposals and select consulting services for feasibility study and work plan 4.D. Engagement with the selected consultant to perform an HIE-to-HIE integration feasibility study and work plan	<ul style="list-style-type: none"> • HIE work plan progress report • HIE-to-HIE feasibility RFP • Proposal evaluation • Feasibility report

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Develop provider notification capabilities while ensuring accurate sharing of lab and radiology results with key provider organizations	1.A. Expand clinical lab and radiology results sharing as initiated in prior DSTI period to at least X additional Electronic Health Record (EHR) system(s) 1.B. Develop outbound Emergency Department (ED) Notification capabilities 1.C. Pilot ED Notification sharing with at least X practice(s)	<ul style="list-style-type: none"> • Data sharing interface document • Report of ED notification capability • ED notification pilot report

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
2. Expand results delivery into the community, and expand ED notification	2.A.Continue expansion of lab and radiology results delivery to X additional EHR systems 2.B.Expand ED Notification to X additional practices	<ul style="list-style-type: none">• Data sharing interface document• ED notification report
3. Develop draft plan to connect disparate HIEs and complete an HIE-to-HIE pilot project	3.A.Develop plan to connect with trading partners' HIE platforms based on feasibility report 3.B.Pilot HIE-to-HIE connection with X selected HIE	<ul style="list-style-type: none">• HIE-to-HIE connectivity draft plan• HIE-to-HIE pilot plan

Project 1.4: Practice Support Center

Project Goal

This project's goal is to design and implement a dedicated support call center to improve the patient experience, improve patient satisfaction, reduce "no-show" appointments, and provide critical primary care practice support to clinicians. These efforts will utilize technology and staffing care extenders to create an enduring, scalable, and flexible support system to better support patients and providers in a high-quality, cost-efficient, integrative model.

The Patient Call Center is the foundation for development and implementation of care coordination which is an integral component of Patient Centered Medical Home (PMCH). Initiatives in this project could include efforts focused on improvements of appointment scheduling and efficient incoming call triage as well as clinical assessment and advice by specially designated nursing resources for the Support Center. Care coordination can be supported by preparing patients for their visits during reminder calls, performing outreach functions for patients with important care gaps, and improving population management with outreach for chronic care. As such, the Patient Call Center will serve a key outreach function of the hospital primary care practice(s)' PCMH.

The Patient Call Center will be the foundation for the development and implementation of care coordination, which will be an integral component of all the DSTI 2.0 projects. The Patient Call Center will be one of the primary sources of information gathering on patient status and needs. Call Center staff will follow-up on all appropriate patients in the three-year period discharged to home from the hospital on an inpatient basis, observation patient basis, and Emergency Department (ED) basis. This project will be expanded in later years to follow-up with those patients who have had invasive outpatient procedures and who are undergoing outpatient care who need close monitoring.

The Patient Call system will supply information on a real-time basis through the Chronic Disease Registry and through direct communication with the Patient Navigation System. The Call Center will concentrate, in the early years of the project, on those identified chronic diseases. The hospital will look for a nationally known best practice system to implement the call center within the first year of the project. The Patient Call Center staff will provide patient support through the development of care protocols and scheduling workflows, utilizing specially trained call center advisors that will help streamline administrative practices and clinical workflow throughout the system.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Develop and launch a Patient/Practice Call Center that enhances patient access while providing necessary support for clinical staff.	X	X
B. Identify issues and barriers associated with scheduling and developing a plan to improve patient continuity.	X	
C. Identify pertinent clinical information and develop plan to include it for the physician for the scheduled appointment.		X
D. Monitor patient service performance.		X
E. Recruit clinically trained staff with multiplicity of skill sets to better direct patient needs	X	

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
F. Provide follow-up on all appropriate patients discharged from the hospital		X
G. Supply information on a real-time basis through Chronic Disease Registry and direct communication with Patient Navigation System.		X
H. Provide outreach to patients with specific, identified chronic diseases.		X
I. Follow patients within the health system at high risk for readmissions or worsening of chronic diseases.		X
J. Provide patient support through the development of scheduling protocols, streamlined administrative practices, and clinical workflow.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Plan Patient Call Center.	1.A.Implementation plan for call center software 1.B.Implementation plan for creating location for call center, staffing and equipment installation	<ul style="list-style-type: none"> Hospital and department project plans
2. Identify best practices and standards for the implementation of a Patient Call Center.	2.A.Documentation of research of best standards throughout the healthcare industry	<ul style="list-style-type: none"> Internal documents and reference material
3. Identify top vendors that provide patient call centers and compare those vendors' services to identified best practices.	3.A.Documentation of minimally two national vendors for patient call centers and their operational products	<ul style="list-style-type: none"> Internal hospital records and documentation
4. Contract with vendor to provide patient call center.	4.A.Signed contract	<ul style="list-style-type: none"> Internal hospital records and documentation
5. Identify patients who would benefit from a follow-up call.	5.A.Documentation of review process, identification of patient population, follow-up questions and time frame for follow-up	<ul style="list-style-type: none"> Internal hospital records and documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Implement patient call center for those patients discharged home with the specified chronic diseases for follow-up calls 48 hours, 7 and 21 days post-discharge.	1.A. Identify 2-3 specific chronic diseases that the Practice Support Center will target 1.B. Report number of patient contacts in the post-discharge calls for the identified 2-3 chronic diseases	<ul style="list-style-type: none">Internal hospital records and documentation
2. Administer appropriate patient satisfaction survey.	2.A. Identification of patient survey questions selected	<ul style="list-style-type: none">Internal hospital records/documentation
3. Monitor patient satisfaction for overall ED experience, as well as measure for patient satisfaction with physician and nursing care.	3.A. Report number of patients ratings overall ED care, MD care and nursing care as “very good” *	<ul style="list-style-type: none">Press Ganey data
4. Expand outbound calls to additional department(s).	4.A. Report detailing percentage of specified population called within appropriate time frame*	<ul style="list-style-type: none">Internal hospital records/documentation

Project 1.5: Implement Patient Navigation Services

Project Goal

The diversity of the U.S. population is not reflected in the community of practicing physicians; across the country clinical staff members do not demographically reflect the patients they serve. This creates a challenging environment wherein “patients may delay seeking care due to perceived cultural insensitivity, concern that they will receive a lower quality of care, or the perception that they have been treated unfairly because of race or ethnic background.”³² In addition, it is also documented that Medicaid beneficiaries in particular are affected by barriers to timely primary care and as such have higher ED utilization due to worse health and possession of chronic medical conditions. To proactively manage patient wellness, facilities need to engage patients in a culturally competent manner to address immediate care needs and effectively transition patients from inpatient and emergency department settings to primary care sites.

The goal of this project is to utilize community health workers, case managers, or other forms of patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigation teams will help and support patients, especially those in need of coordinated care, navigate through the continuum of health care services. Navigation team members will ensure patients receive coordinated, timely, and site-appropriate health care services. Navigation team members may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. Hospitals implementing this project will aid in the development of new kinds of health care workers, who will engage patients in a culturally and linguistically appropriate manner essential to guide patients through fully integrated health care delivery systems.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements.</i>	Structural	Process
A. Establish or expand health care navigation services.	X	
B. Implement patient navigation tools and/or technologies	X	
C. Train health care navigators in the tools and competencies needed to provide effective care		X
D. Deploy innovative health care personnel, such as patient navigators, case workers, and community health workers.		X
E. Provide navigation services to targeted patients who are at high risk of disconnected or fragmented health care (for example Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED).		X
F. Connect patients to primary and preventive care.		X
G. Develop community resources to provide enhanced social support	X	

³² Kripalani, Sunil, MD, MSc, Jada Bussey-Jones, MD, Marra G. Katz, BS, Ingina Genao, MD. *A Prescription for Cultural Competence in Medical Education.* J Gen Intern Med. 2006 October; 21(10): 1116–1120.

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Select an electronic option for ED staff and patient navigation staff to directly book a hospital network-affiliated PCP appointment	1.A. Select registration product and implement	<ul style="list-style-type: none"> Internal Data
2. Develop task force to address community resources	2.A. Establish task force 2.B. Participate in task force meetings	<ul style="list-style-type: none"> Internal Records (Attendance Records/Meeting Minutes)
3. Develop resource database of social and allied health care resources available in the community	3.A. Complete database and publish internally for all hospital staff	<ul style="list-style-type: none"> Internal Records

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. ED top user improvement	1.A. X% reduction in Cohort "X" top user total ED visits from baseline 1.B. X% reduction in unnecessary ED visits	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Increase number of patients receiving navigation services	2.A. X% improvement of targeted population receiving services over baseline*	<ul style="list-style-type: none"> Navigation records
3. Implement and train staff to make hospital-affiliated PCP appointments on electronic option	3.A. X percentage of staff trained*	<ul style="list-style-type: none"> Internal Records
4. Improve number of hospital-affiliated PCP appointments made electronically	4.A. Establish baseline number of hospital-affiliated PCP appointments made electronically 4.B. X% improvement of hospital-affiliated PCP appointments made electronically over baseline* 4.C. Report progress on percent of hospital-	<ul style="list-style-type: none"> EHR Source Data

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	affiliated PCP appointments made electronically over baseline	
5. Improve primary care utilization	5.A. Establish baseline number of eligible ED patients who attended their hospital-affiliated PCP appointment 5.B. X% improvement over baseline of eligible ED patients who attended their Steward primary care appointment*	<ul style="list-style-type: none">• EHR Source Data

Project 1.6 Develop Integrated Acute and Post-Acute Network Across the Continuum of Care

Project Goal

This project will further integrate patient care among acute, primary care and post-acute care settings to enhance coordination of care, improve the quality of care transitions, reduce readmissions, and develop a fully integrated delivery system capable of providing care in the most effective setting. Through the development of an integrated acute and post-acute network, health care delivery system efficiency will be enhanced and providers transformed to an integrated system capable of managing care along the entire care continuum. Integrative partnerships with post-acute care providers will be established that allow for enhanced communication and care coordination. These partnerships will enable providers to better monitor patient care in post-acute settings and ensure appropriate care throughout the entire episode of care. This project will build hospital capabilities for future functioning as an accountable care entity that is able to accept alternatives to fee-for-service reimbursement for a patient's entire episode of care.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Identify significant post-acute providers for patient population.	X	
B. Develop integrative partnerships with post-acute care provider.	X	
C. Develop/implement a plan to improve documented transitions of care notes between Hospital and PCMH and/or post acute provider"	X	
D. Develop/ implement integrative protocols for regular communications between acute and post-acute setting.		X
E. Identify gaps in post-acute care.		X
F. Assist post-acute partners in targeted improvement efforts.		X
G. Evaluate and further develop care management capabilities between hospital and primary care practice/ PCMH		X
H. Evaluate current state, develop and implement strategy for aligning hospital with post-acute provider network	X	

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Explore opportunities to further develop post-acute provider network.	<p>1.A. Establish a post-acute care committee with representatives across selected community organizations and develop a charter with agreed upon goals of those organizations.</p> <p>1.B. Deploy an RFP that will identify potential preferred providers among the selected community organizations.</p> <p>1.C. Establish a strategic relationship and list of preferred providers based on the RFP</p>	<ul style="list-style-type: none"> • Committee Charter • Request for Proposal (RFP) • Documentation of identified “preferred providers”
2. Evaluate current state of the hospital and post-acute provider network	<p>2.A. Identify and measure baseline of up to 3 key performance indicators with the selected preferred providers (e.g. skilled nursing facility (SNF) falls with injury, SNF pressure ulcers stages III and IV, and SNF average length for stay for short term patients)³³</p> <p>2.B. Determine a baseline of Emergency Room utilization for shared patients with preferred post-acute provider³⁴</p> <p>2.C. Determine a baseline readmission rate for</p>	<ul style="list-style-type: none"> • Dashboard of key performance indicators • Report on baseline metric

³³ Parmenter, D. (2007). *Key Performance Indicators: Developing, Implementing, and Using Winning KPIs*. Hoboken, N.J.: John Wiley & Sons.

³⁴ The Lewin Group (2012). Evaluating Emergency Department Utilization: for Researchers using the Centers for Medicare & Medicaid Services Chronic Condition Data Warehouse (CCW). *General Dynamics Information Technology*. May 9, 2012.

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Source(s)</u>
	shared patients with preferred post-acute provider	
3. Further develop strategic relationships with post-acute provider network	<p>3.A. Jointly develop an evidence-based co-management program for a shared population with one partnering preferred post-acute provider to reduce Emergency Room resource utilization.</p> <p>3.B. Jointly develop an evidence-based co-management program for a shared population with one partnering preferred post-acute provider to reduce readmissions</p>	<ul style="list-style-type: none"> • Joint team report

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Sources</u>
1. Evaluate current progress of hospital and PCMH practice care management and coordination of shared hospitalized patients	<p>1.A. Sustain and evaluate the current Transitions of Care protocols for managing identified shared hospitalized patients with the PCMH practice as established in DSTI 1.0.*</p> <p>1.B. Sustain Diabetic Self-Management Education (DSME) referrals for X percent of appropriate shared hospitalized patients with the PCMH being discharged to home*</p>	<ul style="list-style-type: none"> • Joint team report • Report on shared patients discharged to home with referral for DSME

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Sources
2. Plan for expansion of care management and coordination between hospital and PCMH for shared hospitalized patients.	2.A. Further improve documented transitions of care notes between the hospital and PCMH for identified, shared hospitalized patients (e.g. DM, COPD, CHF).*	<ul style="list-style-type: none">• Joint team report with improvement results
3. Identify opportunities to enhance care delivery models with the post-acute network.	3.A. Pilot an evidence-based co-management program and determine a baseline for a shared population with preferred post-acute provider to (1) reduce Emergency Room resource utilization and determine a target improvement measure or (2) to reduce readmissions and determine a target improvement measure.	<ul style="list-style-type: none">• Joint team report
4. Expand care management and coordination between Hospital and PCMH or a primary care practice for shared hospitalized patients.	4.A. Further improve documented transition of care note between the hospital and PCMH or a primary care practice for identified, shared hospitalized patients (e.g. DM, COPD, CHF)* 4.B. Expand the care management process and documented Transitions of Care (TOC) notes to an additional primary care practice for identified, shared hospitalized patients	<ul style="list-style-type: none">• Report on shared patients with documented TOC notes• Joint team report with improvement results

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Sources</u>
5. Implement care management and coordination between Hospital and PCMH for shared hospitalized patients	5.A. Implement a plan to improve documented transitions of care notes between the hospital and PCMH for identified, shared hospitalized patients (e.g. DM, COPD, CHF)	<ul style="list-style-type: none">• Joint team report on process and findings

28. Category 2: Health Outcomes and Quality

The projects identified under Category 2 include the development, implementation, and expansions of innovative care models that have the potential to make significant demonstrated improvements in patient experience, costs, and care management. Examples include:

- i. Implementation of enterprise wide care management or chronic care management initiatives, which may include implementation and use of disease management registries;
- ii. Improvement of care transitions, and coordination of care across inpatient, outpatient, post-acute care, and home care settings;
- iii. Adoption of process improvement methodologies to improve safety, quality, and efficiency;
- iv. Alternative Care Settings for non-emergency room care.

Each project includes a description of how the innovative care model can refine innovations, test new ways of meeting the needs of target populations, and disseminate findings in order to spread promising practices.

Introduction

The Massachusetts health care system is, in many respects, one of the best health care systems in the nation. The Commonwealth Fund ranks Massachusetts first in terms of access and seventh overall among states on its *State Scorecard*, which measures health system performance. Furthermore, trend data for the first five years of CMS's inpatient quality reporting program, demonstrate consistent and pronounced care improvement in Massachusetts acute care hospitals. Patients are receiving the treatments known to produce the best results more often and more reliably each year. Massachusetts' hospital performance over the last five years has exceeded the national average, even as national performance has improved during the same period. However, there is growing consensus that the health care system must move from a volume-based and fragmented health care system to one more based on achieving value for patients and providers through better care, better health, and lower cost.

The health care system is further challenged by many obstacles to innovation. Insufficient sharing of information and coordination of care across multiple providers often leads to disjointed, inefficient, and costly care. Massachusetts safety-net hospitals seek to improve their delivery systems by taking on innovative projects aimed at providing a coordinated care experience, and striving to improve and reduce unnecessary and more costly care. The hospitals are also trying to make improvements in areas where they have persistent challenges due to the social and medical complexity of the patient population they serve. Through these initiatives they can achieve better outcomes and lower costs for their patients.

The Category 2 DSTI projects reflect a set of initiatives for the eligible Massachusetts safety-net hospitals to rapidly adopt proven models of delivery system transformation, while experimenting with emerging models, with a specific emphasis on how best to improve care for the populations they serve. Category 2 projects focus on areas where evidence – and safety net hospitals' experience-- suggest that there is potential for significant improvement in the quality and/or cost

effectiveness of patient care: care management interventions targeting chronic disease or high-risk populations, redesigned care transitions between health care settings, and robust process improvement programs. Successful interventions and models developed from these projects by safety net providers, given the complexity of the patient population they serve, could provide key models for major enhancements in quality care at the lowest cost setting.

First, many Category 2 projects include a focus on care management and care coordination models targeting chronic and high-risk populations. In order to substantially reduce costs, providers must outreach to, and manage smaller subsets of high-need, high-cost patients, with high intensity care approaches tailored to each patient. For low-income patients, this requires the development of cross-functional care teams that span the continuum of physical health, behavioral health, and social services, including long-term supports.³⁵ Better care coordination and care management can also help to ensure that patients receive care in the most appropriate, least intensive setting as possible, and that care is not duplicated or conflicting.

Necessary components of a successful disease management program include the ability to identify and monitor high-risk individuals (e.g. patient logs or registries), apply evidence-based practice guidelines, coordinate care between providers, and encourage patient self-management through education and patient tools. The range of disease management services can include timely initiation of ancillary health services, patient monitoring and empowerment, and coordinating community services.³⁶

Second, improvements around care coordination and communication at critical transition points are also features of several Category 2 projects. Care should be coordinated, with the primary care team and hospitals jointly planning transitions from inpatient and emergency rooms to more appropriate care settings. According to the Institute for Healthcare Improvement (IHI), hospitals that go beyond the basic discharge plan and focus intensively on improving the transition of patients from hospital to community will have a much better impact on reducing readmissions.³⁷

Finally, Category 2 also focuses on process improvement and education aimed at providing better care at lower cost. Much has been published about the safety of healthcare and the amount of waste in its delivery. The Institute of Medicine report *To Err Is Human* noted that according to two studies, between 44,000 and 98,000 Americans die each year because of medical error. Medication errors in particular account for more than 7,000 deaths a year, more than the 6,000 deaths attributed to workplace injuries.³⁸ Factors inside health care organizations needed to improve care include strong leadership for safety, an organizational culture that encourages recognition and learning from errors, and an effective patient safety program. The follow-up document, *Crossing the Quality Chasm*, noted that in order to achieve a safer health system, health care has to be safe, effective, patient-centered, timely, efficient and equitable. Process

³⁵ T. McGinnis, Small D.M. "Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design,." *Center for Health Care Strategies Policy Brief* February 2012, p. 2.

³⁶ Fisher E, McClellan M, et al. "Accountable Care Learning Organization: Toolkit." *Engelberg Center for Health Care Reform. The Dartmouth Institute and The Brookings Institution.* (Jan. 2011) p 118.

³⁷ 5 Million Lives Campaign. "Getting Started Kit: Improved Care For Patients with Heart Failure How- To- Guide." *Institute for Healthcare Improvement.* 2008.

³⁸Kohn L, Corrigan J, and Donaldson M, Editors. "To Err Is Human: Building a Safer Health System." *Institute of Medicine.* 2000.

improvement education and methodologies, with their emphasis on waste reduction and employee empowerment to solve problems at the operational level, help address all of these issues.

The eligible safety net systems may select from among the projects described below, as specified, for inclusion in their Category 2 DSTI plans.

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Project 2.1: Implement Care Management Interventions for Patients with Chronic Diseases

Project Goal

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care.³⁹

Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a hospital's patient population, based on a hospital's assessment of patients' risk of developing complications, co-morbidities or utilizing acute or emergency services. These chronic health conditions may include diabetes, congestive heart failure, chronic obstructive pulmonary disease, among others, all of which are prone to co-occurring health conditions and risks.

Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development.⁴⁰ While this project shares elements similar to the establishment of a Patient Centered Medical Home, these are unique deliverables related to targeted disease specific conditions.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Identify one or more chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services.	X	
B. Review chronic care management best practices (e.g., Wagner Chronic Care model) and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care (e.g., the Institute of Chronic Illness Care's Assessment of Chronic Illness Care—ACIC ⁴¹).	X	
C. Assess common barriers for chronic disease patients to access necessary care and manage their chronic disease effectively using survey or focus	X	

³⁹Rabe KF, Hurd S, et al. "Global Strategy for the Diagnosis, Management and Prevention of COPD." *Global Initiative for Chronic Obstructive Lung Disease* Revised 2011.

⁴⁰ Information on the Wagner Chronic Care Model available at http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2 retrieved on March 11, 2012, and <http://www.grouphealthresearch.org/faculty/profiles/wagner.aspx> retrieved on March 11, 2012.

⁴¹ Developed as a practical tool to help teams improve care for chronic illness, the content of the ACIC was derived for specific evidence-based interventions for the six components of the Chronic Care Model. Like the chronic care model, the ACIC addresses the basic elements for improving chronic illness care at the community, organizational, practitioner and patient level.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
group tools (e.g., the Institute of Chronic Illness Care’s Patient Assessment of Care for Chronic Conditions—PACIC ⁴²).		
D. Design system(s) for identifying and/or tracking chronic disease patients with difficulty managing their chronic disease.	X	
E. Design a program/intervention to address the needs of chronic disease patients.	X	
F. Provide necessary training and education programs for clinicians and staff participating in enhanced care management programs for chronic disease patients.	X	
G. Implement care management intervention(s) and/or programs targeting one or more chronic disease patient populations. Examples of interventions include, but are not limited to 1) patient and family education initiatives; 2) chronic disease care management protocols; 3) chronic disease medication management services; 4) systems to support patients’ use of appropriate care such as patient navigation; and 5) systems to schedule and track rapid follow-up appointments.		X
H. Measure the program and/or intervention(s)’ impact on care management process improvements, patient clinical indicators, and quality.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Develop Comprehensive Diabetes Management (CDM) program.	1.A. Documentation of disease management tracking and communication tools 1.B. Documentation of chronic disease tracking process measures 1.C. Documentation of the percentage of at risk patients 1.D. Documentation of service agreement with partnering practices	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Develop trainings and educational materials for	2.A. Documentation training documents for provider	<ul style="list-style-type: none"> Internal documentation/EMR Report showing staff who

⁴² PACIC measures specific actions or qualities of care, congruent with the chronic care model, that patients report they have experienced in the delivery system.

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
more effective methods of hypertension management and conduct care team training sessions on these methods	and staff training for hypertension 2.B. Documentation of blood pressure measurement competency developed 2.C. Documentation of care team member attendance at educational programs on HTN management, with educational materials distributed to care teams	received education and training a copy of training documents <ul style="list-style-type: none"> • Job breakdown sheet for measurement and completed staff competency sign-off
3. Develop infrastructure to implement hypertension risk factor counseling and patient education for the prevention and treatment of cardiovascular disease.	3.A. Documentation of standard workflow and tools for management of hypertension including: follow-up plan, counseling on nutrition and physical activity and stress management	<ul style="list-style-type: none"> • Documentation of standards, workflows, tools and educational materials to support patient centered care planning and support EMR documentation
4. Develop workflows for IBT in hypertensive patients	4.A. Documentation of guidelines and workflows in IBT for hypertensive patients 4.B. Documentation of baseline of patients with diagnosis of HTN receiving IBT intervention	<ul style="list-style-type: none"> • Copy of IBT workflow, internal documentation from EMR
5. Update training and educational materials and conduct care team training sessions on new methods of cardiovascular disease population management	5.A. Documentation of implementation of educational training to providers and staff on IBT training for cardiovascular disease patients	<ul style="list-style-type: none"> • Report showing staff who received education and training on IBT for pts with cardiovascular disease within the practice
6. Develop or enhance chronic disease patient registry or manual logs to track target patient population with chronic disease/condition (e.g. COPD, hyper or	6.A. Working registry as evidenced by monthly reporting of target patient population activities such as admissions and readmissions, number of	<ul style="list-style-type: none"> • Hospital EHR and data warehouse • ED discharge report and manual or electronic registry

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
hypoglycemia, diabetes).	<p>patients \leq 70 years of discharged from the Emergency Department, etc.</p> <p>6.B. Documentation of enhanced fields added to the chronic disease registry of HF/COPD patients by X date.</p> <p>6.C. Baseline percent of HF patients from registry who are considered complex.</p>	

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Implement comprehensive diabetes management program (piloting first as appropriate).	<p>1.A. Documentation of the percentage of patients participating in pilot.</p> <p>1.B. Documentation of program implementation.</p> <p>1.C. Documentation of the percentage of participating primary patients.*</p>	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Measure A1C levels in diabetes management program participants.	<p>2.A. Documentation of A1c levels in pilot program patients.</p> <p>2.B. Documentation of A1c levels for patients in the comprehensive diabetes management program.</p>	<ul style="list-style-type: none"> Internal hospital records/documentation
3. Measure number/percent of target patient group with a chronic disease/condition contacted by hospital within 24 to 48 hours of hospital discharge (72 hours for weekend discharge).	<p>3.A. Documentation of follow up calls in the outpatient EHR as evidenced by documentation of a sample of 10 charts or chronic disease log</p> <p>3.B. Document number of</p>	<ul style="list-style-type: none"> Hospital Access Coordinator, Information Systems, Phone Logs Call Center documentation and Navigator records.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	target population who can "teach back" one lifestyle change needed during call.*	
4. Measure timeframe for appointment access in chronic disease management program/center.	4.A. Documentation of the % of follow-up appointment scheduled within specific time frame	<ul style="list-style-type: none"> Internal hospital records/documentation
5. Measure adherence to best practice standard for follow-up interval for hypertensive patients with uncontrolled blood pressures.	5.A. Assess baseline adherence to follow-up standard for hypertensive patients with uncontrolled blood pressure scheduled for a return primary care provider visit within 30 days 5.B. Report on the percentage of hypertensive patients with uncontrolled blood pressure scheduled for a return primary care provider visit within 30 days*	<ul style="list-style-type: none"> Baseline report showing adherence to follow-up standard for hypertensive patients with uncontrolled blood pressures Internal documentation from EMR
6. Provide routine feedback to providers on performance improvement opportunities, in hypertension initiatives including population health meetings	6.A. Documentation of HTN Population Health meetings in primary care	<ul style="list-style-type: none"> Sample of weekly clinical huddle minutes
7. Assess key clinical indicators for management of hypertension in high-risk populations	7.A. Documentation of baseline for the percentage of hypertensive patients 18-75 with chronic kidney disease (CKD) or proteinuria who are	<ul style="list-style-type: none"> Internal documentation/EMR Baseline report showing ACE/ARB therapy for patients with CKD or proteinuria Report on hypertensive patients 18-75 with chronic

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	treated with ACE or ARB therapy. 7.B. Report on the progress of the percentage of hypertensive patients 18-75 with chronic kidney disease (CKD) or proteinuria who are treated with ACE or ARB therapy.*	kidney disease (CKD) or proteinuria who are treated with ACE or ARB therapy
8. Report progress towards the use of IBT for patients with known hypertension	8.A. Report showing percentage of staff using IBT with hypertensive patients.	<ul style="list-style-type: none"> Internal hospital documentation/records.
9. Measure number/percent of the target population admitted to hospital with a chronic disease/ condition who are enrolled in the patient registry/entered into a manual log.	9.A. Documentation of target population admitted to hospital with a chronic disease/ condition that are enrolled in the patient registry/entered into a manual log.	<ul style="list-style-type: none"> Hospital Task Force, Information Systems, Manual log
10. Measure number/percent of target patient group with a chronic disease/condition that have follow-up appointments made prior to discharge.	10.A. Documentation of number/percent of target patient group with a chronic disease/condition that have follow-up appointments made prior to discharge.*	<ul style="list-style-type: none"> Electronic discharge instructions; patient registry
11. Measure the number/percent of patients with self-management goals for patients with chronic disease(s) at defined pilot site(s) compared to baseline.	11.A. Document the number or percent of patients with self-management goals documented.*	<ul style="list-style-type: none"> Internal hospital records/documentation Navigation documentation
12. Measure the number/ percent of patients meeting criteria for chronic condition at pilot site(s) contacted or receiving enhanced chronic disease condition services for patient education, self-management coaching, teach-back,	12.A. Document the number or percent of patients contacted for intervention 12.B. Document the number of HF and/or hypertensive patients in registry who receive specific instructions.*	<ul style="list-style-type: none"> Internal hospital records/documentation Call Center records

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
medication management, development of action plan or other intervention.	12.C. Track number of HF patients who receive medication education from pharmacist prior to discharge using Teach Back method.* 12.D. Track number of HF & COPD complex patients who are referred to the transition team.*	
13. Nurses complete warm handover for heart failure patients transitioning to skilled nursing facility (SNF) for rehab by communicating critical patient information.	13.A. Documentation of the % of transfers of heart failure patients to SNF where warm handover was completed*	<ul style="list-style-type: none"> • Medical record documentation
14. Analyze hospital data to establish a baseline on “all cause” readmissions for target patient group with a chronic disease/condition.	14.A. Monthly tracking of all cause readmissions with subset of primary or diagnostic code of identified chronic diseases 14.B. Document an in depth review performed on COPD patients who are readmitted for any reason	<ul style="list-style-type: none"> • Internal hospital records/documentation
15. Track number of chronic disease (HF & COPD) inpatients who are tobacco users as they are at risk for heart attack and stroke	15.A. Document tobacco users admitted who received smoking cessation counseling prior to discharge.* 15B. Baseline percent of Heart Failure/COPD patients in registry who use tobacco.	<ul style="list-style-type: none"> • EHR
16. Implement multi-disciplinary clinical care team meetings on chronic disease management program patients	16.A. Documentation of consistent multi-disciplinary care team meetings on chronic disease management program patients.	<ul style="list-style-type: none"> • Internal hospital records/documentation
17. Update training and	17.A. Documentation of	<ul style="list-style-type: none"> • Report showing staff who

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
educational	training and education materials for X% of clinical staff for hypertension. 17.B. Documentation of blood pressure measurement competency implemented for X% of clinical staff. 17.C. Documentation of X% of care team member attendance at educational programs on hypertension management with educational materials.	received education and training and copy of training documents
18. Update training and educational materials and conduct care team training sessions on new methods of cardiovascular disease population management	18.A. Documentation of implementation of educational training to X% of providers and staff on Intensive Behavioral Therapy training for cardiovascular disease patients.	<ul style="list-style-type: none">• Report showing staff who received education and training on Intensive Behavioral Therapy training for patients with cardiovascular disease with the target practice

Project 2.2: Implement Improvements in Care Transitions

Project Goal

The goal of this project is to implement improvements in clinical care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care—for example from hospital to home or nursing home, or from facility to home- and community-based services—have been shown to be prone to errors.⁴³ Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in post-acute care facilities. High-risk patients often have multiple chronic diseases, combined with social determinants of health that are attributed to poor health outcomes. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases.⁴⁴ The discontinuity of care during transitions typically results from a failure to recognize social determinants of health and prepare the patient and caregivers to manage the confounding factors.⁴⁵ The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Hospitals may focus on providing safer and more seamless care transitions that improve at-risk or “high-risk,” or all patient outcomes. Typically, “high-risk” patients are “complex patients” which may include patients with two or more conditions, such as COPD, CHF, AMI, pneumonia, diabetes, behavioral health, and other conditions or social complexity issues. Specific goals may include but are not limited to: 1) expand the scope of transition of care services to enhance care for more complex patients at home; 2) apply Lean in Healthcare thinking to analyze key processes of care transitions, such as information transfer and communication with other providers and/or patient education and engagement; 3) implement a transformational organizational alignment between hospitals and post-acute care providers along the care continuum such as home care, post-acute facilities, and primary care that can improve outcomes for complex patients; 4) discharge complex patients from the hospital at lower cost, with better health outcomes and with higher satisfaction rates, and 5) improve clinical care transitions through evidenced-based practices that improve communication between providers, patients, and caregivers.

⁴³Coleman EA. “Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs.” *Journal of the American Geriatrics Society* (2003) 51:549-555

⁴⁴ Rittenhouse D, Shortell S, et al. “Improving Chronic Illness Care: Findings from a National Study of Care Management Processes in Large Physician Practices.” *Medical Care Research and Review Journal* (2010) 67(3): 301-320

⁴⁵ Coleman, E., Parry, C., et. al. “The Care Transitions Intervention: a patient centered approach to ensuring effective transfers between sites of geriatric care.” *Home Health Care Serv Q* (2003) 22 (3): 1-17

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following elements:</i>	Structural	Process
A. Develop and sustain a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, home care providers, patients, caregivers or representative from Patient Family Advisory Committee.	X	
B. Advance care transitions analytical capabilities to support performance improvement efforts and/or conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement’s (IHI) State Action on Avoidable Re-hospitalizations (STAAR ⁴⁶) tool) and/or patient interviews to drive performance improvement.		X
C. Identify baseline top readmission diagnoses and populations at high risk for readmissions, including mental health and substance abuse.	X	
D. Review best practices from a range of models (e.g. RED ⁴⁷ , BOOST ⁴⁸ , STAAR, INTERACT ⁴⁹ , Coleman ⁵⁰ , Naylor ⁵¹ , GRACE ⁵² , BRIDGE ⁵³ , etc.).	X	
E. Identify and implement evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.		X
F. Implement one or more intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of: <ul style="list-style-type: none"> a. Patient care transition processes between hospital and other post-acute providers, and “warm handoff” communication plans and/or “closed-loop communications” with receiving providers which may include post-acute care facilities and/or visiting 		X

⁴⁶ IHI launched State Action on Avoidable Re-hospitalization (STAAR) Initiative in May 2009 – a ground breaking, multi-state, multi-stakeholder approach to dramatically improve the delivery of effective care at a regional scale. The STAAR initiative aims to reduce re-hospitalization by working across organizational boundaries and by engaging payers, stakeholders at the state, regional and national level, patients and families, and caregivers at multiple care sites.

⁴⁷ The Re-engineered Hospital Discharge, known as Project RED, is designed to re-engineer the hospital workflow process and improve patient safety by using a nurse discharge advocate who follows 11 discrete, mutually reinforcing steps shown to improve the discharge process and decrease hospital readmissions.

⁴⁸ Better Outcomes for Older Adults through Safe Transitions, a 2009 Society of Hospital Medicine (SHM) initiative working with hospitals to reduce readmission rates by providing them with proven resources and monitoring to optimize the discharge transition process, and enhance patient and family education practices

⁴⁹ Interventions to Reduce Acute Care Transfers (INTERACT) is a quality improvement program that focuses on the management of acute change in resident conditions. Developed by the Georgia Medical Care Foundations with support from CMS.

⁵⁰ The Care Transitions Intervention Program is a model developed by Dr. Eric Coleman in response to the need for a patient-centered interdisciplinary intervention that addresses continuity of care across multiple settings and practitioners.

⁵¹ Also referred to as the Transitional Care Model (TCM) Naylor is an intensive nurse-led care management program provided to high-risk seniors during and after hospitalization.

⁵² Geriatric Resources for Assessment for the Care of Elders model is a physician/practice-based care coordination model. GRACE is conducted for a long term/indefinite amount of time and requires a nurse practitioner and social worker.

⁵³ A novel hospital-to-home transition program for patients with cardiovascular disease which has shown to significantly reduce 30-day readmission rates and emergency department visits.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following elements:</i>	Structural	Process
<ul style="list-style-type: none"> nurse agency (VNA)/home health, and/or primary care providers. b. Patient and family education initiatives including patient self-management skills and “teach-back.” c. Post-discharge medication planning which may include prescription fulfillment services at patient discharge and pharmacist and care team-led patient medication education. d. Early follow-up such as home care visits, primary care outreach, and/or patient call-backs. e. Redesign patient hospital discharge process and transfer of care documentation which may include input from patient and family representatives and input from post-acute providers. f. Development, implement and assess an inter-disciplinary program for screening and treating patients at risk and diagnosed with perinatal mood and anxiety disorders. g. Develop and implement a hospital care delivery system for the elderly population. h. Develop, implement and assess a plan for appropriate follow-up care between hospital and selected community providers for adult inpatients i. Develop and implement hospital and community capabilities to manage “super utilizer” patients and/or those with behavioral health conditions in the Emergency Department. j. Redesign of hospital care management department to a care transitions focus. 		
<p>G. Evaluate the intervention(s) impact on readmissions and patient care and identify “lessons learned,” which may include opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations, or evaluate intervention processes, using quantitative and qualitative data to collect from providers, complex patients and family members, and the health system.</p>		X
<p>H. The new use of health information technology, such as BEACON– Alerts or Electronic Medical Record tools, may be developed to support care transitions, and may be utilized to notify the team of a complex patient’s key providers when she or he is admitted to the hospital and/or emergency department.</p>		X
<p>I. Education of clinicians, staff, and/or community partners on care transitions improvement initiatives above.</p>		X

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Establish Cross Continuum Team to support or lead Care Transitions project. Identify team of stakeholders to work on improving appropriate Emergency Department utilization and transitions.	1.A. Establishment of Cross Continuum Care Transitions Team. 1.B. Emergency Department Care Transitions and Utilization Stakeholder Team. 1.C. Cross Continuum Team Meetings.	<ul style="list-style-type: none"> Internal hospital records/ documentation
2. Distinguish roles of Care Transitions Department. Develop and explore role for navigator/community health worker.	2.A. Explore and distinguish roles of Care Transitions Department, through human resources records/ job descriptions and Cross Continuum Team review. 2.B. Job descriptions for navigator/ community health worker roles. 2.C. Hire or assign patient navigator/ community health worker.	<ul style="list-style-type: none"> Internal hospital records/documentation, such as meeting minutes or agenda. Internal hospital records/ documentation.
3. Gap analysis regarding patient communication with doctors, nurses, and/or discharge information. Develop an analytical capability and/or assessment tool to identify patients who are at high risk for readmission or who have been readmitted. Assess perinatal mood and anxiety disorders screening and services.	3.A. Gap analysis complete 3.B. Readmissions data analytics and/or tools workplan. 3.C. Selection/development of readmission assessment tool, which may include work plan for readmission assessment. 3.D. Assess current state of perinatal mood and anxiety disorder screening and services.	<ul style="list-style-type: none"> Internal hospital records/ documentation
4. Engagement of patient/ family representatives in care transition improvement. Collect consumer input on patient satisfaction by sharing discharge tool experiences/HCAHPS scores with Patient	4.A. Report findings and recommendations of patient/family representatives to improve patient discharge documentation. 4.B. Document consumers and family caregivers are members of the Cross Continuum team. 4.C. Discharge tool and/or HCAHPS scores will be a standing agenda	<ul style="list-style-type: none"> Internal hospital records/ documentation

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Source(s)</u>
Family Advisory Council (PFAC).	<p>item on the PFAC Committee.</p> <p>4.D. PFAC Committee provides input into redesign of admission packet so patients receive discharge preparation upon admission.</p> <p>4.E. Hospital implements redesign of admission packet so patients receive discharge preparation upon admission.</p>	
5. Develop and share plan(s) and/or processes which may be across the care continuum for a (1) hospital care transition processes or programs such as hospital and community capabilities to manage patients with behavioral health in the emergency department or (2) develop tools or manual for complex patient care transitions that may identify key care continuum providers, preferred modes of information transfer regarding patient medical information and scheduling appointments.	<p>5 A. Manual for Complex Patient Care Transitions.</p> <p>5.B. Develop cross continuum care coordination program for “super utilizer” patients, which may include warm handoffs or other program elements.</p> <p>5.C. Develop a comprehensive and culturally appropriate inpatient Perinatal Mood and Anxiety Disorder program.</p> <p>5.D. Develop process to schedule follow-up appointments for adult inpatients discharged to home using an evidence-based protocol.</p> <p>5.E. List of post-acute providers and physician groups participating in the Transition Process Improvement.</p>	<ul style="list-style-type: none"> Internal hospital records/ documentation
6. Assess knowledge of and barriers to implementing evidence-based care transitions tool.	6.A. Completed survey.	<ul style="list-style-type: none"> Internal records

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Source(s)</u>
1. Improve discharge documentation	1.A. Report number and/or percentage of patients for whom evidenced-based practice was utilized for	<ul style="list-style-type: none"> Internal hospital records/documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	<p>inpatient discharge documentation.</p> <p>1.B. Implement identified improvements, which may include patient/family recommendations, in patient discharge documentation.</p> <p>1.C. Develop improved electronic medical record tools to support care transitions for patients with inpatient discharges.</p> <p>1.D. Engage post-acute provider input into the continuing care documentation.</p> <p>1. E. Improve the percentage of patients for whom evidenced-based practice was utilized for inpatient discharge documentation.*</p>	
<p>2. Readmission assessment. Collect information and /or analyze data on factors contributing to preventable readmissions within 30 days.</p>	<p>2.A. Conduct interviews with patient/family members regarding preventable 30 day hospital readmissions.</p> <p>2.B. Review readmission data and factors contributing to preventable readmissions.</p> <p>2.C. Report on readmissions assessment work.</p> <p>2.D. Determine baseline metric for all cause 30-day readmissions.</p> <p>2.E. Monitor 30-day all cause readmissions on a monthly basis.</p>	<ul style="list-style-type: none"> • Internal hospital records/documentation
<p>3. Training and education for relevant hospital staff and/or other care transition partner organizations on standard use of evidence-based care transition tool, framework, or initiative which may include a focus on care of the</p>	<p>3.A. Number or X% of hospital staff and/or care transition partner organization staff trained*</p> <p>3.B. Copy of education/training curriculum.</p> <p>3.C. Educate nursing leadership.</p> <p>3.D. Train patient navigators/ community health workers/ transition teams, such as through training certificates for community health workers/navigators.</p>	<ul style="list-style-type: none"> • Internal hospital records/documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
elderly population such as comprehensive geriatric resource nurse education program, depression and/or anxiety, or maternal child health and/or other care transitions improvement. Educate appropriate clinical staff on key contributing factors to preventable readmissions.	<p>3.E. Educational sessions with key clinical staff on preventable readmissions and/or provide feedback on readmission performance improvement.</p> <p>3.F. Implement comprehensive education program, such as for geriatric nurse education program for elderly-specific care.</p> <p>3.G. Educate at least X percent of Maternal Child Health care team in Perinatal mood and anxiety disorder screening for inpatient post-partum patients.*</p> <p>3.H. Educate nursing staff.</p>	
4. Perinatal mood and anxiety disorder (PMAD) initiative.	<p>4.A. Develop an evidenced-based PMAD screening tool for inpatient post-partum patients⁵⁴</p> <p>4.B. Implement evidence-based screening tool with inpatient post-partum patients.*</p> <p>4.C. Improve the number of inpatient post-partum patients screened.*</p>	<ul style="list-style-type: none"> Internal hospital records/documentation
5. Develop and implement warm hand-offs/ closed loop communications (a clinician to clinician real time live communication or “closed-loop communication”) or other program elements at transitions of care for a target population that support seamless care transitions and impact preventable 30-day readmissions.	<p>5.A. Development of workflows and/or tools, which may include electronic medical record documentation and staff education, to support a “warm handoff” or “closed loop communication” for patients discharged from a hospital’s inpatient service to post-acute setting.</p> <p>5.B “Closed-loop communications” or Warm Handoffs used for number or X percent of target population transitioned from inpatient units to alternative care settings (e.g., area SNFs, Rehabs, home with VNA</p>	<ul style="list-style-type: none"> Internal hospital records/documentation, which may include survey documentation from partners.

⁵⁴ Edinburgh Postnatal Depression Scale (EPDS); Postpartum Depression Screening Scale (PDSS); Patient Health Questionnaire-9 (PHQ-9)

Cox, J.L., Holden, J.M. and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	<p>services, or PCMHs).*</p> <p>5.C. Test and evaluate “warm handoff” process between hospital unit and skilled nursing facility.</p> <p>5.D. Test and evaluate “warm handoff” process between hospital unit and home health agency.</p> <p>5.E. Track and document the patient discharges to the skilled nursing facility where a “warm handoff” of communication is timely and complete based on survey results.</p> <p>5.F. To evaluate the “warm handoff,” survey home health agency on the timeliness and effectiveness of the process.*</p> <p>5.G. Assess the cross continuum care coordination program for shared “super utilizer” patients by reporting completed “warm handoffs” to the patient-centered medical home for at least X percentage of super utilizer patients who presented to the emergency room.</p> <p>5. H. Completion and education of new documentation process for X percentage of defined staff.*</p> <p>5.I. Improve the percentage of patients discharged patients to selected post-acute care setting(s) for whom a “closed-loop” communication occurred.*</p>	
<p>6. Improving follow-up care through appointment scheduling prior to discharge.</p>	<p>6.A. Report on capacity, process, and baseline percentage of adult inpatients discharged to home with a follow-up appointment.*</p> <p>6.B. Report on the evidenced-based process for follow-up appointments scheduled prior to discharge with the selected community provider to target adult</p>	<ul style="list-style-type: none"> Internal hospital records/ documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	<p>inpatient population discharged to home.*</p> <p>6.C. Expand the program on follow-up appointment scheduling.</p>	
7. Improve care management process, care transition process, or readmission assessment tool process for patient populations.	<p>7.A. Implement at least X number of process improvement interventions to improve the care management process or care transition process.*</p> <p>7.B. Report progress on the improvement initiatives implemented.</p>	<ul style="list-style-type: none"> • Internal hospital records/documentation
8. Implement evidence-based intervention(s) to improve the care transitions for patients discharged from inpatient services to home care. Survey a sample of the hospital's discharged complex patients who received home care services on their experience of care and satisfaction levels.	<p>8.A. Implementation of evidence-based intervention to improve hospital to home care transition process.</p> <p>8.B. Report on survey of complex patient sample who received home care services on experience of care and satisfaction levels.*</p>	<ul style="list-style-type: none"> • Internal hospital records/documentation
9. Re-engineer hospital discharge process through selection of evidence-based framework. Implement evidence-based tools.	<p>9.A. Identify and select an evidence-based framework for re-engineering hospital discharge process and/or supporting seamless care transitions.</p> <p>9.B. Implement tools such as INTERACT to prevent avoidable nursing home to hospital transfers.*</p> <p>9.C. Design both new and modified discharge processes in accordance with selected evidence-based framework.</p> <p>9.D. Implement new and modified discharge processes in accordance with selected framework.</p>	<ul style="list-style-type: none"> • Internal hospital records/documentation
10. Develop report on lessons learned and	10.A. Development of "Lessons Learned" report*	<ul style="list-style-type: none"> • Internal hospital records/documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
share with health system leaders and/or health care community.		
11. Develop transition process improvements for high risk patients using Lean in Healthcare Value Stream Mapping or other improvement action plan	11.A. Transition process plan for high-risk complex patients. 11.B. Value Stream Mapping Report.	<ul style="list-style-type: none"> Internal hospital records/documentation
12. Develop and launch hospital and/or community capabilities to manage patients with behavioral health issues and/or “super utilizers” in the emergency room.	12.A. Define and identify a “super-utilizer” target population of shared patients with the PCMH who present to the Emergency Department. 12.B. Pilot use of Social Worker in the Emergency Room to identify gaps in care coordination 12.C. Evaluate and select an evidence-based risk stratification tool to identify “super utilizer” patients in the emergency room that includes interventions addressing the care delivery needs of the population. 12.D. Implement above risk stratification tool. 12.E. Develop referral, assessment, and follow-up treatment planning processes for complex, high utilizer patients in the emergency department. 12.F. Track repeat emergency department visits of high utilizer patients and interview patients to gain understanding of reason for frequency. 12.G. Document high utilizer patients referred to the transitions team who return to the emergency department within 30 days.* 12.H. Number of high utilizer patients	<ul style="list-style-type: none"> Internal hospital records/documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	<p>returning to the emergency department within 30 days who are interviewed by the transitions team.*</p> <p>12.I. Document treatment plans completed for high utilizer patients to be shared with the emergency department and primary care provider with patient consent.*</p>	
13. Document workflow protocol which may include use of evidenced-based care transition tool, framework, or electronic medical record (EMR) capabilities.	<p>13.A. Completion of written workflow protocol.</p> <p>13.B. Development of EMR tools to support care transitions.</p>	<ul style="list-style-type: none"> Internal hospital records/documentation
14. Implement a program to provide prescription fulfillment services to patients at discharge on selected inpatient units.	<p>14.A. Development of EMR tools to support communication and prescription delivery.</p> <p>14.B. Implement and/or expand the program to selected inpatient units and report on program operations.</p>	<ul style="list-style-type: none"> 1 Internal hospital records/documentation
15. Identify and implement evidence-based communication tool. Utilize cross continuum team relationships and/or meetings to create bi-directional communication processes to improve care transitions.	<p>15.A. Document and monitor utilization of evidence-based communication tool by staff and partners.*</p> <p>15.B. Cross continuum team monthly meetings to facilitate care transition communications.</p> <p>15.C. Establish baseline staff utilization of evidence-based communication tool.</p> <p>15.D. X% improvement over baseline staff utilization*</p>	<ul style="list-style-type: none"> Internal records
16. Improve patient communication regarding discharge and/or advance patient understanding of management of their health post-hospital	<p>16.A. Monitor improvement in HCAHPS: Discharge Information (mean percent over baseline).*</p> <p>16.B. Track complex patients discharged to home with a self-designed treatment plan who respond “yes” to the follow-up</p>	<ul style="list-style-type: none"> Internal records and/or Press Ganey

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
care.	phone call question: “when you left the hospital did you have a good understanding of the things you are responsible for in managing your health.”*	
17. Implement and advance use of inpatient bedside patient education which may include those with high risk medications or high prevalence conditions.	<p>17. A. Report number or percent of patients with high prevalence condition, such as congestive heart failure who received patient education.*</p> <p>17. B. Report number or percent of target patient population prescribed a high-risk medication, such as warfarin, who received patient education.*</p> <p>17. C. Report number or percent of patients with high prevalence condition, such as chronic obstructive pulmonary disease, who received patient education*</p>	<ul style="list-style-type: none"> • Internal hospital records/ documentation

Project 2.3: Develop or Expand Projects to Re-Engineer Discharge Processes

Project Goal

Comprehensive discharge processes -- wherein the patient and the hospital share an understanding of care and follow up plans -- are critical to successful implementation of accountable care models. To prepare in this regard, hospitals may need to refine, and in some cases re-engineer, their existing discharge processes to reduce unnecessary readmissions, increase adherence to follow up care recommendations and thrive under alternatives to fee-for-service payments. Projects will focus on standardizing and personalizing the complex hospital discharge process to reduce unnecessary readmissions and improve quality, thereby better positioning the hospital system for success in a global payment environment.

The project may be specifically tailored to address the unique challenges disadvantaged populations have as they change care settings and improve both medical, patient experience, and utilization outcomes. It may also use an interdisciplinary approach of case managers, pharmacists, social workers, and patient navigators will work together to deliver customized transition support specifically addressing the medical, psychological and social needs of disadvantaged patients.

Potential Project Elements	Structural	Process
<i>DSTI hospitals undertaking this project may select from among the following project elements:</i>		
A. Design and implement a hospital wide program to improve transitions from hospital to home or other care settings for all patients, building off of pilot experience and leanings.	X	
B. Develop the necessary tools for team members to utilize in readmissions reduction work, including patient education and communication tools.	X	
C. Develop the use of health information technology, such as newly implemented electronic health records, to assist clinicians in identifying high-readmissions risk patients.		X
D. Coordinate the work of case managers, pharmacists, social workers, and patient navigators to work together to deliver customized transition support specifically addressing the medical, psychological and social needs of disadvantaged patients.		X
E. Identify and prioritize evidenced-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.		X
F. Education of clinicians, staff, and/or community partners on care transitions improvement initiatives above		X

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Design and implementation of a hospital wide transitions of care program.	1.A. 12-month project plan	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Develop tools and materials such as patient discharge education materials and risk assessment tool(s) to support efforts to reduce readmissions.	2.A. Copy of patient discharge education materials. 2.B. Copy of Readmission risk assessment tool.	<ul style="list-style-type: none"> Internal hospital records/documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Streamline process for identifying and assessing patients for readmission risk at admission	1.A. Implementation of readmission risk assessment in inpatient electronic health record by end of SFY 2016.	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Implementation of strategies for patient follow-up after discharge including outreach calls.	2.A. Documentation of process for making outreach phone calls to discharged patients within 72 hours of discharge.	<ul style="list-style-type: none"> Internal hospital records/documentation
3. Track patient outreach activities, such as outreach calls placed to high-risk patients, aimed at reducing readmissions.	3.A. Percentage of outreach phone calls made to high-risk discharged patients within designated time after discharge*	<ul style="list-style-type: none"> Internal hospital records/documentation
4. Measure patients assessed for readmission risk at admission through electronic medial record and presented with patient discharge education material.	4.A. Percentage of patients assessed for readmission risk at admission* 4.B. Percentage of discharged patients presented with discharge education material.*	<ul style="list-style-type: none"> Internal hospital records/documentation

Project 2.4: Implement Primary Care Based System of Complex Care Management for High Risk Population(s)

Project Goal

This project's goal is to develop and implement a primary care-based system of complex care management to improve patient health and reduce avoidable costs for safety-net patients determined to be at high risk. High-risk populations may be defined by the hospital's population specific criteria, including a combination of factors such as recent inpatient or emergency room utilization or utilization of high-cost health care services, risk stratification based on utilization and clinical indicators, poor control of a chronic disease (medical and behavioral), the presence of multiple chronic conditions and/or patients who have an acute change in their medical, social or behavioral health condition. Additionally, hospitals may identify a "super utilizer" population based on the criteria above, define an actionable population from these super utilizers and engage with these patients in an integrated care management program. Primary care-based care management or complex care management teams will provide complex care management of medical conditions and behavioral health conditions and may also coordinate a range of social service supports such as effective patient engagement, housing, transportation, and/or nutrition. Functional assessment evaluations may also be initiated for high-risk patients. These teams will also coordinate with inpatient, emergency department, and post-acute care management systems to facilitate a seamless care transition experience for patients. Complex care managers will enhance patient connections with appropriate primary and mental health care to prevent escalation of underlying medical and behavioral health issues.⁵⁵

Project elements may include emergency services and/or hospitalization prevention strategies, and/or evidence-based approaches to measure and advance patient activation. Patient activation refers to a patient's knowledge, skill, and confidence for self-management of health conditions. This is an important area of focus toward population health goals of the Affordable Care Act and especially for vulnerable patients and high risk patient populations. Measurement, such as through the Patient Activation Measure (PAM), is a validated tool for measuring the level of patient engagement in their health care, which is an intermediate outcome of care that is linked to improved health outcomes.⁵⁶ Research findings have shown that more activated patients have better health outcomes and better care experiences than less activated patients; furthermore, research has revealed that patient activation can be enhanced over time by interventions, such as tailored coaching.⁵⁷

Safety-net patients have complex health care needs and utilization behaviors that are significantly different than and far exceed expected patterns in the commercial population.⁵⁸ Development of primary care-based systems of care management has been linked to substantial improvements in quality of care and reduced cost.⁵⁹ Safety-net patient populations face not only co-occurring medical and mental health concerns but also social acuity, including linguistic, cultural, literacy, economic, psychological or cognitive barriers. These social determinants can factor into missed appointments,

⁵⁵ K.R. Enard, D.M. Ganelin. Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. *Journal of Health Care Management*. 2013 Nov-Dec; 58(6): 412-27.

⁵⁶ Hibbard, Judith, Greene, Jessica. What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs. *Health Affairs*, 32, no.2 (2013): 207-214.

⁵⁷ Ibid.

⁵⁸ Tang, N. et al. "Trends and Characteristics of U.S. Emergency Department Visits 1997-2007." *JAMA* (2010) 304(6): 664-670.

⁵⁹ Cosway R, et al. "Analysis of Community Care of North Carolina Cost Savings." *Milliman, Inc.* 2011.

Project Goal
no-shows for follow-up tests, medication problems, disease progression and health care utilization patterns. The discontinuity of care can lead to otherwise preventable complications and/or hospital admissions and emergency room use. Projects under this heading will attempt to address these challenges through comprehensive care management programs for complex patients. Initiatives in this project are distinct from projects that a hospital may implement on chronic disease management.

Potential Project Elements	Structural	Process
<i>DSTI hospitals undertaking this project may select from among the following project elements:</i>		
A. Design and develop integrated care management or care coordination intervention program for target super utilizer sub-populations or identified high-risk population(s). Identify appropriate metrics and definitions to track utilization. Develop structure for complex care management program for high-risk patients including multi-disciplinary framework.	X	
B. Develop methodology for identifying high-risk patients/super-utilizers. Establish risk stratification protocol for identified populations.	X	
C. Develop model for utilizing community health workers in complex care management.	X	
D. Enroll high-risk patients into primary care-based complex care management program and/or in care coordination intervention.		X
E. Design and implement new Patient Activation Initiative and/or functional assessment evaluations, including evidenced-based tools, for complex care management patients. Train staff on new Patient Activation Initiative and/or functional assessment evaluation protocol and implement initiative. Establish follow-up Patient Activation Measure completion protocols and monitor progress and improvement for identified population.		X
F. Phase-in expansion of community health worker model to support primary care and complex care management.		X
G. Assess the impact of the primary care-based complex care management model in areas that may include: patient characteristics, inpatient or emergency care patterns or follow-up, improving patient engagement or satisfaction, and/or wellness/clinical indicators, health care services utilization and trends, self-perceived health state of the identified population, and/or health care costs as available. Report improvements related to demographics of patients enrolled in complex care management.		X
H. Advance initiative(s) to improve of health care and care management for vulnerable, high-risk patients identified through high Emergency Department and/or hospitalization utilization or other super-utilizers. Track progress. Hospitals may engage additional subpopulations over time.		X
I. Develop and conduct training or educational programs for complex care management staff.		X
J. Implement key components of integrated care management program for a target super-utilize or high risk sub-population. Additional subpopulations may be implemented in subsequent year(s). Components to identify staffing models and customized care management strategies.		X

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Design and develop integrated care management program and/or structure for target super-utilizer sub-populations or high-risk patient populations. Identify appropriate metrics and definitions to track utilization.	1.A. Copy of driver diagram with potential design elements. 1.B. Care management program description. 1.C. Staffing model. 1.D. Copy of super-utilizer metrics to track use patterns. 1.E. Outline of program structure.	<ul style="list-style-type: none"> • Internal hospital and/or payer records/documentation
2. Develop methodology for identifying high-risk patients/super-utilizers for the program. Establish risk stratification protocol for patients in identified populations.	2.A. Identification of Population 2.B. Detailed descriptive analysis identifying total super utilizer population and appropriate segmentation 2.C. Summary report describing the utilization drivers, identification of actionable population subsets for improvement and potential design elements of program to impact target population(s). 2.D. Establish risk stratification protocol for patients in identified populations to identify the highest risk patients.	<ul style="list-style-type: none"> • Internal hospital records/documentation.
3. Develop model for utilizing community health workers in complex care management.	3.A. Submission of community health worker organizational structure, roles, competencies and/or deployment plan.	<ul style="list-style-type: none"> • Internal hospital records/documentation.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Develop complex care coordination intervention program for identified population	1.A. Complex care coordination intervention program for identified population, including outreach, access, patient-centered care plan development, and multi-disciplinary and community	<ul style="list-style-type: none"> • Internal hospital records/documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	team meetings.	
2. Enroll high-risk patients into primary care-based complex care management program or enroll highest risk patients in identified population in care coordination intervention.	2.A. Enroll high-risk patients into complex care management. 2.B. Report baseline and/or on subsequent year enrollment level.*	Internal hospital records/ documentation.
3. Design new Patient Activation Initiative, including evidence-based tools, for complex care management patients. Train staff on Patient Activation Initiative. Establish follow-up Patient Activation Measure (PAM) completion protocols. Increase percentage of initial of PAM completion using the Insignia Health validated tool for identified population. Develop opportunities for program improvement based on lessons learned.	3.A. Development of new Patient Activation Initiative, which may include workflows and reporting capacity. Establish baseline for patients enrolled in complex care management with completed initial PAM using the Insignia Health validated tool. 3.B. Train staff on PAM tool. 3.C. Establish follow-up PAM completion protocols and establish baseline percentage of enrolled complex care management patients with follow-up PAM scores. 3.D. Report progress on the proportion of enrolled complex care patients with follow-up PAM scores. Report program opportunities and lessons learned. 3.E. Improve the percentage of patients enrolled in complex care management with completed initial PAM scores using the Insignia Health validated tool.*	<ul style="list-style-type: none"> Internal documentation.
4. Phase-in expansion of Community Health Worker (CHW) Model to support primary care and complex care management.	4.A. Report on the CHWs assigned to complex care management teams or primary care sites consistent with the model.	<ul style="list-style-type: none"> Hospital documents and/or EMR records.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
5. Assess the impact of the complex care management model in areas that may include: patient characteristics, inpatient or emergency care patterns or follow-up, improving patient engagement or satisfaction, wellness/clinical indicators, health care services utilization and trends, self-perceived health status of the identified population, and/or health care costs as available.	5.A. Written assessment of the impact of the primary care-based complex care management model over a specified period of time.	<ul style="list-style-type: none"> Internal hospital records/documentation.
6. Launch super-utilizer or vulnerable patient population initiative for actionable sub-population. Test, build and advance approaches to improvements in health care and care management for vulnerable, high-risk patient population, identified with high emergency department utilization and/or other characteristics. Hospitals may engage additional subpopulations over time and increase overall number of targeted super-utilizers and/or follow the identified population longitudinally.	<p>6.A. Summary descriptive document on super-utilizer or identified vulnerable patient population, which may include design of intervention initiative(s).</p> <p>6.B. Implement improvement initiative for identified vulnerable patient population, identified with high emergency department utilization. Report baseline number and/or percentage of patients from the vulnerable patient cohort who are enrolled in complex care management.</p> <p>6.C. Report impact of improvement initiatives on care management activities and initiatives that improve health and utilization indicators for identified vulnerable patient population followed longitudinally.</p> <p>6.D. Document super-utilizer outreach/engagement and care plans for each sub-</p>	<ul style="list-style-type: none"> Internal hospital records/documentation.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	population. 6.E. Improve the percentage of patients in the vulnerable patient cohort who are enrolled in complex care management.*	
7. Develop and conduct training or educational programs for complex care management staff. Training may include competency testing.	7.A. Develop educational program for complex care coordination for identified population. Program may include a pre- and post-test to assess knowledge and likelihood to apply the practice. 7.B. Implement comprehensive complex care management staff training plan and report on proportion of staff receiving training. Curriculum may include motivational interviewing/patient activation skills and/or “refresher” skills. 7.C. Documentation showing X percentage of primary care providers of target population received education regarding principles on complex care intervention program*	<ul style="list-style-type: none">• Internal documentation, such as educational materials, training program documentation and/or training attendance.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
8. Tailor key components of integrated care management program for a target super utilizer sub-population. Additional subpopulations may be implemented in subsequent year(s). Components to identify staffing models and customized care management strategies.	8.A. Documentation of program staff to manage sub-population 8.B. Documentation of customized approaches to managing population. 8.C. Documentation of customized approaches to super utilizer segment populations. 8.D. Sample custom guides for engagement and care of target patient population. 8.E. Copy of sample dashboard populated with sample data. 8.F. Documentation of a template dashboard report for clinical sites.	<ul style="list-style-type: none">• Hospital records and/or documentation.
9. Develop functional assessment evaluation protocol for high risk patients and related initiative.	9.A. Copy of functional assessment evaluation protocol. 9.B. Training program for providers and staff on functional assessment evaluations. 9.C. Implementation of functional assessment protocol for all appropriate high risk patients in target population. 9.D. Documentation of high-risk patients in targeted population assigned to a care manager evaluated for functional assessments.*	<ul style="list-style-type: none">• Hospital records and/or documentation.

Project 2.5: Implement Process Improvement Methodologies to Improve Safety Quality and Efficiency

Project Goal

The overarching goal of this project is to implement either hospital-wide care management methodologies in a behavioral health hospital or specific process improvement methodologies in an acute care hospital to improve geriatric patient safety, quality, and efficiencies. Hospitals may design customized initiatives based on various care management systems such as Care Logistics™, or utilize evidence-based process improvement methodologies to care for geriatric patients, such as, Nurses Improving Care for Health System Elders (NICHE) tools,

For hospitals implementing new care management models for behavioral health settings, the rationale is clear: To pursue Triple Aim results aggressively requires an intense focus on what happens to patients before and especially post discharge. Anecdotally, behavioral health clinicians have reported numerous instances when they have been unable to make warm hand-offs with community mental health centers to set up timely follow-up psychiatric appointments. There are many access barriers to face in obtaining follow-up care, not the least of which is waiting time for a next available appointment or a patient's failure to show up for the appointment. For discharged behavioral health patients who have comorbidities in high-risk chronic conditions, such as diabetes or asthma, there is another level of difficulty in care transitions: connecting the patient to primary or specialty care medicine. Behavioral health and physical medicine are two sides of the same coin for these complex patients. If either the behavioral health or the physical health condition is poorly managed upon discharge, it is likely that the worsening condition will negatively impact the other condition. If either hypothetical scenario results, it frequently can set up a series of ED visits and eventual hospital admissions, and/or psychiatric or substance abuse inpatient stays. Projects adapting the Care Logistics™ patient-centered, care coordination model involves managing the simultaneous logistics of a patient moving through the entire hospital. It may be used to help hospitals transform their operations to improve patient flow, by creating cross departmental hubs and providing actionable data in real-time on key performance indicators, such as, but not limited to, length of stay, patient flow times, discharge process times, re-admission rates, and patient, provider and staff satisfaction.⁶⁰

For hospitals pursuing process improvement initiatives in caring for geriatric patients, the rationale is also clear: Geriatric patients are not one sub-group of patients but rather a core component of health care in this country today, representing the majority of primary and home care visits, hospital admissions, and long-term care residents. Recent Census Bureau projections show that the rapid growth rate of those over 65 will not begin to decrease until after 2040. Hospitals may design a process improvement initiative utilizing the NICHE program framework, which aims to facilitate the infusion of evidence-based geriatric best practices throughout institutions to improve nursing care for older adult patients. NICHE is based on the use of principles and tools to support a systemic change in nursing practice and in the culture of healthcare facilities to achieve patient-centered care.⁶¹ Projects may include front-line health care employees as well as direct care providers engaged in education and improvement projects to continually address the health needs of elderly patients, specifically around delirium and ambulation. An enhanced focus on continual learning will allow provider to quickly address any need for improvement, complement efforts to provide seamless and value-based care for the geriatric population, improve overall patient satisfaction and care quality and enable facilities to achieve systematic nursing change that will benefit hospitalized older adults.

⁶⁰ <http://www.carelogistics.com/>

⁶¹ <http://www.nicheprogram.org/>

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Develop training modules on evidence-based tools, process improvement methods and assessment tools for improving geriatric patient care in the hospital.		X
B. Establish utilization rate baselines for evidence-based process improvement methodologies.		X
C. Monitoring utilization rates for evidence-based process improvement methodologies.		X
D. Provide training and education to hospital leadership, clinical and administrative staff on hospital-wide care management models for improving behavioral health patient care or evidence-based process improvement strategies, methodologies, and culture for improving geriatric patient care.		X
E. Define “current state” of care management at the hospital.		X
F. Develop and implement educational communication plans for new, hospital-wide care management models.	X	
G. Define key safety, quality, and efficiency performance indicators and develop a new care management system for continuous data collection, analysis, and dissemination of results.	X	
H. Adopt new care management model in “Operational Go Live.”		X
I. Conduct “gap analyses” between hospitals existing IT system capacities and interfacing requirements of new care management system.	X	
J. “Go Live” with new care management software.		X
K. Implement software to integrate interdepartmental workflows and provide real-time performance feedback and actionable data to improve behavioral health patient care and efficiencies.	X	
L. Develop reports on “lessons learned” in implementing new care management models		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Define or identify current state of care management at the hospital.	1.A. Completion of reports on care management activities	<ul style="list-style-type: none"> • Documentation of report
2. Define operational procedures needed to improve overall efficiencies in care management throughout the hospital.	2.A. Report on operational procedures needed to improve overall efficiencies in care management	<ul style="list-style-type: none"> • Internal hospital records/documentation

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
3. Review Hospital's Clinical Assessment Center staffing model and develop new model that adapts care management principles and design elements.	3.A. Report on New Clinical Assessment Center Staffing and Design	<ul style="list-style-type: none"> Hospital documentation
4. Define key performance indicators for the new care management model.	4.A. Report on new care management indicators	<ul style="list-style-type: none"> Documentation of report

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Implement the new care management system hospital-wide.	1.A. New organizational and technological systems for care management 1.B. Gap analysis of the hospital's information technology system and interfacing capacities with new care management system 1.C. "Report on Operational Go Live" 1.D. "HIT System Configuration Confirmation"	<ul style="list-style-type: none"> Internal hospital documentation HIT system configuration documentation
2. Development of implementation of training modules	2A. Training module(s) created	<ul style="list-style-type: none"> Copy of training document
3. Train specified staff on selected training module for the geriatric patient.	3.A. X% of specified staff trained *	<ul style="list-style-type: none"> Training records
4. Improve utilization of selected tool in EMR	4.A. Establish baseline for tool utilization in EMR 4.B. X% improvement over baseline*	<ul style="list-style-type: none"> Internal records
5. Improve utilization of selected physician order in EMR	5.A. Establish baseline for physician order utilization in EMR 5.B. X% improvement over baseline*	<ul style="list-style-type: none"> Internal records

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
6. Engage hospital leadership team in educational activities, such as seminars and site visits on organizational and technical features of new care management model	6.A. Documentation of educational activities: Site Visit Agenda and Attendance List 6.B. Documentation of educational activities: Seminar Outline and Attendance List 6.C. Presentation on New Care Management System. Staff Attendance at Employee Engagement Education*	<ul style="list-style-type: none">• Hospital documentation
7. Develop educational communication plan for new care coordination models.	7.A. Develop a communication plan for new care coordination model 7.B. Copies of Communication Plan* 7.C. Status Report on Implementing Educational Communication Plan*	<ul style="list-style-type: none">• Hospital documentation
8. Assess “lessons learned”	8.A. Report on “lessons learned”	<ul style="list-style-type: none">• Hospital documentation

Project 2.6: Provide an Alternative Care Setting for Patients who Seek Non-Emergent Department Care

Project Goal

The overarching goal of this project is to provide an alternative care setting for patients with non-emergent complaints who present to the emergency department (ED) for care. This concept will provide patients with a convenient primary care access point for those patients who routinely come to the hospital campus ED for primary care. Two more granular goals include: 1) To pilot with other providers and payers new policies, processes and payment systems to educate and incentivize patients who habitually seek non-emergent care in the ED to utilize new primary care delivery alternatives; and 2) To develop a methodology to measure the financial and health outcomes of ED utilization for frequent non-emergent care, determine the potential cost savings and the potential health benefits with alternate primary care options.

Within this population of non-emergent ED patients, there are at least three, target sub-populations. Each sub-population may require its own alternate delivery model to replace or significantly reduce non-emergent ED utilization. The three sub-populations include: 1) “High-End ED Utilizers or “frequent flyers;” 2) Patients who may frequently call an ambulance or cab to bring them to the ED because they are confused and/or anxious; and 3) Medically fragile homeless persons who are discharged from acute care hospitals back to their homeless or transitional without sufficient care giver support. Project leaders may also identify other significant sub-populations who are habitual, non-emergent ED patients.

The HEU program design will be modeled, in part, on the recent evidence and best practice of working with patients that frequently access a hospital ED in Camden, New Jersey, through the efforts of Dr. Jeffery Brenner and the Camden Coalition of Healthcare Providers.⁶² This project will also look to the promising practice of complex care management being done by Hennepin County’s Coordinated Care Center, in Minnesota, to provide team-based primary care that integrates physical and behavioral health for Medicaid patients with complex health problems. The recipient of the National Association of Essential Hospitals’ Gage Award for Population Health, the Coordinated Care Center reduced ED visits by 37% and inpatient stays by 25%.⁶³ The promising practice of respite care for homeless persons fills the gap in care. In the East Bay Area of California, the John Muir Health System runs the Respite Care Shelter for the Homeless.⁶⁴

⁶² Gawande, A. (2011, January 24). The hot spotters: can we lower medical costs by giving the neediest patients better care? Retrieved from http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande

⁶³ Accessed from: <http://betterhealth.mckesson.com/2013/08/practicing-award-winning-population-health/>

⁶⁴ Accessed from: <https://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-alliance/our-programs/access-care-and-services/respite-care-shelter-for-the-homeless.html>

Project Goal
<p>Through patient education about the alternative site, and creative staffing with independently licensed providers, patients will be encouraged to use primary care providers for non-emergent care rather than the more expensive ED. Despite improvements in primary care access in many communities, patients continue to rely on emergency departments for care that should be provided in a primary care setting. Having a reliable source of primary care alone is not sufficient for these individuals and will not entirely eliminate hospital ED use, however, it remains the most effective health care resource to meet and improve a population’s health.</p> <p>Strong evidence suggests that having a regular source of care produces better health outcomes, reduces disparities, and reduces costs. This initiative will reduce overall costs for the state and allow for all patients to receive better continuity of care and more efficient care.⁶⁵</p>

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Identify the patient subpopulations that utilize the ED for non-emergent complaints.		X
B. Develop new service delivery model(s) to provide accessible, primary care access point for patients who routinely come to the hospital campus ED for primary care.		X
C. Devise a methodology to measure ED utilization and cost savings associated with new service delivery models.	X	
D. Meet with area provider groups to gauge the relative need and feasibility for providing a respite care alternative for medically fragile homeless persons and identify best practice service delivery models, cost factors and benefits.	X	
E. Pilot a respite care delivery model for medically-fragile homeless persons discharged from the hospital.		X
F. Create clinical and/or social service staffing for new care delivery models.	X	
G. Create multidisciplinary hospital workgroups to analyze non-emergent ED use and develop new service delivery models.		X
H. Deliver “progress reports” and “lessons learned reports” on implementing new service delivery models and their respective impacts on costs and quality outcomes.		X
I. Conduct “gap analyses” between current service capacities and relative sizes of high-end utilizer subpopulations.		X

⁶⁵ According to the Commonwealth Fund’s 2006 health Care Quality Survey, health care settings with a medical home component that offer a patient a regular source of care, enhanced access to physicians, and timely, well-organized care, have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities.

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Source(s)</u>
1. Meet with area provider groups to gauge the relative need and feasibility for providing a respite care alternative for medically fragile homeless persons and identify best practice service delivery models, cost factors and benefits	1.A. Report on need for respite care alternative: Report on the need for respite care delivery for medically-fragile homeless persons and service delivery options 1.B. Report on need for respite care alternative: Progress report and recommendation on respite care delivery in the community	<ul style="list-style-type: none"> • Hospital documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Source(s)</u>
1. Analyze hospital non-emergent ED utilization by patient demographics, diagnose type, payer source, utilization, costs and impacts on ED patient flow and provide guidance to alternate care options.	1.A. Identify target sub-populations of ED high utilizers 1.B. Report on hospital's ED non-emergent care	<ul style="list-style-type: none"> • Hospital documentation
2. Assemble hospital workgroup to analyze non-emergent ED utilization	2.A. List of "Non-Emergent ED Utilization Workgroup" Participants	<ul style="list-style-type: none"> • Hospital documentation
3. Conduct gap analysis for ED's current non-emergent high-end utilizer (HEU) patient sub population	3.A. Gap analysis report on ED high utilizers	<ul style="list-style-type: none"> • Hospital documentation
4. Design and implement a process to educate high-end utilizer patients without PCPs about the benefits of primary care and scheduling PCP appointments before they leave the ER.	4.A. Report on numbers of high utilizers educated and number of PCP appointments made	<ul style="list-style-type: none"> • Hospital documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
5. Devise system for identifying hospital inpatients who are homeless and cannot be discharged to emergency shelter.	5.A. Hospital care management policies and procedures for identifying hospital inpatients who are homeless and require care transitions.*	<ul style="list-style-type: none"> Hospital documentation
6. Assess lessons learned in developing alternate care delivery models to health system leaders	6.A. Report on lessons learned in developing alternate care delivery models	<ul style="list-style-type: none"> Hospital documentation
7. Pilot respite care delivery model for medically-fragile homeless persons discharged from hospital.	7.A. Report on target achievement of percentage of respite patients who receive discharge consultation*	<ul style="list-style-type: none"> Hospital documentation
8. Develop plan to deploy staff to work as liaisons with respite care providers	8.A. Establish baseline and improvement target for percentage of respite patients who receive discharge consultation.*	<ul style="list-style-type: none"> Hospital documentation
9. Develop and implement casework and educational plan for ED high-end utilizer patients	9.A. Detail on high utilizer services. 9.B. Plan for case management for ED high-end utilizers 9.C. Staffing schedule for providing case management to hospital ED's high-end utilizer patients.* 9.D. Report on baseline number of high utilizers to be educated and have PCP appointments scheduled 9.E. Report on case management services.*	<ul style="list-style-type: none"> Hospital documentation

Project 2.7: Reduce Variations in Care for Patients with High Risk Conditions

Project Goal

Develop and/or implement evidence-based clinical care pathways or guidelines to reduce variations in care, improve health outcomes, and engage patients in disease management. Effective care management requires the standard implementation of clinical best practices as well as patient understanding and engagement in care. For conditions such as congestive heart failure or pneumonia, non-uniform care and poor communication places patients at high risk for readmission and subsequent complications. This project will implement a standard set of “best practices” or guidelines for conditions with high risk of complication and/or readmission. Additionally, this project may implement a standard set of “best practices” or guidelines based on their clinical relevance to the care of disadvantaged populations. Care pathways may span the continuum of care from inpatient to outpatient, post-acute care, home care and other settings. Pathways will not only reduce variations in care within the hospital, but ensure smooth handoffs between hospital departments and from the hospital to post-acute care.

These projects may include adoption of evidence-based guidelines, such as “Choosing Wisely”, an initiative of the American Board of Internal Medicine, in collaboration with other major medical specialty societies, for appropriate use of testing and medications. Through “Choosing Wisely”, each participating specialty has created lists of “Things Physicians and Patients Should Question” that provide specific guidance regarding testing and treatment for a wide variety of conditions.

Potential Project Elements	Structural	Process
<i>DSTI hospitals undertaking this project may select from among the following project elements:</i>		
A. Identify one or more diagnoses at high risk for readmission, complications, co-morbidities, and/or variations in care.	X	
B. Review and select evidence-based clinical “best practices,” pathways, or guidelines.	X	
C. Develop supporting educational materials for evidenced based guidelines.	X	
D. Implement selected evidence-based guidelines into Electronic Medical Record.		X
E. Define standards for expected duration of stay and use of tests and treatments.	X	
F. Implement evidence-based standardized clinical care pathways targeting selected high-risk condition(s)		
G. Monitor use of specific evidence-based guidelines, framework, or pathway with appropriate patients in care.		X
H. Examine care team roles to ensure most efficient and appropriate allocation of responsibility.	X	
I. Address patient satisfaction by educating patients and their families about the plan of care and involving them more fully in its implementation.		X
J. Identify “lessons learned,” adopt refinements to clinical pathway, including special considerations for safety net patient populations.		X
K. Create a Diabetes Advisory Board to design and develop a Diabetes program that will be shared across the continuum.	X	

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
L. Incorporate Diabetes self-management Education tools that meet the national standards for Diabetes education, in both English and Spanish that teach healthy behaviors for patients.		X
M. Hardwire diabetes screenings at PCP visits at affiliate PCP offices and non-affiliated PCP offices in order to initiate preventive treatment/education and monitoring.		X
N. Develop and share individual treatment and self management education plans for specific chronic diseases.		X
O. Improve transitions of care for the complex diabetic patient population.		X
P. Use an electronic chronic disease registry to manage the Diabetic patient 70 years old and younger, by tracking data pertinent to the prevention and control of their chronic disease.		X
Q. Address key areas for the identified diabetic patient younger than 70 years old in all healthcare settings (e.g. healthy behaviors, quality of life, self management goals, smoking status and readiness to quit).		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Identify evidence-based frameworks or guidelines that support improved care transitions and health care outcomes. If necessary, customize guidelines for safety net population.	1.A. Selection of an evidence based framework 1.B. List of potential Choosing Wisely guidelines for implementation and rationale for selection	<ul style="list-style-type: none"> Care management and transitions protocol documentation Internal hospital records/documentation
2. Develop evidence-based care pathways.	2.A. Care pathway	<ul style="list-style-type: none"> Documentation
3. Develop supporting educational materials for newly selected evidenced based guidelines.	3.A. Educational materials	<ul style="list-style-type: none"> Internal hospital records/documentation
4. Establish a Diabetes Advisory Council to coordinate and develop a Diabetes Care Program across the continuum.	4.A. Documentation of regular Council meetings until program is sustained.	<ul style="list-style-type: none"> Minutes and attendance list of meetings

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Design and build selected number of evidence-based guidelines into electronic medical record. Additional evidence-based guidelines may be implemented by hospitals in subsequent years.	1.A. Design document and implementation sign-off for newly selected guidelines.	<ul style="list-style-type: none"> Internal hospital records/documentation
2. Use specific evidence based guidelines, framework, or pathway with appropriate patients in care.	2.A. Percentage of patients managed according to specified guideline 2.B. Percentage utilization of care pathway	<ul style="list-style-type: none"> Internal hospital records/documentation
3. Track identified patients in registry for 30 days for: 1) ER visits and 2) admissions for hyper or hypoglycemia to obtain a baseline	3.A. Percent of patients in the log who are readmitted or seen in the ER <30days of last discharge each month. 3.B. Track patients seen in ED for hypo and hyperglycemia each month.	<ul style="list-style-type: none"> Internal hospital records/documentation
4. Enter names of identified, admitted patients with a medical history of Diabetes ≤70 years old into a registry for tracking and follow up purposes.	4.A. Number of patients <70 years old admitted each month with a medical history of Diabetes entered into a registry.	<ul style="list-style-type: none"> EHR; Manual registry until electronic is available.
5. Provide training to hospital staff on best practices on managing and preventing Diabetes in the hospital	5.A. Establishment of training programs developed and conducted by clinicians. i.e. Pharmacists, Diabetic Educators, Endocrinologist	<ul style="list-style-type: none"> List of programs and dates; attendance
6. Develop patient friendly self-management educational tools that will promote self care health management using best practices to be shared across the continuum as approved by the Diabetes Advisory Council.	6.A. Calendars for recording blood sugars, patient designed treatment plans, evaluation tools, healthy eating and exercise plans will be taught to patients using Teach Back; vouchers for Farmers' Market and exercise programs in the community.	<ul style="list-style-type: none"> Copies of tools, vouchers and educational materials and receipts from other facilities where materials are shared.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
7. Identify diabetic patients in the registry who have a second chronic disease such as COPD/CHF/Depression as they are at higher risk and considered complex	7.A. Number of patients admitted each month with diabetes who are considered complex	<ul style="list-style-type: none"> Internal hospital records/documentation
8. Assign navigator to assist complex diabetic patients with developing a treatment plan	8.A. Number of complex diabetic patients who have a treatment plan* 8.B. Number of complex Diabetics who have achieved one goal.*	<ul style="list-style-type: none"> Internal hospital records/documentation
9. Develop a referral process to the Transitions team /Navigator for complex patients seen in the ED with hyper and hypoglycemia	9.A. Document implementation of work flow process and identification of complex patients process in the ED	<ul style="list-style-type: none"> Internal hospital records/documentation
10. Refer patients seen in the ED with Hypoglycemia and Hyperglycemia to a “Transitions Team” after being identified as complex.	10.A. Number of complex diabetic patients seen in the ED referred to the Transitions Team for follow up and development of a self designed treatment plan with goals documented*	<ul style="list-style-type: none"> Internal hospital records/documentation
11. Develop referral protocols via the Diabetes Advisory Council to use in primary care practices and hospital when a patient’s HgbA1c result is ≥ 6.5 , BP >130/80 and LDL >100 or they suffer from depression.	11.A. Protocols for PCP office and hospital protocols. 11.B. Track diabetic patients 18-75 years from PCP site who received depression screening 11.C. Report the number and/or percentage of discharged complex patients who were screened for depression at follow-up appointment.	<ul style="list-style-type: none"> Copies of protocols Internal hospital records/documentation
12. Ensure diabetic patients from primary care practices identified in Chronic Disease Registry have documented self-management goals.	12.A. Number of all Diabetic patients in the registry with documented self-management goals.* 12.B. Number of complex diabetic patients who have updated care plans.	<ul style="list-style-type: none"> Chronic Disease Registry and IHI Measurement Tool documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
13. Review of care/treatment plan with diabetic patients every 3 months by primary care provider and/or navigator to evaluate if patient is meeting self-designed goals.	13.A. Number of primary care providers and/or navigators who are participating in diabetes care management 13.B. Track number of complex diabetic patients who have an updated care plan/treatment plan.*	<ul style="list-style-type: none">• Primary care practice documentation
14. Call diabetic patients in the chronic disease registry who are discharged from the ER or inpatient within 48-72 hours to review discharge plan and request “teach back” of a lifestyle change.	14.A. Percentage of the patients in the Diabetes log discharged each month contacted for discharge plan review and teach back of one lifestyle change.*	<ul style="list-style-type: none">• Internal hospital records/documentation
15. Provide diabetic patients will a follow up appointment prior to leaving the hospital if admitted for hypo or hyperglycemia.	15.A. Number of patients who are scheduled for a follow up appointment before discharge.	<ul style="list-style-type: none">• PCP records• Internal hospital records/documentation
16. Provided admitted diabetic patient who are identified as tobacco users will receive counseling by a Smoking Cessation Counselor prior to discharge.	16.A Number of diabetic users who receive counseling by a Smoking Cessation Counselor*	<ul style="list-style-type: none">• EHR and internal hospital records/documentation

Project 2.8: Clinical Pharmacy Program to Transform Medication Safety and Quality

Project Goal

The goal of projects under this heading is intended to improve the overall process of medication management and increase safety and quality of care for patients. Evidence-based literature suggests that medication errors leading to adverse drug events are associated with increased morbidity and mortality, prolonged hospitalizations, and higher costs of care (approximately \$2,000-\$4,000 per preventable adverse drug event)⁶⁶. Adverse drug events comprise the largest single category of poor outcomes experienced by hospitalized patients (19% of all injuries) that can lead to increased unplanned readmissions.⁶⁷

Proper medication reconciliation is frequently cited as the most influential factor contributing to success of a care transition. Greater than forty percent of medication errors occur due to insufficient reconciliation during transitions, and fifty-nine percent of them are potentially harmful to the patient⁶⁸. Key characteristics of successful medication reconciliation include: 1) clear policies and procedures among the organization in updating, displaying, and providing the list to patients, facilities, and in-house; 2) defined, periodic reconciliations; 3) obtaining information in accordance with 6 medication rights; 4) identifying over-the-counter medications; and 5) adequate staff training in prompting information from patients⁶⁹. Additionally, sixty-seven percent of patients admitted to the hospital have unintended discrepancies that follow the patient through hospitalization and are still present at discharge⁷⁰.

Many approaches led by various disciplines have been implemented nationally to improve medication management. A pharmacy-led process has been found to significantly decrease medication-related readmissions and the number of inappropriately prescribed medications at hospital discharge, and the number of missed doses during hospital stays has been reduced⁷¹. This project envisions a clinical pharmacy team will work together to increase the likelihood of identification of and recommendations for medication discrepancies during the reconciliation process. The clinical pharmacy team's goal throughout a patient's hospitalization will be to reduce poly-pharmacy and potentially inappropriate medications for older adults who are especially at risk due to the complex nature of their health status and therapeutic disease management regimens. Projects under this heading will seek to improve medication access which contributes to readmissions, particularly for low-income patients and will focus on reducing the need for prior authorization for insurance coverage of discharge medications.

⁶⁶ Bates DW, Spell N, Cullen DJ, et al. The costs of adverse drug events in hospitalized patients. Adverse Drug Events Prevention Study Group. JAMA. 1997; 277(4):307-11

⁶⁷ Institute of Medicine of the National Academies. Preventing Medication Errors: Quality Chasm Series. 2006. <http://iom.edu/Reports/2006/Preventing-Medication-Errors-Quality-Chasm-Series.aspx>.

⁶⁸ Agency for Healthcare Research and Quality. 2008. Medication reconciliation. *Patient safety and quality: An evidence-based handbook for nurses*

⁶⁹ World Health Organization. 2007. *Assuring medication accuracy at transitions in care*. <http://www.cforpatientsafety.org/common/pdfs/fpdf/presskit/PS-Solution6.pdf>

⁷⁰ Medication reconciliation during transitions of care as a patient safety strategy. 2013. *Annals of Internal Medicine*

⁷¹ Implementation of a pharmacy technician-centered medication reconciliation program at an urban teaching medical center. 2014. *American Journal of Health-System Pharmacy*

Timely completion of prior authorizations is an arduous process for prescribers and healthcare staff, which currently requires navigating the insurance companies' process with numerous phone calls, faxes, and hard-copy request forms. In an effort to mitigate medication access barriers, the clinical pharmacy team will develop a process to ensure patients have authorization for medications prior to discharge. In summary, the clinical pharmacy program will optimize medication access and administration to ensure safety and quality at each step of the patient's journey through the hospital.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Develop a clinical pharmacy team to ensure medication history is comprehensive and accurate for hospitalized patients.	X	
B. Ensure medication history is comprehensive and accurate for hospitalized patients		X
C. Design and achieve a comprehensive and culturally-appropriate integrated medication management program.	X	
D. Develop medication intervention registry to track recommendations made to physicians.	X	
E. Utilize medication intervention registry in order to reduce polypharmacy.		X
F. Evaluate and enhance the hospital pharmacy formulary to ensure enhanced patient access to medications.		X
G. Create a medication safety and quality dashboard.	X	

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Ensure medication history is comprehensive and accurate for hospitalized patients on selected unit	1.A. Utilize Medication Reconciliation Pharmacy Technician(s) for transitioning patients admitted from the emergency room to a selected unit	<ul style="list-style-type: none"> • Job Description
2. Design a comprehensive and culturally-appropriate integrated medication management program	2.A. Determine the elements of a comprehensive and culturally-appropriate integrated medication management program based on evidence of best practices (e.g. workflows, team-based medication reconciliation, medication access). 2.B. Develop and utilize a medication intervention	<ul style="list-style-type: none"> • Clinical pharmacy team report • Report on medication intervention registry for reducing polypharmacy

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	registry to track recommendations made to physicians on reducing polypharmacy for inpatient older adults on the selected unit	
3. Implement and achieve a comprehensive and culturally-appropriate integrated medication management program	3.A. Implement X element(s) identified for creating a comprehensive and culturally-appropriate integrated medication management program 3.B. Implement at least one additional element identified for creating a comprehensive and culturally-appropriate integrated medication management program	<ul style="list-style-type: none"> • Report on implementation
4. Implement organizational transparency in medication safety reporting and quality	4.A. Create medication safety and quality dashboard that includes baseline of medication errors	<ul style="list-style-type: none"> • Dashboard reporting baseline medication errors
5. Ensure patient medication access and insurance coverage	5.A. Develop and implement a standardized process to obtain medication authorization prior to discharge for patients on the selected unit	<ul style="list-style-type: none"> • Documented team plan and process map
6. Evaluate effectiveness and performance of the Clinical Pharmacy Program interventions	6.A. Report on the clinical pharmacy program progress regarding medication safety and quality.	<ul style="list-style-type: none"> • Report on data, interventions, and outcomes

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Ensure medication history is comprehensive and accurate for hospitalized patients on selected unit.	1.A. Establish baseline percentage of patients who have a documented medication history in the electronic medical record by the clinical pharmacy team	<ul style="list-style-type: none"> • Report on baseline metric • Report on improvement results

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	upon admission to the selected unit. 1.B. Increase the percentage of patients on the selected unit who have a documented medication history in the electronic medical record by the clinical pharmacy team upon admission to the selected unit*	
2. Design a comprehensive and culturally-appropriate integrated medication management program	2.A. Establish baseline percentage of patients within the hospital's target population with high risk medication utilization. 2.B. Decrease the percentage of patients within the hospital's target population with high risk medication utilization*	<ul style="list-style-type: none"> • Report on baseline metric • Report with improvement results
3. Advance medication history to facilitate a comprehensive and accurate medication reconciliation process throughout the transitions of care	3.A. Establish baseline percentage of patients on the selected unit who have had medications managed by the clinical pharmacy team prior to discharge	<ul style="list-style-type: none"> • Report on baseline metric
4. Analyze hospital pharmacy formulary to evaluate patient medication access	4.A. Analyze MassHealth coverage and access to medications included in the current hospital pharmacy formulary	<ul style="list-style-type: none"> • Gap analysis of MassHealth pharmacy formulary
5. Expand interdisciplinary medication history and reconciliation	5.A. Develop and utilize a medication intervention registry to track all recommendations made to physicians regarding high risk medications to avoid potentially inappropriate medications (PIMs) for inpatient older adults on the selected unit	<ul style="list-style-type: none"> • Report on medication intervention registry for PIMs
6. Evaluate hospital pharmacy formulary to ensure patient medication access	6.A. Analyze data on the percentage of medications in hospital pharmacy	<ul style="list-style-type: none"> • Report on data analysis

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	formulary requiring a prior authorization for discharge medications	
7. Expand interdisciplinary medication history and reconciliation	7.A. Increase the percentage of patients on the selected unit who have had medications managed by the clinical pharmacy team prior to discharge*	<ul style="list-style-type: none">• Report with improvement results

Project 2.9 Medication Safety at Transitions of Care

Project Goal

This project aims to improve the quality of care and safety of patients. Multiple errors of various types are noted at discharge on a patient's medication list. It is imperative that the discharge team is certain of the correct medication list that the patient was admitted on as it is entered in the emergency department and kept up-to-date with any changes at transition points within the hospital. It is also crucial that the discharge medication process is uniformly performed and that patients are made aware of any medications that may have been discontinued, any doses that have been changed or any substitutions that may have been used because they are on the hospital formulary. Proper medication reconciliation at each point of transition can significantly reduce the number of medication errors, many which cause a patient serious harm. Many patients fail to fill new prescriptions, renew prescriptions or discontinue prescriptions that may be duplicated at discharge. Wrong dose, wrong medication, poly pharmacy, and high-risk medications can all contribute to falls, adverse effects and side-effects and ultimately another hospital admission. As a high risk patient is discharged home, and in that next vital week after the discharge, the Pharmacist and team will use their expertise to address potentially inappropriate medications, duplicate therapies, dosage changes, medications requiring prior authorization and reduce poly pharmacy through recommendations to the patient's provider. Effective medication reconciliation requires accurate and complete information collection, a standardized process for information hand-offs, and a multidisciplinary approach. When done right, medication reconciliation can be a cost-effective tool to reduce costs and improve patient care. For example, in a 2012 study of 563 patients admitted to Johns Hopkins Hospital, a collaborative nurse-Pharmacist medication reconciliation effort, which included pharmacist review and identification of medication discrepancies, dramatically and cost-effectively decreased the risk of Adverse Drug Affects (ADEs). The researchers found that, at a cost of \$113.64 per potentially harmful discrepancy, the program would need to prevent one ADE per 290 patients to offset costs. In fact, the program prevented 81 potentially harmful ADEs per 290 patients.

Potential Project Elements	Structural	Process
<i>DSTI hospitals undertaking this project may select from among the following project elements:</i>		
A. Improve the quality of care and safety of patients by reducing or eliminating the various types of medication errors during discharge during review of a patient's medication list		X
B. Establish a Standard Process for discharge medication reconciliation.	X	
C. Develop system to formally address potentially inappropriate medications, duplicate therapies, dosage changes, medications requiring prior authorization and reduce poly pharmacy through recommendations to the patient's provider.	X	
D. Review best practices from a range of models (e.g. AHRQ, IHI)	X	
E. Develop and sustain a cross-continuum team comprised of clinical and administrative representatives.	X	
F. Implement one or more intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of: <ol style="list-style-type: none"> 1. Discharge checklists 2. Patient care transition processes between hospital and other 		x

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
post-acute providers, and “hand off” communication plans and/or “closed-loop communications” with receiving providers which may include post-acute care facilities and/or visiting nurse agency (VNA)/home health, and/or primary care providers 3. Wellness initiatives targeting at-risk patient populations or those with specific chronic health conditions 4. Patient and family education initiatives including patient self-management skills and “teach-back”		
G. Execute post-discharge medication planning.		X
H. Establish formal communication pathways with primary care providers.		X
I. Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce medication errors.	X	
J. Redesign patient hospital discharge process and transfer of care documentation which may include input from patient and family representatives and input from post-acute providers.	X	
K. Develop and implement a hospital care delivery system for the elderly population.		X
L. Develop plan for appropriate follow-up care between hospital and selected community providers for adult inpatients	X	
M. Redesign hospital care management department to a care transitions focus.	X	
N. Evaluate the intervention(s) impact on readmissions and patient care and identify “lessons learned,” which may include opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations, or evaluate intervention processes, using quantitative and qualitative data to collect from providers, complex patients and family members, and the health system.		X
O. Educate clinicians, staff, and/or community partners on care transitions improvement initiatives.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Establish standard process for discharge medication reconciliation	1.A. Documentation of standard process and work flow for performing medication reconciliation within 7 days of the patient’s discharge to home (e.g.,	<ul style="list-style-type: none"> Internal hospital records/documentation

Key Structural Measures		
<i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
	medication reconciliation pathway).	
2. Hire or appoint and train additional pharmacy support to assist in the medication reconciliation process at points of care transition	2.A. Documentation of hire or transfer of pharmacy support staff	<ul style="list-style-type: none"> • Internal hospital records/documentation
3. Implement an education program for providers and clinical staff on principles and structures for comprehensive medication reconciliation	3.A. Education program principles and structures for comprehensive medication reconciliation 3.B. Documentation of provider and clinical staff training on principles and structures for comprehensive medication reconciliation	<ul style="list-style-type: none"> • Internal hospital records/documents. Copy of program's principles and structures • Internal hospital records/documentation. Competency sheets or sign-in sheets for training session(s)

Key Process Measures		
<i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Review medications for patients in target population within 7 days of discharge from hospital to home and establish a baseline percentage of patients discharged with medication errors.	1.A. Report documenting patients in first population discharged from hospital to home with medication errors. 1.B. Report documenting patients in second population discharged from hospital to home with medication errors. 1.C. Report documenting patients in third population discharged from hospital to home with medication errors.	<ul style="list-style-type: none"> • EMR, Data Warehouse, Practice Management System
2. Sustain or advance improvements over baselines established of patients in target population(s); performing a medication reconciliation for patients within 7 days of discharge from hospital to home	2.A. Report gap to goal (X percent) improvement methodology over baseline with a hospital-defined target of X percent or attainment at target for first population patients discharged.*	<ul style="list-style-type: none"> • EMR, Data warehouse, Practice Management System

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	2.B. Report gap to goal (X percent) improvement methodology over baseline with a hospital-defined target of X percent or attainment at target for second population patients discharged.* 2.C. Report gap to goal (X percent) improvement methodology over baseline with a hospital-defined target of X percent or attainment at target for third population patients discharged.*	

29. Category 3: Ability to Respond to Statewide Transformation to Value-Based Purchasing and to Accept Alternatives to Fee-For-Service Payments that Promote System Sustainability.

The projects identified under Category 3 include an array of initiatives to build safety net hospital capacity and core building blocks essential to preparations for payment reform and alternative payment models. Evidence-based and industry best practices indicate a range of building blocks are integral to a successful transition, especially for safety net hospital patient populations. The following menu of projects are recognized by leading industry and policy groups as key elements in preparation for payment reform and the ability to accept alternative payment models.^{72 73}

Examples include:

- i. Enhancement of performance improvement and reporting capabilities
- ii. Development of enhanced infrastructure and operating and systems capabilities that would support new integrated care networks and alternative payment models to manage within new delivery and payment models
- iii. Development of risk stratification functionalities

Introduction

Massachusetts, building on its health care coverage expansion, is now moving toward payment reforms that focus on alternatives to fee-for-service payments and that align with population health, wellness, and models that foster greater accountability and value in the health care system. Massachusetts' safety net hospitals aspire to the Triple Aim goals of improving the health of populations, improving the experience of care, and health care cost effectiveness. While each of the hospitals has a unique starting place and community context for the work ahead, all of the participating hospitals seek to increase their capacities to participate in alternative payment arrangements that foster the Triple Aim goals.

The Massachusetts Special Commission on the Health Care Payment System recommended a move toward global payment frameworks and models of health care delivery that encourage the clinical and financial accountability of networks of providers for the coordinated care of patient populations.⁷⁴ The journey toward new payment reform models necessarily requires a transformed health care delivery system to develop the capabilities to take on these new types of responsibilities – some of which have previously been vested in payers and other aspects are novel.

Safety net hospitals have unique challenges and opportunities in preparing for reform, including constraints in financial resources, limited commercial insurance populations, and high concentration of Medicaid and low-income patient populations that present a set of unique characteristics, including multiple chronic health conditions.

⁷² Fisher E, McClellan M, et al. "Accountable Care Organization Learning Network Toolkit." *Engelberg Center for Health Care Reform / The Dartmouth Institute and The Brookings Institution*. Jan. 2011.

⁷³ Moore K, Coddington D. "The Work Ahead: Activities and Costs to Develop An Accountable Care Organization." *American Hospital Association and McMannis Consulting* 2011.

⁷⁴ "Recommendations of the Massachusetts Special Commission on the Health Care Payment System." *Massachusetts Special Commission on the Health Care Payment System*. July 16, 2009.

Safety net hospitals and health systems need to develop a set of core capabilities to transform health care delivery in the context of new payment reform models and the highly concentrated government payer populations they serve. New models have the potential to overcome existing gaps in care delivery by moving clinical care management activities to the point of care and aligning incentives more effectively at the provider level. To meet these goals, safety net hospitals and systems must organize with: (1) a clear mission; (2) a set of core capabilities; (3) collaborative relationships across their communities, providers, and payers; and (4) strong executive and provider leadership.⁷⁵ There is an opportunity to develop and begin to implement a range of models in different Massachusetts safety net hospital delivery system contexts. New accountable care models require hospitals and providers to consider organizational, governance and operational requirements to operate in new payment paradigms, enhance performance measurement and data and health care analytics, and transform health care delivery to ultimately achieve better health and high-value health care.⁷⁶ A recent case study identified 23 activity areas in 4 domains (network development and management; care coordination, quality improvement and utilization management; clinical information systems; and data analytics) important in the development of accountable care or other organizational models that seek to manage the health of a defined population and accept performance-based reimbursement.⁷⁷

For Medicaid and low-income populations, new delivery system models require a strong foundation in patient-centered, team-based care to manage patients across a continuum of medical, behavioral, and social services. Targeted and intensive complex care management is needed to identify, outreach to, and tailor care management to a subset of the high-need, high-cost patients. Robust data systems and analysis skills, including risk stratification, business intelligence and clinical decision support and reporting, are required to translate clinical and claims-based information into care management activities.⁷⁸

The Category 3 DSTI projects reflect a customized set of initiatives for the eligible Massachusetts safety net hospitals to develop core capabilities to prepare for alternative payment models and strategies to be successful in this new environment.

The eligible safety net systems may select from among the following projects, as specified, for inclusion in their Category 3 DSTI plans.

⁷⁵ McGinnis, T. and Small, D. "Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design." *Center for Health Care Strategies*. Policy Brief (Feb. 2012) pages 1-2.

⁷⁶ Fisher E, McClellan M, et al. "Accountable Care Organization Learning Network Toolkit." *Engelberg Center for Health Care Reform | The Dartmouth Institute and The Brookings Institution*. Jan. 2011.

⁷⁷ Moore K, Coddington D. "The Work Ahead: Activities and Costs to Develop An Accountable Care Organization." *American Hospital Association and McMannis Consulting*. 2011.

⁷⁸ McGinnis, T. and Small, D. "Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design," *Center for Health Care Strategies*. Policy Brief (Feb. 2012) page 2.

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Project 3.1 Develop Risk Stratification Capabilities for Patient Populations and Alternative Payment Models

Project Goal

As a core part of preparations toward accepting alternative payment methods and improving quality and coordination of patient care, hospitals need to develop the capabilities for risk stratification, risk adjustment, and/or the development of comprehensive diagnostic patient profiles. These capabilities are essential tools to support effective strategies to improve the care, outcomes, and cost-effectiveness of care for high-risk patients and/or patients with specific chronic conditions by collecting and disseminating accurate patient data and stratifying by health risk indicators and utilization indicators. Hospitals plan to develop the capability to target high-risk patients by collecting accurate patient data and stratifying the patient population by health risk indicators and utilization indicators. The development of risk stratification capabilities has been identified by health care experts and learning collaboratives, such as the American Hospital Association and Brookings-Dartmouth, as integral to accepting alternative payment models and impacting the Triple Aim goals.^{79 80}

Risk stratification means arranging patients according to the severity of their illness, utilization, costs, and/or other factors that classify patients according to risk profiles. Implicit in this definition is the ability to predict outcomes from a given intervention based on preexisting illness or the severity of intervention. The usefulness of any risk stratification system arises from how the system links severity to a specific outcome.⁸¹

Through these projects, hospital system will acquire a better understanding of the chronic conditions, risk, and utilization profile of their patient population. This process may include sharing data between the hospital system and insurers to better understand the health risk indicators, utilization trends and patterns, and costs of the shared patients. The hospital system may utilize patient profiling and/or risk stratification for determining the most prevalent chronic conditions and/or the top highest risk, highest cost patients. These risk stratification tools will allow the hospital system to assign patients to care management and/or design interventions to better coordinate care, to improve health, and contain cost. In developing these capabilities, the safety net hospital system will be positioned to better manage utilization and population health under alternative payment methodologies, and advance the Triple Aim goals.

Potential Project Elements	Structural	Process
<i>DSTI hospitals undertaking this project may select from among the following project elements.</i>		
A. Develop risk stratification criterion that may be payer population-specific, to better identify high- risk patients or patients that would benefit from care management, disease management and other special programs.	X	
B. Develop capabilities to work with risk stratification information to identify high-risk patients.	X	

⁷⁹ Fisher E, McClellan M, et al. "Accountable Care Organization Learning Network Toolkit." *Engelberg Center for Health Care Reform / The Dartmouth Institute and The Brookings Institution*. Jan. 2011.

⁸⁰ Moore K, Coddington D. "The Work Ahead: Activities and Costs to Develop An Accountable Care Organization." *American Hospital Association and McMannis Consulting*. 2011.

⁸¹ Ferraris V, Ferraris S. "Risk Stratification and Comorbidity: Historical Perspectives and the Purpose of Outcome Assessment: Nightingale Codman, and Cochrane." *Cardiac Surgery in the Adult 3rd Edition* (2003) p.187-224.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements.</i>	Structural	Process
C. Conduct risk stratification for patients with the health risk and utilization indicators and/or targeted chronic conditions.		X
D. Apply the risk stratification methodology, utilize risk scores for the patients, and assign associated patients to the appropriate medical home, primary care based care management, centralized care management, or disease management program.		X
E. Expand risk stratification capabilities from an initial insurer population to one or more additional insurer populations.		X
F. Develop organizational plan to improve accuracy in hierarchical condition categories (HCC) data submissions to accurately reflect the health status of a patient population.	X	
G. Deploy hospital resources to improve the quality and accuracy of patient records.		X
H. Develop reports to identify patients that require a scheduled provider visit.	X	
I. Identify patients with chronic conditions requiring management or monitoring and prioritize those with high-cost cases.	X	
J. Develop reporting tools on the prevalence of specific health conditions in the patient populations and to ensure patients with specific conditions receive proper testing and evaluation.	X	
K. Leverage health information technology within the medical practice, including the electronic medical record, electronic discharge summaries, patient registries, and risk stratification tools to integrate care between the acute and ambulatory settings.		X
L. Improve communication between the primary care practice and high-risk patients and their families after discharge through telephone calls and rapid access to follow-up appointments with the patient's primary care physician		X
M. Identify the economic, social and behavioral determinants of readmission for each patient upon discharge to provide targeted outpatient interventions mitigating these risk factors that may prevent access to care in the ambulatory environment		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Based on information generated from readmission and risk stratification reporting, determine multi-faceted approach to intervention on patients identified as high and medium risk	1.A. Develop process for conducting structured alternative clinical encounters by MD/NP within 2 business days of discharge to address transitional care needs such as:	<ul style="list-style-type: none"> Note template for post-discharge alternative clinical encounter. Report showing discharge follow-up visits for high and medium risk patients

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
for readmission	<ul style="list-style-type: none"> • Medication reconciliation • Pending and abnormal test results • Follow-up care • Community services and resources <p>1.B. Establish baseline for high and medium risk target population seen by a primary care provider within seven calendar days of discharge after an unplanned medical admission from hospital</p>	

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Implement a validated risk stratification tool to identify ambulatory patients at risk for admission	<p>1.A. Implement LACE risk stratification tool and practice guidelines that can be utilized for patients receiving outpatient primary care at target practice upon their discharge from hospital</p> <p>1.B. Report on progress on the application of the LACE risk stratification tool for patients receiving outpatient primary care at pilot target practice following discharge from an unplanned medical admission from designated hospital.*</p>	<ul style="list-style-type: none"> • Report showing risk strata for and practice guidelines for target practice patients discharged from designated hospital
2. Engage care team members in root cause analysis for readmissions within target practice	2.A. Train care team members on completion of IHI State Action on Avoidable Rehospitalization (STAAR) tool for understanding the root	<ul style="list-style-type: none"> • Job Breakdown Sheet (JBS) detailing process for completion of IHI STAAR tool by care team • Five sample STAAR tool worksheets including chart review data, interviews, and summary of

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	<p>causes of readmission through chart review and interviews with patient, family members and care team members</p> <p>2.B. Conduct readmission root cause analysis using Massachusetts STAAR methodology for target practice and present recommendations to care team</p>	<p>resulting recommendations</p>
<p>3. Implement outpatient intervention as appropriate based on risk stratification for patients receiving outpatient primary care at target practice.</p>	<p>3.A. Implement structured alternative encounters by MD/NP within two business days of discharge on patients identified as high and medium risk for admission from target practice</p> <p>3.B. Advance # high and medium risk, target practice patients who were seen by a primary care provider within seven calendar days of discharge after an unplanned medical admission from designated hospital*</p> <p>3.C. Report percentage of high and medium risk target practice patients who were seen by a primary care provider within seven calendar days of discharge after an unplanned medical admission from hospital.*</p>	<ul style="list-style-type: none"> • Report showing alternative clinical encounters performed post-discharge from target practice • Report showing discharge follow up visits for high and medium risk patients

Project 3.2: Design and Implement a Hospital-Based 360 Degree Patient Care Program

Project Goal

The goal of this project is to Build on a successful 360° Patient Care Management Program for seniors and commercial managed care patients to create an integrated program specifically designed for a very different clientele with different needs. In this project, we distinguish two patient populations: Population A, the at-risk Medicaid population and Population B, Managed Medicare patients, the population that we worked with to aggressively manage care and total medical expense in the Waiver 1.0 project. We anticipate that with the addition of Population A we reach approximately another 4000 patients with the goal of improving population health.

Building on Demonstration Years 15 – 17, we will design and implement an innovative, comprehensive program to identify and manage the most seriously ill members of a defined populations, on the theory that “paying the best and brightest physicians to care for the sickest patients as simply and effectively as humanly possible”⁸² will yield the best medical and psychosocial patient outcomes, yet decrease overall costs of care by eliminating that which is neither necessary nor desirable. While some of the lessons-learned from our experience with the 360 Patient Care Management Program may be able to be applied to the Medicaid population, Medicaid patients have unique challenges compared to commercial and Medicare plan members. These include the weight of disease burden, cultural and language differences, in some cases difficult social and environmental circumstances, the lack of a culture of continuity of medical care, and heavier use of emergency department facilities. While we understand what led to success with a different population, we are not sure those strategies will be successful in the new population of patients. We do not want to short-change the new population by not completely assessing its circumstances, needs, and barriers to improving health. While using the core premises of the existing 360° Patient Care Management team, this project will entail the rapid recruitment of an additional physician or midlevel practitioner as well as construction of a much more robust support team of patient Care Manager, case/disease management nurses, care coordinator, and primary physicians. A, highly sophisticated managed care team, involving clinical and administrative team members, will be dedicated to working with the most severely ill members of the defined populations to enhance the care experience and ensure optimal care planning, coordination and integration. This hybrid of 360-degree Patient Care program and the patient-centered medical home⁸³, taking the best attributes of both, will improve the transitions of care for patients who are covered in population risk products and will ultimately improve quality and reduce costs. An integrated, coordinated and well-structured program can improve outcomes by reducing hospital admissions and length of stay, improving the quality of care and simultaneously decreasing the cost for the highest risk patients in the designated population, as measured initially by decreased admission rates. The care of patients enrolled in this program will be safe, high quality, cost effective, coordinated with a tremendous degree of patient and family satisfaction.

⁸² Browne M. “Concierge and Primary Care Medical Home Hybrid Model of Care *Policy*” *Pershing Yoakley & Associates*. 2011.

⁸³ Pines J, Meisel Z. “Can Better Access to Health Care Really Lower Costs? Concierge medicine versus patient-centered medical homes: debating the benefits of enhanced access to care.” *Medical Insider* (2012) Jan. 23.

Project Goal
<p>We also need to develop imaginative programs to encourage patients' participation in their health care, from following up with their designated physician(s) and their teams to making life style changes as possible given their socio-economic limitations and filling their prescriptions and taking their medications.</p> <p>Our goals and metrics for this program will reflect the challenges of caring for a Medicaid population. There is little in the medical literature to help us with already successful solutions; we will take what is there and create the rest ourselves and with our community partners</p>

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements.</i>	Structural	Process
A. Define the role of the hospital based team members, including: 1) Determining skill sets and education required; 2) Identifying chronic conditions to be followed; and 3) Creating essential policies, protocols and pathways for care.	X	
B. Identify risk population to be served initially.	X	
C. Implement 360 Degree Patient Care Program.		X
D. Coordinate complex care.		X
E. Validate arrived follow-up visits.		X
F. Coordinate with post-acute care, including visiting nurses.	X	
G. Track and report on progress, such as number of co-managed patients, hospital admissions data.		X
H. Develop an implementation plan: 1. Create a communication plan; 2. Develop a budget; 3. Develop a scorecard to measure outcomes; 4. Determine when to add resources and expand coverage; 5. Develop a risk evaluation tool.	X	

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Creation of team to manage Medicaid patients that were sick enough to have had a hospitalization This will include hiring & training an additional physician and/or a midlevel (NP or PA) provider with modeled after the hospital-based 360° team; configure and hire support team members; Develop a process to	1.A. Additional Team members hired and trained 1.B. Written process to identify Population presenting to ED	<ul style="list-style-type: none"> Appointment, hire or transfer documentation; job descriptions; on boarding documents; written Patient Identification Protocol

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
identify Population A patients with an SMG primary care provider as part of the ED registration		
2. Develop strategy and process to drill down to target population demographics ⁸⁴	2.A. Documented strategy and process to drill down to target population demographics	<ul style="list-style-type: none"> Report documenting strategy and process used to define demographics
3. Conduct demographic analysis using strategy and process of SFY2015 and outline a screening process with the implementation of a risk evaluation tool.	3.A. Report identifying key demographics of population	<ul style="list-style-type: none"> Demographics data and screening process outline
4. Assess disease burden within target population based on co-morbidities and problem lists. Population patients with complex medical problems will require outpatient follow-up care after hospital discharge	4.A. Report of findings of disease burden assessment for the enrolled patients 4.B. Care Manager hired to facilitate risk-evaluation screening and follow-up on post-discharge care visits on two occasions during the 30 days after hospital discharge. 4.C. One month log documenting X percentage of patients assessed by care manager with documentation of the two patient contact points during the 30 days following hospital discharge.	<ul style="list-style-type: none"> EMR, Data Warehouse, Practice Management System, screening tool. Human Resources; Care Manager Log
5. Develop baseline admission/1000 to hospital for target Population	5.A. Baseline report of admissions/1000 for identified population for 3 month period	<ul style="list-style-type: none"> Data Warehouse

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Care Manager will follow-up after discharge with	1.A. Report documenting the baseline percentage of	<ul style="list-style-type: none"> Log of patients contacted and follow up appointment

⁸⁴ Demographics may include, but not necessarily be limited to, primary language, English fluency, cultural background or country of origin, income and geographic location.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
target population patients discharged from hospital to home. Follow-up will include either a post-discharge visit within 7 to 14 days or two touch points within the 30 days following discharge to home	<p>patients who completed the post-discharge visit within 7 to 14 days or two follow-up touches by the care manager within 30 days of discharge.</p> <p>1.B. Report documenting the percentage enrolled and risk screened during hospitalization</p> <p>1.C. Improvement in the number or percentage of patients who completed either the post-discharge visit within 7 to 14 days or two touch points within 30 days following discharge.*</p>	attended
2. Enroll and risk-evaluate target population patients at the time of hospitalization	2.A. Report documenting baseline percentage of patients enrolled and risk evaluated	<ul style="list-style-type: none"> Outline of planned risk-evaluation strategy and enrollment and assessment log of patients (de-identified of protected health information)
3. Advance target population patients enrolled and risk-evaluated	3.A. List of patients enrolled and risk-evaluated*	<ul style="list-style-type: none"> Enrollment and assessment log of patients
4. Monitor the rate of admissions/1000 to hospital for targeted population	<p>4.A. Report baseline rate of admissions/1000 to hospital for targeted population for 3 month period</p> <p>4.B. Report the rate of admissions/1000 for identified population for 3 month period*</p>	<ul style="list-style-type: none"> Data warehouse, Internal Hospital data

Project 3.3: Develop Governance, Administrative, and Operational Capacities to Accept Global Payments/Alternative Payment

Project Goal

The goal of this project is to develop governance, administrative and operational safety net health system capacity to transform toward alternative payment models including global payments and other models as well as to participate in alternative payment methodology contracts. Hospital-defined projects will focus on developing the building blocks and key capabilities needed by the specific-hospital system to move along the continuum towards participating in new payment models and begin to participate in alternative payment methodology contracts. Key capacities may include creation of appropriate legal entities, operating agreements, completion of health information technology inventory, development of information management and analytic capabilities in preparation for accepting alternative payments, health information exchange capabilities, formalization of leadership models to manage the transition to new accountable care models quality/cost benchmarking, development of new care management and clinical care models, education of network physicians about the cost of care, quality/cost benchmarking and local opportunities for managing cost and quality, among others.

In addition, this project may evaluate models for an Accountable Care Organization (ACO) and/or formally implement and operationalize an ACO that takes responsibility for providing care to a defined population, and establishes a system that provides comprehensive and coordinated care and assures access across the continuum. The accountable care or integrated care organizational models of care delivery are specific recommendations of leading national organizations and experts to address the challenges inherent in the current fee-for-service system, such as the volume driven use of services toward a high value system focused on better health, better quality and patient experience of care, and improved cost-effectiveness of care.⁸⁵ Key issues facing the delivery of care to medically vulnerable populations include: 1) assuring quality of care and appropriate and timely access to services; 2) delivering care in a more cost-effective manner by eliminating duplications and lack of coordination; and 3) assuring that this new delivery system approach results in a healthier population.

Integrated delivery systems are focused on a number of transformative goals aligned with the Triple Aim including:

- Improving care and reducing cost;
- Advancing the management of chronic disease;
- Reducing avoidable hospital admissions and preventable readmissions;
- Improving patient satisfaction;
- Managing financial risk for performance under an alternative payment or global payment arrangement over time.

Hospitals electing this project have different organizational structures, initial operational capabilities, and different pathways for advancing next steps toward payment reform readiness.

⁸⁵ Fisher, E.S. "Doctor's pay, a key to health care reform: share saving with doctors." *The New York Times* (2009) June 18
Message posted to <http://www.roomfordebate.blogs.nytimes.com/2009/06/18/better-medical-carefor>.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements.</i>	Structural	Process
A. Develop expertise in preparation for transition to a risk-bearing Accountable Care Organization.	X	
B. Develop financial management capabilities leading to a shared understanding, across participants, of the cost of healthcare and associated drivers of cost.	X	
C. Formalize creation of an accountable care organization.	X	
D. Develop capability to understand and monitor total medical expense of ACO population.		X
E. Establish, and monitor against, benchmarks for ACO health care cost and/or utilization growth trends.		X
F. Develop competencies and/or strategies to address utilization/cost issues		X
G. Analyze data to create baseline and identify potential savings opportunities.		X
H. Determine and/or implement model for clinical care delivery.		X
I. Utilize actuarial expertise to assess impact of potential risk-based alternative payment contracts.		X
J. Develop and utilize strategies to enhance the quality of care for high complexity ACO patients through the use of tools such as care plans.		X
K. Participate in alternative payment methodology contracts.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Formally create ACO infrastructure and develop ACO capabilities.	1.A. Documentation of ACO Board and Committees. 1.B. Identification of key ACO staff. 1.C. Documentation of ACO implementation plan. 1.D. Documentation of case and care management policies of the ACO. 1.E. Documentation of implementation plan to expand ACO capabilities.	<ul style="list-style-type: none"> Internal ACO records/documentation
2. Develop abilities and tools to understand and analyze populations under an alternative payment methodology.	2.A. Acquire analytic resource to analyze population data within an alternative payment methodology. 2.B. Obtain data for understanding the cost of	<ul style="list-style-type: none"> Documentation of analytic resource Meeting Minutes Utilization and cost reporting plan

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	care rendered to PHO patient populations. 2.C. Develop a plan to institute utilization and cost benchmarking, measurement and reporting.	
3. Develop a shared understanding of the cost of patient healthcare among ACO/PHO/ICO participants to participate in alternative payment methodologies.	3.A. Analyze claims data and stratify populations according to baseline cost and utilization. 3.B. Develop education for physicians on the cost of care of different types of services. 3.C. Inform ACO/PHO/ICO risk participants of risk-sharing formulas as appropriate.	<ul style="list-style-type: none"> • Sample reports • Education materials • Meeting Minutes
4. Develop a shared understanding of the drivers of healthcare cost among PHO/ICO participants and	4.A. Educate all PHO/ICO risk participants on results of alternative payment methodology contract. 4.B. Measure the change in per member per month cost/utilization compared to benchmark.	<ul style="list-style-type: none"> • Communication documents to PHO/ICO risk participants • Utilization reports • Meeting Minutes

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Analyze and use data to understand the cost of MassHealth patient care for primary care patients at ACO sites.	1.A. Actuarial report on patient cost and utilization for MassHealth patients at ACO sites. 1.B. Document total medical expense budget. 1.C. Define growth rate target.	<ul style="list-style-type: none"> • Payer data • Internal records/documentation
2. Analyze and/or monitor progress against ACO TME benchmark and target rate of growth for primary care	2.A. Report on total medical expenses and growth rate over prior year. 2.B. Recommendation to	<ul style="list-style-type: none"> • Internal records or documentation • Payer data • Actuarial analysis

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
patients and/or identify strategies to improve areas of utilization above benchmark.	<p>address spending above benchmark</p> <p>2.C. ACO report of opportunities for reductions in cost/utilization.</p> <p>2.D. Evaluate utilization reports and identify areas of utilization above benchmarks and possible strategies to improve.</p> <p>2.E. ACO Board approval of TME growth cap document</p> <p>2.F. Achieve improvement in at least one area of utilization above benchmark.*</p>	<ul style="list-style-type: none"> • Meeting minutes • Report with improvement results
3. Assess and/or implement ACO contracts with payers under alternative payment arrangements. Additional alternative payment contracts may be assessed/executed in subsequent years DSTI	<p>3.A. Documentation of ACO/payer alternative payment contract(s).</p> <p>3.B. Actuarial analysis to support alternative payment arrangement(s).</p> <p>3.C. Report on quality thresholds in alternative payment arrangements.</p>	<ul style="list-style-type: none"> • Internal ACO/payer document(s) • Actuarial report • Meeting minutes
4. Create and implement care plans for hospitalized patients.	<p>4.A. ACO approved inpatient care plan template</p> <p>4.B. Number of patients with inpatient care plan</p>	<ul style="list-style-type: none"> • Internal hospital and/or ACO documents
5. Implement and expand care plan(s) for targeted high complexity primary care patients.	<p>5.A. Number of high complexity primary care patients with care plans.*</p>	<ul style="list-style-type: none"> • Internal hospital records
6. Develop competencies to address utilization/cost issues under alternative payment methodologies.	<p>6.A. Implement strategies to reduce identified utilization above benchmarks.</p> <p>6.B. Implement utilization reporting plan for risk participant providers.</p>	<ul style="list-style-type: none"> • Implementation Report • Meeting Minutes • Action Plan

Project 3.4: Develop an Integrated Care Organization to Enhance Capacity and Respond to Alternative Payment Systems

Project Goal

In order to transform toward value-based purchasing and build the capacity to respond to alternative payment systems, it is critical for hospitals and affiliated independent physicians and independent physician groups to develop and implement integrated organizational structures, including governance structure and board, physician leadership and administrative staff. This integrated care organizational structure is essential to advance shared accountability for the cost and quality of care for a population of patients. The Integrated Care Organization (ICO) is distinct from an ACO because it does not envision comprising all of the components of health care delivery from academic medical center to nursing homes, and home care. Rather it is a component of an ACO, built on a health system's capabilities, and expertise, accountable but not comprising all of the parts. It envisions participation in a larger accountable care organization. For hospitals without a network of owned or employed physicians, it is imperative to develop a strategy that aligns the hospital and independent physicians through both clinical and administrative integration.

This project will develop an ICO's capability to coordinate care across providers and begin to work with select patient populations to provide better care, reduce cost and succeed under alternative payment systems. Those capabilities may include development of new care management and clinical care models for disease-based, payer-based or provider-based populations, implementation of a centralized referral management program to enhance access to local care provided at a lower cost than at a tertiary center and development of a quality reporting and performance improvement program across the ICO. Participation in alternative payment systems should facilitate this work through enhanced information access to be able to understand and identify opportunities to collaborate with independent physicians in an aligned fashion to reach out to patient populations, improve their care and become a high value ICO.

In the dynamic healthcare marketplace, many employers are actively seeking lower cost insurance plans that can deliver quality results with managed care. Health Net of Arizona believes that "narrow networks" can reduce insurance premium costs by 10-20% and Blue Shield of California predicts a 10-15% cost savings on premiums.⁸⁶ Other health insurance companies are pursuing the narrow network approach for employers seeking cheaper ways to provide quality care to employees. Specific goals include: 1) To develop for physician groups and area hospitals a Clinically-Integrated Network (CIN) that can deliver high-value cost and quality results and prepares all partners to move from a fee-for-service business model to value-based payment models that require full accountability and risk; 2) To devise and operationalize, with provider partners, a CIN to transform care delivery between the hospital and local medical community; 3) To develop and submit a CIN proposal to payers for a payer population based on an alternative payment method; 4) To provide the health care market with additional "narrow network" capacity for insurers to offer lower cost-high quality healthcare policies to employers and other groups covered by unmanaged care, including Medicare and Medicaid

⁸⁶ Burns, J. (February 2012). Narrow networks found to yield substantial savings: an early managed care idea that the marketplace once rejected is now being embraced by employers. *Managed Care*. Accessed from: http://www.managedcaremag.com/archives/1202/1202.narrow_networks.html

Project Goal
beneficiaries; 5) To report CIN performance outcomes and demonstrate improvement in a minimum set of quality and financial measures; 6) To reduce variations in patient care and outcomes among network providers.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements.</i>	Structural	Process
A. Structure or re-structure and design the hospital's related Physician-Hospital Organization (PHO) into an Integrated Care Organization (ICO) to advance integration between the hospital and local medical community.	X	
B. Develop associated organizational and governance requirements, such as Articles of Organization and bylaws.	X	
C. Design the integrated ICO's or CIN organizational structure.	X	
D. Build initial capacity, including essential personnel and systems, to administer the integrated ICO.	X	
E. Identify and develop physician leadership for integrated ICO or CIN.	X	
F. Devise work plan and timelines for ICO initiatives in systems and care coordination capabilities.	X	
G. Design integrated ICO proposal for a payer population to accept an alternative payment method.	X	
H. Develop a patient-centered care management program for populations such as disease-based, payer-based or provider-based populations	X	
I. Develop a centralized referral management program to enhance access to local care including <ul style="list-style-type: none"> a. Improving PCP awareness of capabilities of local specialists b. Identifying gaps in specialty care available locally c. Providing interpreter assistance to local practices d. Improving communication between PCP and specialty practices electronically 		X
J. Develop a quality reporting and performance improvement program to understand how care of patients with chronic diseases may impact and improve the health of the population under alternative payment methods.		X
K. Develop organizational and governance requirements, such as, but not limited to, Articles of Organization and bylaws.	X	
L. Design the CIN's organizational structure.	X	
M. Build initial capacity, including essential personnel and systems, to administer the CIN.	X	
N. Identify and develop physician leadership for the CIN.	X	

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements.</i>	Structural	Process
O. Implement work plan and timelines for CIN initiatives in IT systems, care coordination and care transition capabilities.		X
P. Secure value-based payer contracts for the CIN.		X
Q. Demonstrate improvement in a minimum set of quality and financial measures.		X
R. Build a network infrastructure capable of managing global payments and other evolving payment systems.	X	

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Evaluate opportunities for care management and coordination within the population of the PHO/ICO	1.A. Stratify populations based on data available and patient care needs in order to determine pilot populations appropriate for care management within the PHO, such as a disease-based, payer-based or provider-based populations.	<ul style="list-style-type: none"> Report on determination of pilot population for care management
2. Plan and design CIN organizational structures, governance model and build essential capacities, including personnel and IT systems to run critical functions	2.A. Develop and conduct a variety of planning, analysis and organizational infrastructure activities to build CIN 2.B. Presentation on CIN Strategy to senior leadership team of health system 2.C. Focus Group Report on CIN Strategy: Feedback and Recommendations 2.D. CIN Steering Committee Description and Membership List 2.E. Report on Network Design 2.F. Copies of Participant Prospectus and Participation Agreement 2.G. Report on Successful Regional Affiliation	<ul style="list-style-type: none"> Hospital documentation Hospital/Steering Committee Documentation Entity of CIN documentation Hospital or CIN documentation

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	Models 2.H. CIN Business Plan 2.I. Copy of Enrollment Form 2.J. Management Team List 2.K. Report on IT Infrastructure 2.L. IT Screen Shots of Clinical Performance Reporting System 2.M. Documentation of Care Management Design Staff 2.N. Care Management System Configuration. Report 2.O. List of CIN organizational members	

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Plan, develop, and pilot a patient-centered care management program within the PHO/ICO.	1.A. Establish PHO/ICO pilot population: Utilize personnel or external resources to establish a PHO/ICO care management team and leadership structure. 1.B. Establish PHO/ICO pilot population: Map care management process and goals and implement for at least one identified pilot PHO/ICO population. 1.C. Establish PHO/ICO pilot population: Develop evaluation criteria for the PHO/ICO care management program	<ul style="list-style-type: none"> • Care management team description • Care management plan for pilot population • Meeting minutes
2. Utilize PHO/ICO referral management program initiated in prior DSTI period under the Clinical Integration Committee work plan, to enhance access to local specialists and	2.A. Build on Clinical Integration Committee work to enhance access and reduce costs: 2.B. Evaluate metrics of the PHO/ICO referral management program such as specialty gaps and wait times 2.C. Implement X goal(s) identified	<ul style="list-style-type: none"> • Metrics data • Report on action to close specialty gap • Report on interpreter options and assistance implemented

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
reduce cost by keeping care local.	for Year 2 of the prior Three-Year Plan to close an ongoing specialty gap. 2.D. Evaluate options and implement X option(s) for interpreter assistance that can be used by PHO/ICO practices to enhance access to care.	
3. Develop and implement a PHO/ICO Quality Reporting and Performance Improvement Program.	3.A. Create Quality Reporting and Performance Improvement Elements: Develop reporting on publicly available hospital and physician quality results to PHO membership on a regular basis. 3.B. Create Quality Reporting and Performance Improvement Elements: Acquire an analytic resource to prepare and coordinate quality reporting. 3.C. Create Quality Reporting and Performance Improvement Elements: Identify X quality improvement opportunity(s) from results of reporting and implement a pilot improvement initiative.	<ul style="list-style-type: none"> • Sample results report and reporting schedule • Documentation of analytic resource • Meeting minutes with implementation plan
4. Evaluate PHO/ICO care management pilot	4.A. Expand pilot population based on analysis: Evaluate the effectiveness of the PHO/ICO care management pilot program using evaluation criteria and identify opportunities for improvement. 4.B. Expand pilot population based on analysis: Identify X additional population(s) within the PHO/ICO appropriate for care management, such as disease based, payer based or provider based.	<ul style="list-style-type: none"> • Program evaluation report • Report on population analysis
5. Improve and expand referral management	5.A. Enhance referral management and interpreter services	<ul style="list-style-type: none"> • Referral program growth report

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
program and interpreter services and evaluate effectiveness through care retention analysis.	<p>elements:</p> <p>5.B. Expand PHO/ICO referral management program to additional PHO/ICO primary care practice(s).</p> <p>5.C. Evaluate options for expanding interpreter services to PHO practices.</p> <p>5.D. Analyze reports to determine retention of care in the local area</p> <p>5.E. Create action plan to improve retention of care in the local area</p> <p>5.F. Evaluate use of electronic tools by referral representatives and make at least X improvement(s) in referral work flow processes.</p>	<ul style="list-style-type: none"> • Interpreter services evaluation report • Care retention reports • Retention improvement action plan • Work flow process improvement report
6. Enhance the PHO/ICO Quality Reporting Program so data can be reported on a timelier basis.	6.A. Work with PHO/ICO practices and hospital to determine processes to improve timeliness of data reported (dashboards) to Board and membership.	<ul style="list-style-type: none"> • Meeting minutes
7. Integrate “triple aim” “lessons learned” from MSSP program and translate to CIN operations	7.A. Report on Triple Aim Lessons Learned from MSSP Program and Implications for the Clinically-Integrated Network	<ul style="list-style-type: none"> • Hospital or CIN documentation
8. Market value-based CIN proposal to at least one (1) payer and secure contract and populate network.	<p>8.A. Engage Payer(s) about CIN value: Cover letter from CIN</p> <p>8.B. Engage Payer(s) about CIN value: Copy of contract</p>	<ul style="list-style-type: none"> • Hospital or CIN documentation

Project 3.5: Develop Administrative, Organizational, and Clinical Capacities to Manage the Care for Complex Patients

Project Goal

The overarching goal of this project is to develop programs that have administrative, organizational and clinical capacities to manage the care of complex patients, including dual eligible patients and populations in a global payment environment. More specific goals include: 1) to steadily increase complex patient enrollment into such programs over the Waiver period and demonstrate cost, quality and patient satisfaction improvements; 2) to fully integrate behavioral health services into the complex patient care delivery model; 3) to establish formal partnerships with local housing providers in ways that can extend complex patient services into select places where dual eligible participants reside and improve costs and health outcomes; 4) to create a teaching and learning collaborative with the region's professional schools for developing curricula, clinical internships and practicums for professional students, incorporating the complex patient integration model; 5) to provide health care and supportive services that are culturally and linguistically appropriate; and/or 6) to implement a range of care improvement initiatives that may include depression monitoring, nursing home utilization review to assess opportunities for best meeting population needs in the community, and medication reconciliation.

Reducing healthcare costs and utilization for the dual eligible population is a big challenge. While the challenge is difficult to resolve, some successful programmatic interventions had common characteristics, including: "...frequent in person contact with patients, strong working relationships between coordinators and patients' physicians, strong patient education programs using motivational interviewing or other behavior change tools, medication management programs, [and] transitional care interventions."⁸⁷

Of particular relevance to the pursuit of an integrated care model is the evidence-based model, Project GRACE, cited as one of only four models eligible for state funding under the Aging and Disability Resource Center initiative provided in the Older American's Act.⁸⁸ The GRACE model includes a "support team" of a nurse and social worker who conduct an in-home assessment upon admission into the program. The support team then shares its assessment with a large, multidisciplinary team to develop individualized care plans that integrate physical and behavioral health. Performance outcomes were impressive. Project GRACE high-risk patients tallied fewer emergency department visits, fewer hospital readmissions and reduced hospital costs.⁸⁹

Key capacities include a comprehensive, coordinated, and continuous care approach for managing the care of complex patients that is person-centered and integrated using an interdisciplinary team approach to needs assessment and care planning. Key capacities also include health information and financial management. Development of the capacities to manage complex patients will also provide significant learning opportunities to be utilized in expanding care management models in a global payment environment. The frail elderly comprehensive care model is designed to provide all needed

⁸⁷ Kaiser Family Foundation. (2012, October). Best bets for reducing Medicare costs for dual eligible beneficiaries: assessing the evidence, 2. Retrieved from <http://www.kaiserfamilyfoundation.files.wordpress.com/2013/01/8353.pdf>

⁸⁸ Counsell, S., et. al. (2006). Geriatric resources for assessment and care of elders (GRACE): a new model of primary care for low-income seniors. *Journal of American Geriatric Society*, 54(7), 1136-41.

⁸⁹ Counsell, S., et. al. (2009). Investing in Medicaid home and community. *Journal of American Geriatric Society*, 57 (2), 1420-26.

Project Goal
<p>medical care and long-term supportive services to largely dual eligible adults, aged 55 and older with the flexibility to customize services to each participant and to manage and coordinate services in ways that may minimize the need for hospitalizations and nursing home admissions.⁹⁰</p> <p>The interdisciplinary team integrates care provided by multiple, individual providers into a single comprehensive, individualized care plan that takes into account the need for care 24 hours a day, 7 days a week, 365 days a year. This patient-centered approach represents a fundamental shift from the current fee-for-service model to a model based on the clinical and financial accountability for the population and ensuring the appropriate care, at the appropriate time, and in the appropriate setting. This system of care will have the following benefits: 1) integrated financing; 2) increased accountability; 3) an improved standard for care; 4) prevention and timely intervention; 5) inclusion of patients and family caregivers; 6) education and training for a specific workforce (caregivers and providers); and 7) transportation support.</p> <p>One major focus for project activities will be to integrate behavioral health service delivery and monitoring into the program design. The prevalence of behavioral health conditions among dual-eligible patients makes it imperative to integrate care. Nearly one-half (44%) have at least one behavioral health diagnosis and one-fifth (20%) have more than one.⁹¹</p>

Potential Project Elements	Structural	Process
<i>DSTI hospitals undertaking this project may select from among the following project elements:</i>		
A. Establish a physical site for program operations.	X	
B. Conduct community needs assessment to identify such items as cultural and linguistic needs, number of potential program participants, and other key community identifiers.	X	
C. Identify and implement appropriate mix of health care and supportive services to be offered through the global payment program.		X
D. Enroll eligible participants in global payment program.		X
E. Integrate behavioral health into the on-site service offerings and evaluate the integration process.		X
F. Strengthen coordination of care with local housing sites and place program in select local housing site(s).		X
G. Provide home-based behavioral health services.		X
H. Perform grand rounds between program clinical staff, behavioral hospital clinicians and/or clinical staff from other organizations.		X
I. Establish relationships with local community and health care providers to identify opportunities for collaboration and referral.	X	
J. Pilot the on-site delivery of 12-STEP recovery/aftercare program, the delivery of home-based behavioral health services, clinical placements and		X

⁹⁰ Segelman, Micah, Szydowski, Jill et al. Hospitalizations in the Program of All-Inclusive Care for the Elderly. *Journal of American Geriatrics Society* 2014; 62: 320-324.

⁹¹ Kasper, J., et al. (2010, July). Chronic disease and co-morbidity among dual eligibles: implications for patterns of Medicaid and Medicare service use and spending. Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/8081.cfm>

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
health information exchange.		
K. Pilot and evaluate clinical placements at program site for student(s) from at least one professional school.		X
L. Implement initiative to review nursing home utilization for enrolled patient population for opportunities for improvement..		X
M. Implement clinical workflows for depression monitoring.		X
N. Implement medication reconciliation and review process for medications.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Establish physical site for program operations.	1.A. Hospital plan for physical site, including site location and design of space. 1.B. Opening of site.	<ul style="list-style-type: none"> Internal documentation
2. Conduct community needs assessment to identify such items as cultural and linguistic needs, number of potential program participants, and other key community identifiers.	2.A. Document summarizing assessment of number of frail elders who may be eligible for global payment program, including patient demographics and needs for culturally and linguistically appropriate services.	<ul style="list-style-type: none"> Internal documentation
3. Perform a gap analysis relative to full integration of behavioral health services into complex patient service delivery model.	3.A. Gap analysis report on capacities and readiness for behavioral health integration.	<ul style="list-style-type: none"> Health system documentation
4. Conduct outreach activities at local housing provider sites to identify opportunities for providing complex patient service delivery at local housing site.	4.A. List of local housing provider sites for potential partnership opportunities. 4.B. Report on partnership opportunities with local housing providers.	<ul style="list-style-type: none"> Health system documentation
5. Conduct feasibility study for providing home-based behavioral health services to complex patient population	5.A. Feasibility study on providing home-based behavioral health services.	<ul style="list-style-type: none"> Health system documentation

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
6. Conduct feasibility study for sharing electronic medical records and other requirements for collaboration with local health care providers to provide more integrated care.	6.A. Feasibility study report for possible collaboration with other health providers.	<ul style="list-style-type: none"> • Health system documentation
7. Establish patient advisory council that includes representation from identified diverse patient populations in service area.	7.A. Submission of patient advisory council charter for frail elders global payment program.	<ul style="list-style-type: none"> • Internal documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Enroll eligible frail elders, as program participants in global payment program.	1.A. Enroll eligible frail elders into global payment program. 1.B. Report progress on increasing new enrollment. *	<ul style="list-style-type: none"> • Enrollment records
2. Deliver and evaluate on-site behavioral health services	2.A. Copy of Memorandum of Understanding or Contract. 2.B. Report on the delivery of on-site behavioral health services.	<ul style="list-style-type: none"> • Health system documentation.
3. Identify and provide the mix of health care and supportive services to be offered to complex patients in global payment program.	3.A. Document summarizing comprehensive health care and supportive services for enrolled program participants.	<ul style="list-style-type: none"> • Health system documentation
4. Perform grand rounds between program clinical staff, behavioral hospital clinicians and/or clinical staff from other organizations.	4.A. Schedule of grand rounds 4.B. Report on grand rounds effectiveness survey results. 4.C. Schedule of grand rounds with local health providers.	<ul style="list-style-type: none"> • Health system documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
5. Conduct outreach with community and local health care providers to establish referral relationships and/or potential opportunities for collaboration to provide integrated care.	5.A. Report on meetings on potential opportunities for collaboration with local community and/or health care providers. 5.B. Report on meetings and potential collaborations with additional community organizations including psychiatric and/or substance abuse services organizations.	<ul style="list-style-type: none"> • Health system documentation
6. Pilot and evaluate the on-site delivery of 12-STEP recovery/aftercare program.	6.A. Provide X number of 12-Step meetings.*	<ul style="list-style-type: none"> • Health system documentation
7. Pilot and evaluate clinical placements at program site for student(s) from at least one professional school.	7.A. List of clinical placements for student(s) from professional school(s).	<ul style="list-style-type: none"> • Health system and/or professional school documentation
8. Pilot the delivery of home-based behavioral health services.	8.A. Development of at least X number behavioral health care plans with list of clinical services provided.*	<ul style="list-style-type: none"> • Health system documentation
9. Deliver complex patient services at local housing provider sites.	9.A. Report on collaborations with local housing providers to support frail elder program enrollees. 9.B. Schedule of service delivery. 9.C. Schedule of service delivery to provide nursing hours at X number of housing site(s) at least X number of times.*	<ul style="list-style-type: none"> • Health system documentation
10. Establish and implement initiative to review nursing home utilization for enrolled patient population for opportunities for improvement.	10.A. Report on initiative to review of nursing home utilization. 10.B. Summary of nursing home utilization initiative activities and results.	<ul style="list-style-type: none"> • Health system documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
11. Develop report(s) on “lessons learned” to educate hospital system leaders about integrating behavioral health services into complex patient care model.	11.A. Lessons learned report(s).	<ul style="list-style-type: none">• Documentation of report(s)
12. Implement clinical workflows for depression monitoring.	12.A. Implement clinical workflows for depression monitoring. 12.B. Report summary of depression monitoring initiative.	<ul style="list-style-type: none">• Health system documentation
13. Implement medication reconciliation and review process for medications.	13.A. Summary of medication reconciliation activities, including recommendations for potential interventions. 13.B. Documentation of implementation of at least one recommended intervention.	<ul style="list-style-type: none">• Health system documentation

Project 3.6: Establish an Enterprise-Wide Strategy for Information Management and Business Intelligence

Project Goal

The focus of this project is to implement an enterprise-wide strategy to move from fragmented silos of information and integrate data into a unified data warehouse, enhancing the efficiency by which clinical and operational reporting and analytical activities are conducted. Goals may also include developing information management and business intelligence tools to improve performance and decision making, placing greater emphasis on monitoring and improving costs and quality. New delivery models, such as the patient-centered medical home and alternative reimbursement methodologies, will require hospitals to leverage the new information management platform to address the myriad of alternative reimbursement methodologies challenges and imperatives facing the healthcare industry by applying the tools to perform analyses areas that may include the following:

- Financial analysis - Needed visibility into the full scope of financial operations, use of resources by patients and providers;
- Quality performance and safety analysis – monitoring performance comparisons across quality, patient access, patient satisfaction and utilization;
- Market and patient satisfaction analysis – reporting on patient satisfaction supports the goal within the organization for increased accountability among healthcare providers;
- Claims and clinical data analysis – analyzing and monitoring claims will help determine the biggest risk areas and devise the most effective rate structures and pricing when participating in alternative reimbursement methodologies or bundled payments;
- Patient care analysis – the new strategy will enable the right people to access the right information at the right time, delivering a single platform for sharing information with patients for better decision-making and connecting patients across hospital, nursing home, physician office, and community social support settings.

The data warehouse may provide the capabilities over time to compare providers by: patient outcomes based on National Patient Safety and Quality measures; utilization of resources for their Top 10 clinical diagnoses, Volumes by Top 10 clinical diagnoses, and mortality rates. Key performance indicator (KPI) goals and benchmarks are additional areas of focus that a hospital may develop to empower the organization to answer crucial questions such as:

- How are physicians performing in relation to costs and quality?
- What could be done to improve performance in individual departments?
- How to improve capacity and throughput without modifying facilities?
- How to identify patients during a hospital stay who are at risk for readmission?

The hospital plans to continue to implement an enterprise-wide strategy to integrate data into a unified data warehouse enhancing the efficiency by which clinical and operational reporting and analytical activities are conducted. Hospital will continue to transform the delivery of healthcare services by helping to improve quality, reduce costs, and increase access and coverage by leveraging technology. Utilizing the data warehouse and the appropriate tools/software for extraction of data for analysis and stratification of the hospital's patient population's health, its affiliated providers will follow patients managing their clinical outcomes to improve efficiency and manage risk. The expansion of the data

Project Goal

warehouse coupled with the Chronic Disease Registry and Transition of Care system will be important to allow the hospital and its affiliated and non-affiliated physician practices to have concurrent, real time data reporting and analysis of both patient and operational outcomes. This model for using information will allow our health care system to identify and address community health problems. Three key design principles working in concert will drive the activities of the hospital's model:

- Information at the point of care or during the time of visit;
- Information that is integrated into the natural workflow of the practice and allow providers to use the information to manage population of patient's health; and
- Feedback loops that will align with reimbursement or incentives so that improvement efforts can be sustained across populations.

The hospital will proactively use the data warehouse and Chronic Disease Registry to help characterize, monitor, and affect the health of the community and to enhance our ability to diagnose and investigate health problems, disparities, and health hazards in the community.

Expansion of the data warehouse will help identify opportunities for clinical preventive services in real time at the point of care. HMC will utilize the data warehouse, Chronic Disease Registry, and business intelligence to evaluate clinical data real-time during the patient visit to determine whether patients are eligible for specific preventive services. The hospital will use clinical data to drive measurable improvement in the health of patients with chronic diseases.

Moving forward with the enterprise-wide strategy, HMC will stratify patients by severity related to chronic disease such as Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes and Depression. With proper use of the technology, The hospital will be able to identify subsets from among populations with these chronic diseases and communicate with patients to notify them of potential gaps in their care or the availability of services. As a clinical microsystem, practitioners and staff could employ these tools to develop techniques to improve the care provided to these populations and subsequently scale-up those techniques to other patient populations both in health maintenance and management of chronic disease.

A Clinical Microsystem is defined as "a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients" and having clinical and business aims, linked processes, and shared information environment to produce performance outcomes.

Using a combination of alerts, clinical decision support, redesigned patient workflows, standing orders, and routine registry searches for population care surveillance, The hospital will achieve measurable improvement in both processes of care and patient outcomes for those patients with chronic diseases.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Evaluate current data collection systems by performing a gap analysis to determine ability to respond to value-based purchasing and continuous quality improvement (e.g., where is patient data collected, who is collecting data, how is it collected, and how is it used?)	X	
B. Identify current alternative reimbursement methodologies and KPI field requirements which are not captured electronically utilizing the data collection systems identified in the gap analysis.	X	
C. Document requirements for assessment of data warehouse and business intelligence software to include capabilities to include integration with hospital and provider health information systems, web user interface, and ability to create data marts and real-time dashboards related to business operations and select best-qualified vendor.	X	
D. Identify human and capital resources needed to create and utilize data warehouse and business intelligence tools.	X	
E. Develop a training and education plan for data warehouse and business intelligence tool users.	X	
F. Implement population improvement projects that utilize data warehouse and business intelligence tools.		X
G. Develop dashboards and reports that enable quality improvement and respond to alternative payment methodologies.		X
H. Increase the delivery of key clinical preventive services that are known to reduce morbidity and mortality.		X
I. Expand the number of patients whose care can measurably improve through the use of the data warehouse, business intelligence, and Chronic Disease Registry.		X
J. Improve the care of patients through better coordination across different care settings.		X
K. Deliver actionable information to healthcare providers.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Integration of Chronic Disease Registry, and Health Information Exchange to expand the centralized reporting structure and performance dashboards.	1.A. Evidence of Chronic Disease Registry, and Health Information Exchange integration.	<ul style="list-style-type: none"> • Diagram of system integration and interfaces.
2. Design implementation of CCMR analytics module.	2.A. Population health data visualization dashboard by diagnosis	<ul style="list-style-type: none"> • Print screen of population health data visualization dashboard by diagnosis

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
3. Develop cost utilization dashboards for hospital and primary care practices to gain insight into the total cost spent for inpatient and outpatient beneficiaries.	3.A. Evidence of cost utilization dashboard	<ul style="list-style-type: none"> Business Intelligence System CCMR report.
4. Develop clinical quality dashboards to measure primary care practice provider outcomes vs. payer-defined quality measures.	4.A. Evidence of quality dashboard for primary care practice provider outcomes vs. payer-defined quality measures. 4.B. Action plan to address gaps	<ul style="list-style-type: none"> Business Intelligence System CCMR report.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Determine identification criteria for select chronic diseases, identify patient population for these diseases, and stratify patients by severity.	1.A. Report identifying patients and stratifying them by severity for Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, or Depression. 1.B. Criteria for identifying patients with target chronic diseases	<ul style="list-style-type: none"> Business Intelligence System CCMR report
2. Develop report to show visits to primary care for selected chronic diseases	2.A. Report of patients with Heart Failure, COPD, Diabetes or Depression showing visits with primary care provider for these diseases	<ul style="list-style-type: none"> EMR
3. Develop system to notify primary care providers when patients with selected diseases are admitted or discharged	3.A. Evidence of daily notification to PCP for hospital admission or discharge for patients with COPD, HF, Diabetes or Depression. 3.B. Gap analysis of services utilizing referral system.	<ul style="list-style-type: none"> EMR
4. Develop a report to identify patients with multiple	4.A. Report identifying percentage of patients by	<ul style="list-style-type: none"> EHR

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
chronic conditions by age and race.	number of chronic conditions by age and race. 4.B. Stratify report by number of office visits 4.C. Summarize analysis of report	
5. Develop report(s) to track mortality rates for Heart Failure and Chronic Obstructive Pulmonary Disease by age and race.	5.A. Report identifying mortality rates for Heart Failure and Chronic Obstructive Pulmonary Disease by age and race.	<ul style="list-style-type: none"> EHR
6. Create cross-departmental committee to identify data collection issues preventing accurate reporting without manual intervention and create action plan to address these areas.	6.A. Committee member list, minutes from initial meeting and action plan	<ul style="list-style-type: none"> Internal documents
7. Implement referral management using electronic health exchange and Business Intelligence System to identify areas for improvement in streaming lining referrals to specialist.	7.A. Implementation plan with dates for CCMR Smart Referrals. 7.B. Analysis of Smart Referral management and X% completion of action plan to address appropriate areas for improvement.	<ul style="list-style-type: none"> Internal documentation
8. Implement three-tier referral system for Preferred, In-Network and Out of Network specialist for applicable Valley Health System practices.	8.A. Policies and procedures for selection of Preferred and In-network specialist 8.B. Gap analysis of services utilizing referral systems data.	<ul style="list-style-type: none"> Internal documentation
9. Create physician practice enterprise-wide quality metrics matrix, identifying quality metrics collected, collection source and method, responsibility party, affiliated programs and submission information to ensure consistency and allow for standardized alerts.	9.A. Metrics matrix and evidence of alert configuration	<ul style="list-style-type: none"> Internal documentation

Project 3.7: Implement Global /Risk-Based Payments

Project Goal

Ultimately, all DSTI projects should rapidly transition safety net providers to operate under value-driven global payment arrangements that reward quality and care coordination, rather than volume of encounters for Medicaid patients. In particular for the selected safety net hospitals, infrastructure must be developed to implement alternatives to fee-for-service reimbursement from public payers. Global payment arrangements are an effective alternative to the traditional fee-for-service model, as global payment and shared risk arrangements reward the appropriate management of lower total medical expenses and importantly, high quality care in the right settings. Under this project, DSTI hospitals will work with MassHealth, state government, and/or other payer(s) who provide services to eligible state-subsidized low-income patients (herein after, the “payers”) to implement a global payment, risk-based, or ACO-like demonstration.

Global payment and risk arrangements often vary significantly with respect to quality and performance requirements, adding to administrative cost and making implementation of these arrangements cumbersome. To meet this challenge, facilities will work with commercial health plans, MCOs, and state health insurance program payers to develop more uniform performance based standards that include common best practice requirements, quality metrics, and overall administrative requirements. Ultimately, aligning payer contracts will allow facilities to achieve scale, better manage infrastructure needs, and increase quality through standardized value-based programs.

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Collaborate with payer(s) for state-subsidized low-income patients to develop and refine features of global/risk-based contract(s).	X	
B. Develop data-sharing capabilities and execution of data-sharing agreement with payer(s).		X
C. Execution of global payment contractual agreement with payer(s).	X	
D. Implement risk-based contracts with physicians and post-acute providers.		X
E. Educate impacted physicians and post-acute providers.		X

Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
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Key Structural Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. Global or other Risk-based payment agreement	1.A. Develop contracting specifications for a risk bearing agreement 1.B. Execute agreement(s) with state-sponsored MCO payor	<ul style="list-style-type: none"> Global payment/risk-sharing agreement
2. Risk-sharing for achieved savings/loss.	2.A. Execute at least one upside only contract in SFY 2.B. Introduce downside risk into one current upside only risk-sharing agreements(s)	<ul style="list-style-type: none"> Documentation in agreement
3. Certification as a Risk-Bearing Provider Organization	3.A. Completion Risk-Bearing Provider Organization Certification or Transitional Waiver 3.B. Obtain recertification	<ul style="list-style-type: none"> Division of Insurance letter or certificate

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources and must also include the validated improvement measure specified below.

Measure	Metric(s)	Data Source(s)
1. Build infrastructure to educate physicians to support population health management. Steward Carney – please note numbering changes throughout – due to deleted metric.	1.A. Develop “university” web portal modules on population health management. 1.B. Launch web portal with educational modules on population health management strategies and enroll at least X network physicians.* 1.C. Expand enrollment to at least X network physicians and build additional tutorials.* 1.D. Refine existing tutorials	<ul style="list-style-type: none"> Documentation of educational materials
2. Educate physicians to support population health management.	2.A. X percent of physicians complete at least one of the educational tutorials available for physicians.*	<ul style="list-style-type: none"> Internal hospital records/documentation
3. Standardize primary care quality set for risk-based	3.A. Define standard quality set for state-subsidized health	<ul style="list-style-type: none"> Internal records and documentation

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources and must also include the validated improvement measure specified below.

<u>Measure</u>	<u>Metric(s)</u>	<u>Data Source(s)</u>
contracts	program contracts 3.B. Implement standard quality set for state-subsidized health program contract(s) 3.C. Measure results of standard quality set for state-subsidized health program contract(s) 3.D. Set improvement targets for standard quality set for state-subsidized health program contract(s)	

Project 3.8: Participate in a Learning Collaborative (mandatory)

Project Goal

Collectively, the DSTI projects proposed in Categories 1, 2 and 3 of this plan have the potential to significantly transform the care experience for Massachusetts residents served by eligible safety net hospitals. As important as individual hospital efforts will be, there is even greater potential value in leveraging the hospitals’ efforts for delivery system transformation through the sharing of best practices. Participation in a learning collaborative will provide a forum for eligible DSTI safety net providers to learn from other providers that share similar goals and to capitalize on potential synergies in their efforts. The learning collaborative model supports the development of a shared culture of continuous improvement and innovation, which will facilitate and enhance the individual hospitals’ efforts to advance the Triple Aim through their DSTI projects. Through this project, each hospital participating in DSTI will join an existing learning collaborative – such as the Brookings-Dartmouth ACO Learning Network or another ongoing learning collaborative that aligns with DSTI goals. Alternatively, each DSTI hospital will develop and participate in a new learning collaborative designed to support its transformation goals.

Potential Project Elements	Structural	Process
<i>All DSTI hospitals must select from among the following project elements:</i>		
A. Select a learning collaborative in which to participate, which may consist of either: <ul style="list-style-type: none"> Continue to participate in the existing learning collaborative whose goals align with the Triple Aim and DSTI transformation objectives and report on lessons learned; or Identify, join, and participate in an existing or new learning collaborative whose goals align with the Triple Aim and DSTI objectives and report on lessons learned. 		X
B. In the case that a hospital elects to develop a new learning collaborative, establish and implement a new learning collaborative designed to support the hospital’s delivery system transformation goals under DSTI and to align with the Triple Aim and DSTI objectives.		X
C. Participate actively in the selected or new learning collaborative and present a DSTI hospital project at least once annually.		X
D. Report on lessons learned from participation in a learning collaborative as they relate to the hospital’s delivery system transformation goals under DSTI.		X

Key Process Measures

DSTI hospitals undertaking this project are required to select the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
1. DY18, DY19, and DY20: Participate actively in a learning collaborative.	1.A. Documentation of attendance at, <u>and</u> active participation, via at, in	<ul style="list-style-type: none"> Internal hospital documentation and/or learning collaborative documents.

Key Process Measures

DSTI hospitals undertaking this project are required to select the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	Learning Collaborative meeting(s). 1.B. Documentation of at least one DSTI project presentation per DSTI hospital each year.	<ul style="list-style-type: none">• DSTI hospital's presentation
2. DY18 and DY19: Report on learning collaborative activities as they relate to delivery system transformation goals under DSTI.	2.A. Summary report on learning collaborative activities.	<ul style="list-style-type: none">• Learning collaborative summary report
3. DY20: Report on lessons learned from participation in a learning collaborative as they relate to the hospital's delivery system transformation goals under DSTI.	3.A. Overall report on lessons learned. This report should reflect how the lessons learned have or have not been integrated into hospital improvement activities.	<ul style="list-style-type: none">• Learning collaborative report

Project 3.9: Population Health Management Capabilities

Project Goal

This project is focused on the development and implementation of population health reporting and management capabilities for effective alternative payment model management. Effective reporting strategies to assess impact at the provider level, practice site, and system level of interventions will be deployed to advance improvements in population health, such as high prevalence conditions such as hypertension and heart health conditions. Physician practice or Physician Organized Delivery Systems (PODS) will be advanced to support panel management, population health, and performance improvement under alternative payment models. The reporting and performance management improvement structures developed will be utilized to advance measurable patient care interventions stemming from these reports. Areas for improvement interventions may include areas such as patient panel reconciliation and patient engagement in primary care which is foundational to accountable care and patient engagement; high cost / high utilization / high prevalence conditions; and prevention screening rates, gaps in care, or disease management.

The development and implementation of population health reporting and management capabilities is core to participation in alternative payment models and achieving care improvements. There are essential needs to develop strategic information management tools, and reporting for providers and practices to implement population and panel management.⁹² The hospital system will develop the population health management and related performance improvement functions, structures, and reporting, and utilize these to implement population management activities and drive defined population health intervention initiatives and improvements with measurable results. Focus areas may include evidence-based approaches to improve hypertension and cardiovascular disease, which are leading causes of death, most widespread and costly health problems nationwide, according to the *Million Hearts* initiative.⁹³

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
A. Implement an overall population health performance management and improvement structure, including a governance structure for evidence-based practices or guidelines, related to population health management and alternative payment models.	X	
B. Develop and implement a population health management reporting platform to support population health management and improvement initiatives.		X
C. Implement population management improvement activities utilizing standard reporting package with primary care PODs and ultimately specialty care.		X

⁹² Delbanco, S.F., Anderson, K. Martin, Major, C.E. et al. Promising Payment Reform: Risk-Sharing with Accountable Care Organizations, The Commonwealth Fund, July 2011.

⁹³ *Million Hearts* Fact Sheet (<http://millionhearts.hhs.gov>)

Potential Project Elements <i>DSTI hospitals undertaking this project may select from among the following project elements:</i>	Structural	Process
D. Accomplish provider education on evidence-based guidelines or practices to support population health management activities, which may include initiatives related to high cost/high utilization or high prevalence conditions (such as hypertension and heart health) and preventive care, gaps in care and/or disease management.		X
E. Implement and achieve defined improvements in population health management improvement interventions, which may include: 1) panel reconciliation and primary care outreach to engage a growing proportion of new or inactive patients in select payer population(s); 2) high cost/high utilization or high prevalence condition(s); and/or 3) improvement in areas such as prevention screening rates, gaps in care and/or disease management.		X
F. Report on overall impact of population health management activities in the project, which may include impacts on population health improvement, care delivery improvements, health care utilization, and/or impacts on medical expense.		X

Key Structural Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Include Complex Care Management in primary care POD meetings.	1.A. Document that Complex Care Management topics are reviewed in selected primary care POD meetings.	<ul style="list-style-type: none"> Internal records for selected primary care POD meeting agendas.
2. Develop and implement a formal structure/ process for performance management in medical, surgical and/or behavioral health specialty care.	2.A. Document structure or process to be utilized in medical, surgical and/or behavioral health specialty care.	<ul style="list-style-type: none"> Internal records

Key Process Measures <i>DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.</i>		
Measure	Metric(s)	Data Source(s)
1. Develop initial standard reporting package for population health management for primary care PODs and implement regular process for	1.A. Submission and distribution of initial standard reporting package for use in communicating performance information for primary care POD	<ul style="list-style-type: none"> Initial reporting package and internal documentation.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
distribution of population health management reports to providers/practices and educate primary care PODs.	meetings.	
2. Expand reporting features to standard population health management reporting (such as payer, patient population / demographics, specialty, gaps in care, health care condition / disease prevalence/utilization/ cost).	2.A. Document X number of changes or additions of new reporting features in population health management reporting package.	<ul style="list-style-type: none"> • Internal data and reports.
3. Develop processes for reconciling payer primary care panel reports to hospital's internally-reported panel. Distribute reconciled payer-based panel reports to primary care PODs.	3.A. Document panel reconciliation process, sample of reconciliation and methods for addressing inconsistencies; and provide samples of distributed panel reports, process and frequency for distribution.	<ul style="list-style-type: none"> • Internal records.
4. Establish patient panel empanelment guidelines and outreach activities to engage with new or inactive patients. Achieve outreach to an initial cohort of new or inactive patients for select payer populations(s).	4.A. Submission of empanelment guidelines and summary of outreach efforts demonstrating achievement of outreach to defined cohort of new or inactive primary care panel patients for select payer population(s).	<ul style="list-style-type: none"> • Internal records.
5. Report progress in outreach to engage new or inactive primary care panel patients through outreach and empanelment efforts.	5.A. Progress report on outreach activities to new and inactive primary care panel patients for selected payment reform payer panel(s).	<ul style="list-style-type: none"> • Internal report.
6. Educate primary care PODs on evidence-based practice or guideline that supports population health improvement initiatives such as hypertension and heart health initiatives or those	6.A. Document evidenced-based practice or guideline and the educational tools utilized.	<ul style="list-style-type: none"> • Internal records.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
related to high cost / high utilization or high prevalence conditions.		
7. Advance population health management improvement through providing routine feedback to providers on performance improvement opportunities, including on the selected improvement initiative(s) on population health management.	7.A. Document that population health management performance improvement opportunities are advanced through primary care POD meetings, which may include selected conditions and/or guidelines, such as hypertension and heart health initiative and other initiatives. 7.B. Sample package for use in primary care POD meetings.	<ul style="list-style-type: none"> • Internal records and/or POD meeting sample package.
8. Identify, design and begin implementation of population health improvement initiative targeted to address high cost/high utilization/high prevalence conditions, such as hypertension and heart health.	8.A. Document describing specific improvement initiative, such as hypertension and heart health initiative, during initial year.	<ul style="list-style-type: none"> • Internal documentation and records.
9. Continue to implement and monitor progress on the high cost/utilization or high prevalence initiative, such as hypertension and heart health.	9.A. Document reporting on progress advanced through hypertension and heart health initiative activities implemented, which may include a multi-disciplinary population health approach toward anti-platelet therapy for patients with chronic stable coronary artery disease and blood pressure improvement results from enhanced, evidence-based clinical practices such as care team patient education visits, self-management	<ul style="list-style-type: none"> • Internal documentation and records.

Key Process Measures

DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
	coaching, and/or medication management and/or medical management visits. Report will include lessons learned identified through a process improvement methodology.	
10. Report on overall impact of population health management activities in this project.	10.A. Overall impact report for population health management initiatives, which may include population health improvement in areas such as hypertension and heart health, care delivery improvements, health care utilization including on primary care engagement for new or inactive panel patients, and/or impacts on medical expense.	<ul style="list-style-type: none">• Internal report.

X. CATEGORY 4A: AT-RISK OUTCOMES AND IMPROVEMENT MEASURES RELATED TO CATEGORY 1 – 3 PROJECTS

30. This section includes a menu of Category 4A measures related to improvements that are tied to projects implemented in Categories 1-3. The purpose of Category 4A is to evaluate the impact of the investments and system changes described in Categories 1, 2 and 3 through quality and improvement measures. Category 4 measures must recognize that the project objectives do not guarantee outcomes but result in learning, adaptation, and progress. As such, each eligible safety net hospital receiving DSTI funding must measure and report on selected measures.

- a) All hospitals must report a minimum of 6 outcomes and improvement measures, of which at least 2 measures must be categorized as outcomes measures from the Category 4A measure menu related to Categories 1 – 3 projects and associated with at-risk outcomes and improvement funding referenced in Section VII, Paragraphs 19 and 20. Hospitals may select any of the outcomes and improvement measures on the menu, however, each hospital must select at least 2 outcome measures from among the measure menu.

Category 4A is pay-for-reporting for Year 1 (DY18/SFY 2015). Category 4A is pay-for-performance for Year 2 and Year 3. In DY19/SFY2016, 10% of total annual DSTI hospital-specific funds is associated with Category 4A, with funding allocated evenly for each hospital's pay-for-performance measures in Category 4A. In DY20/SFY 2017, 12.5% of total annual DSTI hospital-specific funds is associated with Category 4A, of which 5% of total annual DSTI hospital-specific funding is allocated to outcomes measures in DY20/SFY 2017 and 7.5% of total annual DSTI hospital-specific funding is allocated to the other Category 4A improvement measures selected by the hospital in DY20/SFY 2017. Recognizing the various starting places and improvement opportunities across DSTI hospitals, hospitals may designate which of their Category 4A measures shift into pay-for-performance in DY19/SFY 2016, provided that the at-risk funding will be allocated across those designated pay-for-performance measures. All measures become pay-for-performance in DY20/SFY 2017.

The outcomes and improvement measures on the Category 4A menu are organized across the transformation domains listed below.

- Clinical Improvement Measures
 - Prevention and Health Management (Vaccinations, Cancer Screening, Blood Pressure Control and Heart Health, Falls Screening)
 - Pediatric Health
 - Behavioral Health
 - Diabetes Mellitus
 - Palliative Care
- System Transformation Measures
 - Medication Reconciliation and Management
 - Decreasing Avoidable Emergency Department and Inpatient Utilization
 - Care Management including for High Risk Populations

- Care Transitions and Readmission Prevention
- Payment and Systems Reforms
- Improving Access.

In general, the Category 4A measures are validated or otherwise supported by national or state entities with a subset of other customized measures reflecting transformation priority areas. Many of the measures on the Category 4A menu are endorsed or supported by organizations such as the National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS) [Core Measure Set, Meaningful Use, Physician Quality Reporting System (PQRS), Hospital-Based Inpatient Psychiatric Services (HBIPS)], MassHealth, Patient Centered Medical Home Initiative (PCMHI), and/or Choosing Wisely among others.

Each hospital, in their hospital-specific plan, will include a narrative on the hospital-specific Category 4A measures it has elected and the rationale for how that measure fits with evaluating the impact of the transformation project being undertaken by the hospital. The menu of Category 4A Outcomes and Improvement Measures that hospitals may choose to report as At-Risk measures is on the following pages.

Updates to technical specifications of outcomes and improvement measures in Categories 4A and 4B shall not require a plan modification and can be implemented by the Commonwealth without further approval.

b) Gap-to-Goal and Improvement Measurement Approach

Such outcomes and improvement measures must adhere to the established improvement methodologies. Hospitals must select measures from the Category 4A measure slate in DY18/SFY 2015 on which their organization has an opportunity for performance improvement relative to the established target or benchmark. However, a hospital may continue with that measure in DY20/SFY 2017 even if the hospital meets the high performance benchmark in DY19/SFY 2016. In instances where the 90th percentile performance benchmark exceeds 90% compliance on a specific measure, then an organization will achieve success toward that benchmark by attaining 90% compliance or gap-to-goal improvement as described below. Variation in performance is acceptable as long as the performance for DY20/SFY 2017 is at or better than benchmark in this case. If a benchmark is not available or if the specific measure is more appropriate to improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures), the organization must improve over year DY19/SFY 2016, unless otherwise specified that the baseline for comparison is DY18/SFY 2015.

- i. All participating hospitals must have a target for outcome and quality improvement indicators in Category 4A. The specified target will be used to determine whether or not the associated metric was achieved.
- ii. The following is a guiding hierarchy for the selection of improvement benchmarks or targets for Category 4A. All performance targets will be

established during DY18/SFY 2015 in the measure menus for Category 4A and will be in place for the demonstration period.

- a. Select the latest available 90th percentile Massachusetts Medicaid (2014) during DY18/SFY 2015. For CMS core inpatient measures and other inpatient measures, utilize available Massachusetts performance data.
 - b. If above not available, select the latest available 90th percentile National Medicaid during DY18/SFY 2015. For CMS core inpatient measures and other inpatient measures, utilize available National performance data.
 - c. If above not available, select other available benchmark (such as other latest available National benchmark) or hospital-defined target during DY18/SFY 2015.
 - d. If above not available or if the specific measure is more appropriate to improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures), any improvement over DY18/SFY 2015 hospital baseline will be the improvement measurement method or as specified
- c) **Metric Classifications for Category 4A Metrics**
Metrics will be classified into the following groups: (1) Clinical care delivery improvement measures; (2) Clinical outcomes measures; and (3) other delivery/outcomes measures where there is not a standardized benchmark and/or if the specific measure is more appropriate to improvement over hospital baseline.

- i. Clinical care delivery improvement measures quantify a performance exhibited by clinical care practices, such as health screenings, and therefore are usually directly observable and can be directly impacted. In general, these metrics fit with a gap-to-goal methodology. All metrics classified as clinical care delivery measures must have an acceptable benchmark. To meet the threshold for success, organizations must achieve closure of 10% of the difference between the hospital's baseline performance and the established benchmark or maintain at or above the benchmark. Each subsequent year would continue to be set with a target using the most recent year's data, unless otherwise specified.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 10\%$$

An example of a clinical care delivery measure is influenza immunization (NQF 0041).

- ii. Clinical outcome measures are metrics influenced by patient case mix, multiple processes, and environmental factors. In general, these metrics fit with a gap-to-goal methodology, depending on the availability of performance benchmarks. Since improvement on outcomes measures requires considerable amounts of resources and time and is dependent on foundational care delivery improvements and patient factors, closure of 5% of the difference between the hospital's

baseline performance and the established benchmark is included. To meet the threshold for success, organizations must meet the 5% gap to goal, where the organization must achieve a minimum of 5% of the difference between the benchmark and the baseline performance or maintain at or above the benchmark. Each subsequent year would continue to be set with a target using the most recent year's data, unless otherwise specified.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 5\%$$

Examples of clinical outcome measures are Controlling High Blood Pressure (NQF 0018) and Comprehensive Diabetes Care: Hemoglobin A1c Control (NQF 0575).

- iii. Non-standardized benchmark delivery/outcomes measures are metrics that do not have an available or acceptable benchmark and/or are specific measures that are more appropriate for improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures). To meet the threshold for success, for pay-for-performance measures applicable to DY19/SFY 2016, organizations must show improvement from baseline (DY18/SFY 2015) to performance year (DY19/SFY 2016). To meet the threshold for success, for pay-for-performance measures applicable to year 3 (DY20/SFY 2017), organizations must show improvement from baseline (DY18/SFY 2015) to performance year (DY20/SFY 2017) or as specified.

Examples of a non-standardized benchmark delivery/outcomes measure is readmission rates or emergency department utilization rates. These measures are influenced by many factors (which may include patient case mix, multiple processes, and environmental factors). Given that these measures are not risk-adjusted approach, the use of an organization's historical performance is a pragmatic approach to DSTI. Another example of a non-standardized benchmark delivery/outcomes measure is the MassHealth TOB-2a: Tobacco Use Treatment. This metric is relatively new and the benchmark is limited/unavailable.

For Policy Discussion Purposes Only
DSTI Category 4A: Outcomes and Improvement At-Risk Measures

Category 4A: Outcomes and Improvement At-Risk Measures								
Ref #	Measure Name	Associated Projects	Measure Steward and Number	Benchmark	Improvement Methodology	Year 1 DY 18 SFY 2015	Year 2 DY 19 SFY 2016	Year 3 DY 20 SFY 2017
	Clinical Improvement Measures							
	Prevention and Health Management							
1	Influenza vaccination	1.2, 3.5	NQF 0041	Medicare MSSP/ACO 2015 90 th percentile = 90%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
2	Pneumococcal Vaccination	1.2, 3.5	NQF 0043	Medicare MSSP/ACO 2015 90 th percentile = 90%	Gap to Goal (10%) or attainment at Target	Baseline where available	Outcome or Baseline	Outcome
3	Breast Cancer Screening	1.1, 1.4, 3.4	NQF 2372	NCQA 2014 Medicare National 90th percentile = 82%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
4	Controlling High Blood Pressure measure (2015 HEDIS Definition)	3.9, 2.1, 1.2, 3.4	NQF 0018	MA Medicaid (HEDIS) 2014 90 th percentile = 85.67%	Gap to Goal (10%) or attainment at Target	Baseline (CY 2014 data)	Outcome	Outcome
5	Falls: Screening for Future Fall Risk (Outpatient)	3.5, 2.4	NQF 0101-A	Medicare MSSP/ACO 2015 90 th percentile = 73.38%	Gap to Goal (10%) or attainment at Target	Baseline where available	Outcome or Baseline	Outcome

For Policy Discussion Purposes Only
DSTI Category 4A: Outcomes and Improvement At-Risk Measures

6	Targeted Fall Rate in Hospital-Specific Target Population	2.5, 1.2, 2.2	Customized Measure	No external benchmark; Hospital-specific benchmark is X% decrease over baseline, (as defined in hospital-specific plan)	Gap to Goal (10%) or attainment at Target	Baseline (baseline measurement periods specified in hospital plans)	Outcome	Outcome
Pediatric Health								
7	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – <u>Counseling for Nutrition</u>	1.1, 3.3	NQF 0024	National Medicaid (HEDIS) 2014 90 th percentile = 78%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
8	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - <u>Counseling for Activity</u>	1.1, 3.3	NQF 0024	National Medicaid (HEDIS) 2014 90 th percentile = 70%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
Behavioral Health								
9	Screening for Clinical Depression and Follow-Up Plan	1.2, 2.1, 2.2	NQF 0418	Medicare MSSP/ACO 2015 90 th percentile = 51.81%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
10	Depression: Utilization of the PHQ-9 Tool	1.2, 3.4, 3.5	NQF 0712	No external benchmark; Hospital Shared Target = 65%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome

For Policy Discussion Purposes Only
DSTI Category 4A: Outcomes and Improvement At-Risk Measures

11	Documentation of the percentage of newly referred patients who had a successful contact with an integrated Behavioral Health provider within 14 days referral.	1.2	Customized Measure	No external benchmark; Hospital target = 70%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
12	Documentation in medical record of continuing care plan which includes next level of care recommendations	1.2	HBIPS-7	CMS Reported National Average 69.92% (4/1/2013 – 12/31/2013)	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
Diabetes Mellitus								
13	Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.2, 2.7, 2.1	NQF 0057	MA Medicaid (HEDIS) 2014 90 th percentile = 91.86%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
14	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (> 9.0%)	1.2, 2.1, 2.7	NQF 0059	MA Medicaid (HEDIS) 2014 90 th percentile = 18.57%	Gap to Goal (10%) or attainment at Target	Baseline (baseline measurement periods specified in hospital plans)	Outcome	Outcome
15	Diabetes: LDL Screening	1.2, 2.7, 3.4	NQF 0063	MA Medicaid (HEDIS) 2014 90 th percentile = 88.59%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
16	Comprehensive Diabetes Care: Eye Exam (retinal) performed	2.1, 3.6	NQF 0055	MA Medicaid (HEDIS) 2014 90 th percentile of 74.47%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome

For Policy Discussion Purposes Only
DSTI Category 4A: Outcomes and Improvement At-Risk Measures

17	Comprehensive Diabetes Care: Blood Pressure Control (< 140/90)	1.1, 2.1, 2.4, 2.7, 3.4	NQF 0061	MA Medicaid (HEDIS) 2014 90 th percentile = 82.74%	Gap to Goal (10%) or attainment at Target	Baseline (baseline measurement periods specified in hospital plans)	Outcome	Outcome
Palliative Care								
18	Palliative care, percent of adult patients who have a serious illness who have a completed MOLST form documented in the medical record for the target population	1.6, 3.2	NQF 1641	No external benchmark; Hospital Shared Target = 50%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
System Transformation Measures								
Medication Reconciliation and Management								
19	Use of High Risk Medications in the Elderly: At least one high-risk medication	2.8, 2.9	NQF 0022 - A	No external benchmark; Hospital Target = 10%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
20	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2.2, 2.5, 2.8	NQF 0646	No external benchmark; Hospital Shared Target = 90%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome

For Policy Discussion Purposes Only
DSTI Category 4A: Outcomes and Improvement At-Risk Measures

	Decreasing Avoidable Emergency Department and Inpatient Utilization							
21	Decreasing Emergency Department Utilization for High Utilizers	1.5, 2.2, 2.4, 2.6	Customized Measure	No external benchmark; Hospital-specific benchmark is X% decrease compared to baseline (as defined in hospital-specific plan)	Gap to Goal (10%) or attainment at target	Baseline where available	Outcome or Baseline	Outcome
22	Follow-Up Post Emergency Department Utilization for High Risk Patients	2.4, 3.5	PCMHI 0013	No external benchmark; Hospital Shared Target = 70%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
23	Decrease in Utilization Over Baseline for Emergency Department and Inpatient based on Longitudinal Tracking of the Super-Utilizer Population	2.4	Customized Measure	No external benchmark; Hospital-specific target of X% decrease compared to baseline	1% decrease compared to baseline		Baseline (4/1/15 – 3/31/16)	Outcome
	Care Management including for High Risk Populations							
24	Care Plans for High-Risk Patients	2.4, 2.1	PCMHI 0014	No external benchmark; Hospital Shared Target = 85%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
25	Adherence to CMS-defined Transitional Care Management protocols	3.1	CMS 77 FR-68978	No external benchmark; Hospital Targets = 25% in SFY 2016, 50% in SFY 2017	Achieve established targets	Baseline	Outcome	Outcome

For Policy Discussion Purposes Only
DSTI Category 4A: Outcomes and Improvement At-Risk Measures

	Care Transitions and Readmission Prevention							
26	CMS Skilled Nursing Facility Days for Target Population	3.3	Customized Measure based on CMS Chronic Condition Data Warehouse (CCW)	CCW Mass 2012 Medicare days/1000 beneficiaries = 2636 Hospital Target = 2636 days / 1000 enrollees or beneficiaries	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
27	HCAHPS: Discharge Information	2.2	HCAHPS	Hospital-specific benchmark is X% based on the highest threshold of Hospital's most recent P4P contracts	Gap to Goal (10%) or attainment at Target	Baseline (CY 2014)	Outcome	Outcome
	Payment and System Reforms							
28	% of MCO members who select a PCP within the DSTI hospital network who are covered under at-risk contracts Increase % of MCO members who select a DSTI Hospital PCP who are covered under at-risk contracts	3.7	Customized Measure	No external benchmark; Hospital-specific benchmark is 100%	Gap to Goal (10%) or attainment at Target	Baseline	Outcome	Outcome
	Improving Access							

For Policy Discussion Purposes Only

DSTI Category 4A: Outcomes and Improvement At-Risk Measures

29	Increase Primary Care Utilization in hospital-defined target population (As measured by increasing percentage of new and/or inactive patients within the cohort who have primary care utilization in the measurement year compared to the baseline year)	1.5, 3.9	Customized Measure	No external benchmark; Hospital shared target is defined percentage improvement over baseline	Improvement compared to SFY 2015 baseline In SFY 2016: by at least 1% point above the SFY 2015 baseline In SFY 2017: by at least 2% points above the SFY 2015 baseline	Baseline	Outcome	Outcome
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Technical Specifications for Category 4A: Outcomes and Improvement At-Risk Measures

MEASURE 6	Targeted Fall Rate in Hospital-Specific Target Population
Measure Steward and Number	Customized Measure
Definition	Targeted Fall Rate in Inpatient Geriatric Target Population (defined in hospital-specific plans)
Data Source	Hospital EMR or records
Numerator	Number of patient falls, with or without injury, on applicable inpatient unit(s)
Denominator	Number of patient days for applicable geriatric inpatient population
Target Population Notes	Hospital A and C: Target population is Inpatient Geriatric Behavioral Health population Hospital B: Target population is Inpatient Geriatric (65+ years) Population
Exclusions	None
Associated Projects	1.2, 2.2, 2.5
Benchmark or Performance Goal	No external benchmark . Hospital-specific benchmark is X% decrease over baseline, specified in hospital-specific plan.
Improvement Measurement Approach	Gap to Goal (10%) or attainment at target
Baseline Year	SFY 2015 (baseline measurement periods specified in hospital plans)
Expected Years for Pay-for-Performance	SFY 2016 and SFY 2017
Notes	Metric subject to modification for refinement

For Policy Discussion Purposes Only
DSTI Category 4A: Outcomes and Improvement At-Risk Measures

MEASURE 11	Documentation of percentage of newly referred patients who had a successful contact with an integrated Behavioral Health provider within 14 days of referral.
Measure Steward and Number	Customized Measure
Definition	The percentage of newly referral patients who had a successful contact with an integrated Behavioral Health provider within 14 days of referral
Data Source	Hospital EMR or records
Numerator	Number of newly referred patients with contact with an integrated behavioral health provider within 14 days of referral
Denominator	Number of Newly referred patients
Target Population Notes	
Exclusions	
Associated Projects	<u>1,2</u>
Performance Goal	Hospital target is 70%.
Improvement Measurement Approach	Gap to Goal (10%) or attainment at target
Baseline Year	SFY 2015
Expected Years for Pay-for-Performance	SFY 2016 and SFY 2017
Notes	Successful contact is defined as: 1) arrived visit to integrated behavioral health provider; 2) successful “warm hand off” from primary care provider to integrated behavioral health provider; and 3) successful telephone contact/conversation with integrated behavioral health provider. Metric subject to modification for refinement

MEASURE 21	Decreasing Emergency Department Utilization for High Utilizers
Measure Steward and Number	Customized Measure
Measurement	Successful achievement of emergency department utilization reduction may include any one of the following: 1) a reduction in the average number of Emergency Department visits per patient, 2) a reduction in total number of Emergency Department visits for a cohort of patients, 3) Emergency Department Utilization/1000 trends calculated for the cohort, OR 4) improvements in the number of patients who experience reductions in emergency department utilization compared to baseline. Utilization trends may be measured on hospital’s Emergency Department data or for overall Emergency Department utilization for a defined cohort of patients (if hospital has access to such claims data). Hospital B: (Total ED visits for target population Year 2 – Total ED visits for target population in Year 1)/Total ED visits for target population Year 1
Data Source	Hospital EMR or records
Target Population Notes	Hospital A: Target population is a patient population with 12 or greater Emergency Department

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DSTI Category 4A: Outcomes and Improvement At-Risk Measures

	visits in a specified 12-month period (CY 2014) that constitutes a significant sub-population in an alternative care delivery program for patients seeking non-emergent Emergency Department care and will be followed longitudinally during the demonstration. Hospital B: 25 top Emergency Department utilizers that visited the Emergency Department 12 or greater times in CY 2014 Hospital C: Target population is a patient population with primary care at Hospital C who have 8 or greater Emergency Department visits within Hospital C in a specified 12 month period (SFY 2015) that will be followed longitudinally during the demonstration. Hospital D: Target population is a patient population with 7 or greater Emergency Department visits within Hospital D in a specified 12 month period who are affiliated with primary care practices associated with Hospital D.
Exclusions	NA
Associated Projects	1.5, 2.2, 2.4, 2.6
Benchmark or Performance Goal	No external benchmark. Hospital-specific target of X% decrease compared to baseline, specified in hospital-specific plan.
Improvement Measurement Approach	Hospital-specific target of X% decrease compared to initial baseline period . Gap to Goal (10%) or attainment at target.
Baseline Year	Baseline set in SFY 2015 [using CY 2014 (Hospitals A and B)]. Hospital C will report baseline in SFY 2016 (based on SFY 2015 data)
Expected Years for Pay-for-Performance	SFYs 2016 and 2017 (Hospitals A and B) SFY 2017 (Hospital C)
Notes	Metric subject to modification for refinement

MEASURE 22	Follow-up Post Emergency Department Utilization for High Risk Patients
Measure Steward and Number	PCMHI 0013
Definition	Percentage of High Risk Patients who received Follow-up after Emergency Department Utilization
Data Source	Hospital EMR or records
Numerator	Patients included in the denominator who received a <u>visit or phone call</u> within <u>7 days</u> post-Emergency Department visit at the specific DSTI hospital
Denominator	<u>Hospital defined high risk patient population</u> with an Emergency Department visit at the specific DSTI hospital during a 12- month measurement period
Target Population Notes:	Hospital A: Target population is high risk patients enrolled in complex care management. Hospital A uses care team members to make outreach and visit encounters. Hospital B: Target population will be patients with high risk conditions, who receive an outreach call from Hospital B’s centralized service. Hospital C : Target population will be PACE participants.

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Exclusions	None
Associated Projects	2.2, 2.4, 3.5
Benchmark or Performance Goal	Shared Hospital Goal = 70%
Improvement Measurement Approach	Gap to Goal (10%) or attainment at target
Baseline Year	SFY 2015
Expected Years for Pay-for-Performance	SFYs 2016 and 2017
Notes	Metric subject to modification for refinement

MEASURE 23	Decrease in Utilization over Baseline for Emergency Department and Inpatient based on Longitudinal Tracking of the Super-Utilizer Population
Measure Steward and Number	Customized Measure
Definition	Average number of emergency department and inpatient visits for a defined cohort
Data Source	Hospital EMR and/or available total claims records for cohort
Numerator	Emergency Room Visits and Inpatient Acute Hospitalizations - Any Acute Hospital. Defined by claims submitted to the Health Plan.
Denominator	Defined cohort of patients with an assigned primary care physician at hospital who: Incurred \$25,000 year in medical expense over the prior 12 months Had 6 or more ED visits in each of the prior two 12 month periods
Target Population Notes	Longitudinal Tracking of Defined Super-Utilizer Population (see denominator)
Exclusions	Observation visits and mental health hospitalizations (numerator only)
Associated Projects	2.4
Benchmark or Performance Goal	No external benchmark. Hospital-specific target of X% decrease compared to baseline.
Improvement Measurement Approach	1% decrease compared to baseline
Baseline Year	4/1/15 – 3/31/16
Expected Years for Pay-for-Performance	SFY 2017
Notes	Metric subject to modification for refinement

MEASURE 24	Care Plans for High-Risk Patients
Measure Steward and Number	PCMHI 0014
Definition	The percentage of active high risk patients with either a newly developed care plan or care plan updated within 6 months (measured based on the average of monthly performance during the measurement period)
Data Source	Hospital EMR or records

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Numerator	Patients included in the denominator who have a care plan that was newly developed or updated within 6 months (measured based on the average of monthly performance during the measurement period)
Denominator	Hospital defined target high risk patient population as of month end during the measurement period
Target Population Notes	Hospital A: Target population is high risk patients actively enrolled in Complex Care Management Hospital B: Target population is active complex patients actively enrolled in high risk registry Hospital C: Target population is active complex patients actively enrolled in high risk registry
Exclusions	None
Associated Projects	2.1, 2.4
Benchmark or Performance Goal	Shared Hospital Target = 85%
Improvement Measurement Approach	Gap to Goal (10%) or attainment at target
Baseline Year	SFY 2015
Expected Years for Pay-for-Performance	SFY 2016 and SFY 2017
Notes	Metric subject to modification for refinement

MEASURE 25	Adherence to CMS-defined Transitional Care Management protocols
Measure Steward and Number	CMS 77 FR-68978
Definition	Patients receiving Transitional Care Management services in the ambulatory environment following an inpatient medical admission
Data Source	Hospital EMR or other hospital records
Numerator	Patients from denominator who met CMS-defined Transitional Care Management protocols in the ambulatory environment Transitional Care Management services, as defined by CMS, requires: <ul style="list-style-type: none"> • Interactive contact with the patient within 2 business days following discharge • Non-face-to-face care coordination, including a review of discharge information, follow-up on pending tests, establishing referrals, and arranging for community resources • A face-to-face visit with the primary care provider within 7 calendar days for high-risk patients, and 14 calendar days for moderate-risk patients http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
Denominator	Patients with a hospital discharge (at the specific DSTI hospital) following an unplanned medical admission during the measurement period from Pod A. Pod A (currently consisting of 4 Internal

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	Medicine providers and over 6,000 patients)
Target Population Notes	Defined target patient population discharged from Hospital A BH from Pod A (currently consisting of 4 Internal Medicine providers and over 6,000 patients)
Exclusions	None
Associated Projects	3.1
Benchmark or Performance Goal	Hospital-defined targets: 25% in SFY 2016, 50% in SFY 2017
Improvement Measurement Approach	Achieve established targets
Baseline Year	SFY 2015
Expected Years for Pay-for-Performance	SFY 2016 and SFY 2017
Notes	Metric subject to modification for refinement

MEASURE 26	CMS Skilled Nursing Facility Days for Target Population
Measure Steward and Number	Customized Measure based on CMS Chronic Condition Data Warehouse (CCW)
Definition	The number of skilled nursing facility/rehabilitation facility days per 1,000 enrollees/beneficiaries
Data Source	Claims data available to hospital
Numerator	Count of Skilled Nursing and Rehabilitation Facility Days
Denominator	Number of Pioneer ACO enrollees/beneficiaries
Target Population Notes	Medicare Pioneer ACO patients attributed to Hospital Choice Plus PHO
Exclusions	None
Associated Projects	3.3
Benchmark or Performance Goal	2636 days / 1000 enrollees or beneficiaries, which is based on CCW Mass 2012 Medicare days/1000 beneficiaries = 2636
Improvement Measurement Approach	Gap to Goal (5%) or attainment at target
Baseline Year	SFY 2015
Expected Years for Pay-for-Performance	SFY 2016 and SFY 2017
Notes	Benchmark source: Health Indicators Warehouse, Chronic Disease and Conditions Developed by the National Center for Health Statistics 2012 Skilled nursing facility Medicare days per 1,000 beneficiaries http://www.healthindicators.gov/Resources/Initiatives/CMS/Skilled-Nursing-Facilities-Report_24/Indicator/Report Metric subject to modification for refinement

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MEASURE 28	Increase Percentage of MCO members who select a PCP within the DSTI hospital network who are covered under at-risk contracts
Measure Steward and Number	Customized Measure
Definition	Percentage of MCO members who select a PCP within the DSTI hospital network who are covered under at-risk contracts
Data Source	Hospital EMR or other records
Numerator	Number of MCO members who select a PCP within the DSTI hospital network covered under an at-risk contract
Denominator	Total number of MCO members who have selected a PCP within the hospital network
Target Population Notes	
Exclusions	MCO members who have not selected a PCP within the hospital network
Associated Projects	3.7
Benchmark or Performance Goal	No external benchmark; Hospital-specific benchmark is 100%.
Improvement Measurement Approach	Gap to Goal (10%) or attainment at target
Baseline Year	SFY 2015
Expected Years for Pay-for-Performance	SFY 2016 and SFY 2017
Notes	Metric subject to modification for refinement

MEASURE 29	Increase Primary Care Utilization for hospital-defined target population
Measure Steward and Number	Customized Measure
Definition	Increase the percentage of new and/or inactive patients in hospital-defined target population who have primary care utilization in the measurement year compared to initial baseline year
Data Source	Hospital EMR or records
Numerator	Patients from the denominator that have at least one primary care visit in the measurement year
Denominator	Hospital target population of new and/or inactive patients
Target Population Notes	<p>Hospital A <u>Target Population</u>: New or inactive patients are patients first assigned to Hospital A by the Medicaid Primary Care Payment Reform (or other payer if no longer in PCPR), who upon their assignment date were new patients to Hospital A primary care or who were not active with primary care at Hospital A, and who were continuously enrolled in PCPR program from their assignment date to the end of the measurement year.</p> <p>Hospital B <u>Target Population</u>: Emergency Department patients that are eligible for patient navigation and scheduled for a Steward primary care appointment. Eligible patients are patients that meet at least one of the following criteria: (1) uninsured, (2) 6+ visits to the Emergency Department in one year,</p>

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	and (3) currently without a primary care provider.
Exclusions	For Hospital A: patients who do remain in the Medicaid payment reform cohort for the full measurement year will be removed from the numerator and denominator.
Associated Projects	3.9, 1.5
Benchmark or Performance Goal	Improvement over SFY 2015 baseline In SFY 2016: by at least one percentage point (1%) above the SFY 2015 baseline percentage In SFY 2017: by at least two percentage points (2%) above the SFY 2015 baseline percentage
Improvement Measurement Approach	Achieve defined improvement targets over FY 2015 baseline.
Baseline Year	SFY 2015 (For Hospital A: Denominator for baseline year will be based on the number of unique patients first assigned to Hospital A by Medicaid PCPR during the period of 6/1/14 – 5/31/15)
Expected Years for Pay-for-Performance	SFY 2016 and SFY 2017 (Hospital A Measurement Year = 7/1 – 6/30)
Notes	Metric subject to modification for refinement

Updates to technical specifications of outcomes and improvement measures in Categories 4A and 4B must be submitted to EOHHS and CMS for review and approval; however, they shall not require a plan modification.

XI. CATEGORY 4B: POPULATION-FOCUSED IMPROVEMENTS

31. All participating safety net hospitals will develop plans to report on a core set of Category 4B measures pursuant to Section XI, Attachment J.

- a) All Hospitals must report on nine Common Improvement Measures and one measure tracking global payment arrangements in DY18/SFY15 through DY20/SFY17, with the exception of measure 4B (7) Early Management Bundle, Severe Sepsis/Septic Shock (NQF 0505) which will commence reporting in DY19/SFY16 as it is a new national measure effective October 1, 2015. Hospitals that do not provide behavioral health and substance abuse services in inpatient psychiatric units will not be required to report on the measure SUB-1: Alcohol Use Screening related to that area.

Category 4B measures are measures in which the majority of DSTI hospitals have opportunities for improvement and represent areas of national and state priority including focus areas on: care transitions and readmission prevention, United States Health and Human Services national quality strategy priorities on a leading cause of mortality (sepsis), patient safety/healthcare associated infections, tobacco use treatment, and substance use screening. Due to the different hospital delivery system services, the common measures are largely comprised of inpatient and care transitions measures. Because this category involves evaluating the initiatives and system changes through population-focused objectives, the common measure set is organized around the Triple Aim, as described below.

As described in VII. Disbursement of DSTI Funds, paragraph 20, Category 4B population-focused improvement measures are pay-for-reporting in DYs 18 – 19 (10% of total annual DSTI hospital-specific funds). In DY20, a component of Category 4B funding (7.5% of total annual DSTI hospital-specific funds) becomes pay-for-performance, of which 5% of annual DSTI hospital-specific funds is allocated to the Category 4B readmission measure(s) and 2.5% of the annual DSTI hospital-specific funds is allocated equally across the specified number of pay-for-performance improvement measures for achievement. In addition, 5% of annual DSTI hospital-specific funds is allocated to pay-for-reporting relative to Category 4B measures (9 indicators for hospitals with inpatient psychiatric services and 8 indicators for hospitals without inpatient psychiatric services).

Given the various starting places and improvement opportunities across DSTI hospitals, 2.5% of at-risk Category 4B funding in year 3 (DY20/SFY 2017) will be payable relative to a hospital's achievement of 5 of the 8 pay-for-performance improvement measures one of which will be 4B (1) on readmissions (note that the measure on global payment arrangement is pay-for-reporting across DYs 18 – 20 to track the progression of global payment arrangements). For DSTI hospitals that do not have inpatient psychiatry services, such hospitals will be required to achieve 4 out of 7 improvement measures.

DSTI hospitals will receive payment when a measure is individually achieved and reported, up to the established number (4 or 5 as described above) of pay-for-

performance improvement measures indicators assigned funding in year 3. The DSTI Hospital is not required to pre-determine which pay-for-performance improvement measures will be achieved in terms of performance goals in year 3.; However, the readmission measure(s) are separately allocated 5% of annual DSTI hospital-specific funding for year 3 achievement. Relative to the 5% of DY20/SFY 2017 annual DSTI hospital-specific funds tied to readmission measure(s), DSTI hospitals can choose either a) 5% allotted to the 30-day all cause readmission measure or b) 2.5% allotted to the 30-day all cause readmission measure and 2.5% allotted to a condition-specific readmission measure. DSTI hospitals will select the option for the readmission measure(s) in their January 2016 semi-annual report.

For hospitals that are at a high performance level for the readmissions measure at baseline (defined at greater than the 80th percentile), an alternate improvement target will be applicable.

The alternate improvement target options for DSTI hospitals that achieve high performance on the readmissions measures at baseline will include:

- Achievement of gap-to-goal improvement toward the 90th percentile of MassHealth population readmissions; or
- The achievement of one of the following three outcomes measures (measured by MassHealth claims data) for the high risk patient target population identified by the respective DSTI hospital in its Community-Based Care Delivery and Integration initiatives, described in Section XII:
 - Decreasing emergency department utilization for target population;
 - Decreasing inpatient utilization for target population; or
 - Decreasing total cost of care for the target population.

High performance hospitals at baseline on the readmissions measures can opt to report both of the alternate improvement options above and achieve improvement on one of the options in order to receive full payment.

For the readmission measure 4B (1) or replacement measure for high performance hospitals, a partial payment policy will apply in the event that partial achievement toward the improvement target is achieved. DSTI hospitals may receive partial payment for making progress towards, but not fully achieving, the readmissions measure outcome improvement target or the alternative improvement measure for high performance hospitals on readmission(s). The partial payment would equal 25 percent, 50 percent, or 75% of the achievement value of that outcome improvement target. Based on the progress reported, the outcome improvement target will be categorized as follows to determine the total achievement value percentage:

- Full achievement (achievement value = 1 or 100%)
- At least 75 percent achievement (achievement value = .75 or 75%)
- At least 50 percent achievement (achievement value = .5 or 50%)
- At least 25 percent achievement (achievement value = .25 or 25%)
- Less than 25 percent achievement (achievement value = 0).

The improvement measurement methodology applicable to Category 4B is outlined below in paragraph 31 (b).

Below is a description of the Category 4B measures.

Better Care: Improve the overall quality of the US health system by making health care more patient-centered, reliable, accessible, and safe.

These goals, set forward by the Institute of Medicine in *Crossing the Quality Chasm*, are important domains for assessing the effectiveness of care improvements. In the context of the DSTI program, there is a focus on both the quality and experience of patient care.

One area of increasing national attention has been a focus on improvement of care transitions between providers or settings of care. Health care transitions, such as moves in and out of hospitals to post-acute care/nursing home care, home care (with and without home care supports), or outpatient care have been shown to be prone to medical errors; poor care coordination, infections and incorrect usage of medications—leading to potentially avoidable hospital readmissions, less than optimal patient health outcomes, and added health care costs. This is especially the case for complex care needs, patients with social acuity, and co-occurring health conditions.

Given the importance of examining patient care transitions and their effect on patient outcomes, three Common Measures, utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey focus on whether patients' felt they had a good understanding of their medications and care needs post-discharge. Medication adherence and errors are a leading source of unnecessary emergency and acute care; therefore, it is an area of shared focus.⁹⁴ Included within the HCAHPS measures is the Three-Item Care Transition Measure (CTM-3). This measure set has recently been added as a voluntary option to the HCAHPS survey.

Better Health: Improve the health of the population by supporting proven interventions and enhancing the quality of care delivered.

Many of today's individual health care processes are designed to respond to the acute needs of individual patients, rather than to anticipate and shape patterns of care for important subgroups. Population health focuses on segmenting the population, perhaps according to health status, level of support from family or others, and socioeconomic status, to facilitate efficient and appropriate care delivery. The Category 4B common measures share a focus on examining population dynamics.

For instance, according to the Centers for Disease Control, cigarette smoking is the leading cause of preventable disease and death in the United States, accounting for more

⁹⁴ Forster AJ, Murff HJ, et al. "The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital." *Ann Intern Med.* (2003) 138:161-167.

than 480,000 deaths every year, or 1 of every 5 deaths.⁹⁵ Two measures in Category 4B aim to change those statistics: NQF 1654 as implemented by MassHealth TOB-2: Tobacco Use Treatment Provided or Offered and NQF 1656 as implemented by MassHealth TOB-3: Tobacco Use Treatment Provided or Offered at Discharge. Studies show that the availability and effectiveness of tobacco dependence interventions have a positive impact on health outcomes for those suffering from and for those who may suffer from tobacco-related diseases. There is an additional benefit of the positive impact on the cost of care if a tobacco-related disease can be avoided.⁹⁶

The shared hospital measures SEP-1 (NQF 0500): Early Management Bundle, Severe Sepsis/Septic Shock and NQF 1717: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure will also impact each hospital's ability to provide better health for their communities. The Severe Sepsis and Septic Shock Early Management Bundle provides a standard operating procedure for the early risk stratification and management of a patient with severe infection. Through applying this standard operating procedure a clinically and statistically significant decrease in organ failure, mortality, and the utilization of health care resources has been demonstrated for over ten years.⁹⁷

Clostridium difficile is responsible for a spectrum of C. difficile infections (CDI), which can, in some instances, lead to sepsis. In recent years, a previously unrecognized strain of C. difficile with increased virulence and high levels of antimicrobial resistance has resulted in outbreaks in healthcare facilities in the United States.⁹⁸ Additionally, CDI has become more common in the community setting, with increased risk in those with a recent inpatient stay in a healthcare facility.⁹⁹

Additionally, for hospitals that provide behavioral health and substance abuse services in an inpatient setting, the SUB-1: Alcohol Use Screening will be reported as a Category 4B shared measure. The goal of the measure is to screen hospitalized patients within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use. Hospitalization provides a prime opportunity to address substance use, and for many patients, controlling their other health problems requires addressing their substance use.¹⁰⁰ Addressing substance use issues can reduce the occurrence of other health problems.

Cost-Effective Care: Improve cost-effectiveness of care through improved care delivery for individuals, families, employers, and the government.

⁹⁵ U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2015 May 19]

⁹⁶ Specifications Manual for National Hospital Inpatient Quality Measures Discharges 01-01-15 (1Q15) through 09-30-15 (3Q15), Version 4.4, Attachment TOB3.

⁹⁷ National Quality Forum, NQF #0500 Severe Sepsis and Septic Shock: Management Bundle, Last Updated Date: Oct 05, 2012, Measure Submission and Evaluation Worksheet 5.0

⁹⁸ Epidemic, Toxin Gene-Variant Strain of Clostridium difficile. N Engl J Med, 2005. 353(23):2433-2441.

⁹⁹ Recommendations for Surveillance of Clostridium difficile-associated Disease. Infect Control Hosp Epidemiol, 2007. 28(2):140-145.

¹⁰⁰ Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: Long-term efficacy and cost-benefit analysis. Alcohol Clin Exp Res. 2002 Jan;26(1):36-43.

Measures that provide insights both into improved opportunities for health care delivery and health care cost-effectiveness are an area of particular focus in the Triple Aim. Many of the DSTI Category 1-3 projects include a specific focus on improving population health outside of the walls of the hospital (e.g. Primary Care Medical Homes, Health Information Exchanges, ACO development, etc.); therefore, it will be important to examine measures within the Category 4 Common Measures that look at hospital care indicators that are ambulatory-sensitive and that have the potential for better care coordination or care venues. Preventable readmissions are an area of nationwide focus, both for their cost and health implications, but also because many readmissions are the result of poor care hand-offs and lack of care coordination post discharge.

Recognizing that payment reform is necessary and a goal of the DSTI program in the Commonwealth, hospitals will report information related to their global payment agreements, including both upside only and upside/downside risk agreements. Such payment agreements take into account the total cost of care and the quality of care, which the hospital industry is concurrently trying to reduce and increase, respectively.

b) Improvement Measurement Approach

Payment-for-performance on these outcome and improvement measures will be based on an objective demonstration of improvement over baseline or attainment at established performance thresholds using a valid, standardized method, as described below. As Category 4B becomes pay-for-performance in year 3 (DY20/SFY 2017), it is possible that some hospitals may be approaching a high performance level on selected measure(s) based on their years 1 and 2 performance (DY18/SFYs 2015 and DY19/2016). In those instances, such hospitals shall be permitted to continue with those specific measures as part of the pay-for-performance measure slate, and the threshold for payment for associated measures will be attainment at or above the specific benchmark. In instances where the 90th percentile performance benchmark exceeds 90% compliance on a specific measure, then an organization will achieve success toward that benchmark by attaining 90% compliance or gap-to-goal improvement as described below.

For Category 4B, if a benchmark is available the organization must meet gap to goal (5% or 10% based on metric classification described below) or as in the specified improvement measurement approach included in the Category 4B measure table below.

In the event that the organization meets the benchmark in year 2 (DY19/SFY 2016, the organization must maintain performance at or above the benchmark in year 3 (DY20/SFY 2017). Any variation in performance is acceptable as long as the performance for year 3 is at or better than benchmark in this case.

If a benchmark is not available the organization or if the specific measure is more appropriate to improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures), the baseline comparison period is specified in the Category 4B measure table below.

If a Category 4B metric is classified as excluded, payment will not be impacted by these metrics.

- i. All participating hospitals must have a target for outcome and quality improvement indicators in Category 4B. The specified target included in the following table for Category 4B measures will be used to determine whether or not the associated metric was achieved.
 - ii. The following is a guiding hierarchy that was used in the Commonwealth's development and selection of the specified improvement method, benchmarks and/or targets for the Category 4B measures as outlined in the table below. All performance targets will be established during SFY 2015 in the measure menus for Category 4B, and will be in place for the demonstration period.
 - a. Select the latest available 90th percentile Massachusetts Medicaid (2014) during DY18/SFY 2015. For CMS core inpatient measures and other inpatient measures, utilize available Massachusetts performance data.
 - b. If above not available, select the latest available 90th percentile National Medicaid during DY18/SFY 2015. For CMS core inpatient measures and other inpatient measures, utilize available National performance data.
 - c. If above not available, select other available benchmark (such as other latest available National benchmark) or hospital-defined target during DY18/SFY 2015.
 - d. If above not available or if the specific measure is more appropriate to improvement over hospital baseline (such as non-risk adjusted, utilization improvement measures, and/or the new national measure SEP-1 (NQF 0500)), any improvement over DY18/SFY 2015 hospital baseline or stated baseline will be the improvement measurement method or as specified in the table below.
- c) **Metric Classifications for Category 4B Metrics**
Metrics will be classified into the following groups: (1) Clinical care delivery improvement measures; (2) Clinical outcomes measures; (3) other delivery/outcomes measures where there is not a standardized benchmark and/or if the specific measure is more appropriate to improvement over hospital baseline; and (4) as it relates to Category 4B Population-Focused Improvements, there may be excluded measures if a hospital does not provide the specific service, serve the specified population, or has a small sample size.
- i. Clinical care delivery improvement measures quantify a performance exhibited by clinical care practices, such as health screenings, and therefore are usually directly observable and can be directly impacted. In general, these metrics fit with a gap-to-goal methodology. All metrics classified as clinical care delivery measures must have an acceptable benchmark. To meet the threshold for success, organizations must achieve closure of 10% of the difference between the

hospital's baseline performance and the established benchmark or maintain at or above the benchmark.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 10\%$$

An example of a clinical care delivery measure is influenza immunization (NQF 0041).

- ii. Clinical outcome measures are metrics influenced by patient case mix, multiple processes, and environmental factors. In general, these metrics fit with a gap-to-goal methodology, depending on the availability of performance benchmarks. Since improvement on outcomes measures requires considerable amounts of resources and time and is dependent on foundational care delivery improvements and patient factors, closure of 5% of the difference between the hospital's baseline performance and the established benchmark is included. To meet the threshold for success, organizations must meet the 5% gap to goal, where the organization must achieve a minimum of 5% of the difference between the benchmark and the baseline performance or maintain at or above the benchmark.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 5\%$$

Examples of clinical outcome measures are Controlling High Blood Pressure (NQF 0018) and Comprehensive Diabetes Care: Hemoglobin A1c Control (NQF 0575).

- iii. Non-standardized benchmark delivery/outcomes measures are metrics that do not have an available or acceptable benchmark and/or are specific measures that are more appropriate for improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures). To meet the threshold for success, for pay-for-performance measures applicable to year 3 (DY20/SFY 2017), organizations must show improvement from baseline (DY18/SFY 2015) to performance year (DY20/SFY 2017) or as specified in the table below.

Examples of a non-standardized benchmark delivery/outcomes measure is readmission rates or emergency department utilization rates. These measures are influenced by many factors (which may include patient case mix, multiple processes, and environmental factors). Given that these measures are not risk-adjusted approach, the use of an organization's historical performance is a pragmatic approach to DSTI. Another example of a non-standardized benchmark delivery/outcomes measure is the SEP-1 (NQF 0500) measure, which is a new national measure and no benchmark data is available.

- iv. Excluded measures are metrics from the Category 4B common measures that are not relevant to a specific hospital because a specific service is not given, a specific population is not served by that hospital, or there are sample sizes less than 30 cases for either the baseline (SFY 2015) or performance year (SFY 2017).

For example, not all hospitals have inpatient hospital psychiatry units, inpatient maternity services, and/or inpatient pediatric services. Therefore, these hospitals are not subject to submitting data on related metrics and will be excluded for those hospitals.

v. Category 4B: Population-Focused Improvements

Category 4B: Common Measures and Steward	Benchmark and DY20 (SFY 2017) Improvement Method	Measurement Period	Reporting Date(s) to EOHHS
<p>4B (1): Readmissions¹⁰¹</p> <p>MassHealth population: Hospital-wide, 30-Day, All-Cause Unplanned Readmission Measure NQF 1789) Or Combination of MassHealth population: Hospital-wide, 30-Day, All Cause Unplanned Readmission Measure (HWR) (NQF 1789) and a MassHealth population condition-specific readmission measure from among the following condition-specific measures: 4B (1a) Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF 1891); 4B (1b) Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate (RSRR) following heart failure (HF) Hospitalization (NQF 0330); 4B (1c) Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate (RSRR) following pneumonia Hospitalization (NQF 0506); or 4B (1d) Hospital 30-Day Readmission Rate following asthma hospitalization all-cause Pediatric (ages 2-18).</p> <p><i>Data Source: MassHealth claims</i></p>	<p>MassHealth population: Hospital-wide, 30-day, All-Cause Unplanned Readmission Measure (HWR) (NQF 1789) or</p> <p>MassHealth population: Hospital-wide, 30-day, All-Cause Unplanned Readmission Measure (HWR) (NQF 1789) and MassHealth population: Condition-Specific Readmission Measure selected from measures 4B (1a) – 4B (1d)</p> <p>Target = MassHealth 80th percentile established based on baseline data. Gap to Goal (10%) Note: See Master DSTI Plan provisions in paragraph 31 for measurement approach for high performance hospitals above the target at baseline</p>	<p>DY18: N/A</p>	
		<p>DY19: 3 year baseline data developed by MassHealth (4/1/12 – 3/31/15)</p>	<p>7/31/2016*¹⁰² (could be data lag beyond this date)</p>
		<p>DY20: 4/1/2016 - 3/31/2017</p>	<p>7/31/2017* (could be data lag beyond this date)</p>

¹⁰¹ DSTI hospitals will select the readmission measure(s) in their January 2016 semi-annual report for payment, upon evaluation of baseline data provided by MassHealth.

¹⁰² EOHHS will use MassHealth claims data to calculate performance on readmissions measures to determine whether hospitals are eligible for payment on this measure. EOHHS anticipates providing readmissions results in August/September of 2016 and 2017, in order to ensure the entire performance period is captured and to calculate the results.

Category 4B: Common Measures and Steward	Benchmark and DY20 (SFY 2017) Improvement Method	Measurement Period	Reporting Date(s) to EOHHS
4B (2): Care Transitions Measure Set (CTM-3) <i>HCAHPS questions; Hospital top box</i> <i>Data Source: Hospital vendor, Hospital Compare or Hospital Compare Preview Report as available</i>	Target = 55.9% Top Box Score (which is the equivalent score related to the 70 th percentile rank as of June 2014 from Press Ganey). Gap to Goal (5%) or attainment at target.	DY18: 7/1/13 – 6/30/14	7/31/2015
		DY19: 7/1/14 – 6/30/15	7/31/2016
		DY20: 7/1/15 – 6/30/16	7/31/2017
4B (3): CCM-2: Transition record with data received by patient at inpatient discharge <i>Data Source: Hospital data</i>	No benchmark available; hospital-shared improvement target = 81.5% ¹⁰³ Gap to Goal (10%) or attainment at target	DY18: 1/1/2014 – 12/31/2014	7/31/2015
		DY19: 1/1/2015 – 12/31/2015	7/31/2016
		DY20: 1/1/2016 – 12/31/2016	7/31/2017
4B (4): CCM-3: Timely Transmission of Transition Record <i>Data Source: Hospital data</i>	No benchmark available; hospital-shared improvement target = 88.7% ¹⁰⁴ Gap to Goal (10%) or attainment at target	DY18: 1/1/2014 – 12/31/2014	7/31/2015
		DY19: 1/1/2015 – 12/31/2015	7/31/2016
		DY20: 1/1/2016 – 12/31/2016	7/31/2017
4B (5): NQF 1654 as implemented by MassHealth TOB-2: Tobacco Use Treatment Provided or Offered <i>Data Source: Hospital data</i>	Target = Joint Commission 75 th percentile = 78.0% Gap to Goal (10%) or attainment at target	DY18: 1/1/2015 – 3/31/2015	7/31/2015
		DY19: 4/1/2015 – 3/31/2016	7/31/2016
		DY20: 4/1/2016 – 3/31/2017	7/31/2017

¹⁰³ CCM-2 hospital-shared improvement target was established based on the 90th percentile of the most recent performance across the DSTI hospital group, as no other benchmark data is available at this time.

¹⁰⁴ CCM-3 hospital-shared improvement target was established based on the 90th percentile of the most recent performance across the DSTI hospital group, as no other benchmark data is available at this time.

Category 4B: Common Measures and Steward	Benchmark and DY20 (SFY 2017) Improvement Method	Measurement Period	Reporting Date(s) to EOHS
4B (6): NQF 1656 as implemented by MassHealth TOB-3: Tobacco Use Treatment Provided or Offered at Discharge <i>Data Source: Hospital data</i>	Target = Joint Commission 75 th percentile = 53.1% Gap to Goal (10%) or attainment at target	DY18: 1/1/2015 – 3/31/2015	7/31/2015
		DY19: 4/1/2015 – 3/31/2016	7/31/2016
		DY20: 4/1/2016 – 3/31/2017	7/31/2017
4B (7): SEP-1: Early Management Bundle, Severe Sepsis/Septic Shock (NQF 0500) ¹⁰⁵ <i>Data Source: Hospital data</i>	No benchmark available; Improvement over hospital-specific baseline reported in SFY 2016 ¹⁰⁶	DY18: N/A	
		DY19: 10/1/2015 – 3/31/2016	7/31/2016
		DY20: 4/1/2016 – 3/31/2017	7/31/2017
4B (8): NQF 1717: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure <i>Data Source: Hospital data</i>	Target = Standardized Infection Ratio (SIR) of 1. Gap to Goal (5%) comparing baseline reported in DY18 to DY 20 performance or attainment at target of 1 or less.	DY18: 1/1/2014 – 12/31/2014	7/31/2015
		DY19: 1/1/2015 – 12/31/2015	7/31/2016
		DY20: 1/1/2016 – 12/31/2016	7/31/2017
4B (9): SUB-1: Alcohol Use Screening <i>Data Source: Hospital data</i> <i>Note: Applicable for hospitals with inpatient psychiatric units</i>	Target = Joint Commission 75 th percentile = 94.2% Gap to Goal (10%) or attainment at target	DY18: 1/1/2014 – 12/31/2014	7/31/2015
		DY19: 1/1/2015 – 12/31/2015	7/31/2016
		DY20: 1/1/2016 – 12/31/2016	7/31/2017
4B (10): A. Percent of Contracts in Global Payment Arrangements (weighted) and B. Percent of attributed primary care panel patients (B. is only applicable to hospitals with primary care panels) under a contract with	N/A; Pay-for-Reporting Only	DY18: Snapshot as of June 2015 (see technical specifications)	7/31/2015
	N/A; Pay-for-Reporting Only	DY19: Snapshot as of June 2016 (see technical specifications)	7/31/2016

¹⁰⁵ SEP-1 (NQF 0500) is a new measure effective October 1, 2015; therefore, baseline data will be submitted in DY19 (SFY 2016).

¹⁰⁶ The improvement methodology for the new SEP-1 measure is improvement over hospital-specific baseline, which will first be reported for the measurement period 10/1/2015 – 3/31/2016. No external benchmark data is available for this new measure, and hospitals do not have baseline experience at this time.

Category 4B: Common Measures and Steward	Benchmark and DY20 (SFY 2017) Improvement Method	Measurement Period	Reporting Date(s) to EOHHS
accountability for total cost of care and quality, broken out by shared savings only versus shared savings/risk; disaggregated by payer category and aggregated (Note: uses CHIA Global Payment definition)	N/A; Pay-for-Reporting Only	DY20: Snapshot as of June 2017 (see technical specifications)	7/31/2017

Updates to technical specifications of outcomes and improvement measures in Categories 4A and 4B must be submitted to EOHHS and CMS for review and approval; however, they shall not require a plan modification.

XII. COMMUNITY BASED CARE DELIVERY AND INTEGRATION

32. Each provider organization seeking to provide high value, community based care in a payment reform environment will need key structural capabilities to manage the health of populations, and in particular high risk (and usually high cost) patients. These capabilities include:

- 1. Identification of high utilizers:** Regularly identifying and tracking high risk/high utilizer patients, based on factors such as frequent emergency department utilization and inpatient admissions
- 2. Formation of community high utilizer collaborations:** Developing community-wide coordinated approaches to care for high risk/high utilizer patients through partnerships with community-based providers, such as through community collaborations that meet regularly
- 3. Development of individual care plans:** Ensuring that key elements of high risk/high utilizer patients' individual care plans are multi-disciplinary and are reflective of community-based care and services coordinated for patients
- 4. Collaboration on care coordination and referrals:** Providing comprehensive, cross continuum care coordination, with those services coordinated among key medical, social, and behavioral health providers, with clear referral protocols, and plans for access to non-emergent care
- 5. Data sharing:** Using standard consent forms and data sharing agreements to facilitate coordination of patient care
- 6. Use of real-time alerts:** Collaborating with providers, payers and/or other partners to develop the capability to send and receive real-time alerts to care managers/coordinators and primary care providers as patients move across the delivery system (e.g., admission, discharge, or transfer notifications)

Requirements and Measures for DSTI Hospital and EOHHS Discussion

DSTI Requirements

Hospitals should demonstrate that they have made significant, measurable progress in the development of the structural capacities/processes described above by the end of Year 3 of the waiver in order to qualify for at-risk payments tied to measures in Category 4A and 2.5% associated with pay-for-performance measures in Category 4B. There is no specific incentive funding that will be paid based on achievement of these metrics; rather, each hospital must demonstrate progress on each of these standards in order to be eligible to receive incentive payments tied to Category 4A measures.

Measures

- 1. Identification of High Utilizers/High Risk Patients (HU) – demonstrate all**
GOAL: To demonstrate that DSTI hospitals have an established process to identify high utilizers.
 - a. Documentation of an established definition of HU actively used to identify HU patients for care management interventions

- i. Each hospital will implement a methodology to identify high utilizers and/or high risk patients for potential care management interventions; the definition may include subpopulations and must, at a minimum, include some Medicaid patients.
 - 1. This methodology may take into account high utilization of inpatient and emergency services, high risk scores, and/or high costs. Hospitals may propose their hospital-specific methodology (but the methodology should not result in an inordinately small population).
 - ii. Hospitals must submit the methodology to MassHealth for review by 12/31/2015. MassHealth will review and provide feedback by 2/28/2016 and approve each hospital's methodology by 3/31/2016, provided that the hospital has addressed any feedback appropriately.
 - iii. Documentation of completion: Each hospital will provide documentation of its definition and MassHealth's approval of that definition.
- b. Hospital has identified high-utilizer/high risk individuals who are HU according to the DSTI hospital's specified definition, for at least the period from January 1-June 30, 2017.
 - i. In order to facilitate identification, MassHealth will provide relevant data for MassHealth members (e.g., utilization and cost data for the DSTI hospital's attributed or served population).
 - ii. Documentation of completion: Each hospital will provide a de-identified list of high utilizers and if applicable, demonstrate how these individuals are divided into subpopulations.

2. **Community HU Collaborative(s) – Demonstrate all**

GOAL: To demonstrate that DSTI hospitals have established structures to collaborate with community partners in order to coordinate care for HU.

- a. Community HU Collaborative(s) (that may be subpopulation based) have been formally established, meet regularly and include key local providers and relevant community partners that provide a significant portion of care for the hospital's HU population/ subpopulation.
- b. The collaborative(s) include medical, social, and/or behavioral health service providers, as applicable to the defined HU population or subpopulation. The collaborative(s) must include partners both within and outside of the hospital system (e.g., primary care practices, community health centers, community behavioral health providers, VNA, and/or homeless services providers).
- c. The goal will be to review the overall care coordination and management process for the HU population and opportunities for further development, which may be highlighted through case reviews. The collaborative(s) will also identify and address treatment and delivery system gaps within the community, with a focus on the HU population.
- d. MassHealth will review and approve each hospital's structure and composition of collaborative(s) that address the needs of high utilizers. Each DSTI hospital must submit a description of its structure(s) to MassHealth for review by 6/30/2016.

MassHealth will review and provide feedback by 8/31/2016 and approve each hospital's structure by 9/30/2016, provided that the hospital has addressed any feedback appropriately.

- e. Documentation of completion: Each hospital will provide documentation of the collaborative(s) structure and composition (and MassHealth's approval), meeting dates, agendas, list of attendees and action items that result from these meetings.
3. **Data Sharing – Demonstrate all**
GOAL: To demonstrate that DSTI hospitals have formal agreements in place in order to share data regarding high utilizers.
- a. Each hospital will establish data sharing agreements with relevant providers, including providers participating in the collaborative(s) described in (2) above.
 - b. Documentation of completion: Each hospital will provide a list of local providers with which they have a data sharing agreement, and will have sample patient consent forms, protocols, and data sharing agreements available if requested by EOHHS.
4. **Patient Engagement and Care Plans – Demonstrate a and b, and report c and/or d**
GOAL: To demonstrate that DSTI hospitals have an established process to incorporate care plans into the care coordination and management of high utilizers(HU).
- a. Documentation of a DSTI hospital's patient engagement plan and standardized care plan format/template for HU.
 - b. Documentation of how key elements of the information in HU care plans are shared with the collaborating care team members to facilitate effective care coordination and management.
 - c. Report percent of HU or HU subpopulation that agree to participate in care management initiative.
 - i. Numerator: All HU that have agreed to participate in the care management initiative
 - ii. Denominator: Total number of HU or subpopulation, as defined by hospital's definition
 - d. Report percent of HU or HU subpopulation who have agreed to participate in the care management initiative that have individual care plans created in accordance with the DSTI hospital's standardized template
 - i. Numerator: All HU that have agreed to participate in the care management initiative with individual care plan that has been created in accordance with the standardized template
 - ii. Denominator: All HU that have agreed to participate in the care management initiative.
 - e. Documentation of completion:
 - i. For a, each DSTI hospital will provide a narrative description of its plan patient engagement, a standardized care plan template and a representative (de-identified) sample of completed standardized care plans.

- ii. For *b*, each DSTI hospital will provide documentation describing how key elements of information in care plans are shared among collaborating care team members.
- iii. For *c* and/or *d*, each hospital will report the percentage of HU that agree to participate in the care management initiative and/or percentage of HU that have care plans. Hospitals should report the numerator, denominator and percentage.

5. **Care Coordination, Referral and Follow-Up** – *Demonstrate two or more (including at least one of a-c and at least one of d-g)*

GOAL: To demonstrate that DSTI hospitals have established resources and protocols for care coordination and are engaging the HU population or subpopulation.

- a. Documentation of operational referral protocols among partnering providers for the HU population or subpopulation.
- b. Documentation of shared care coordination protocols with partnering providers for the HU population or subpopulation.
- c. Documentation of an asset map that documents community resources available to serve HU. The asset map should specify access points for after-hours care (e.g., urgent care centers, nurse care lines, etc.).
- d. Report percent HU or HU subpopulation who have agreed/enrolled in care management with successful contact (phone call or visit) with a care team member within a specified timeframe after an inpatient discharge at the DSTI hospital (e.g., 2 business days or 72 hours).
 - i. Numerator: All HU who have agreed/enrolled in care management with successful contact (phone call or visit) with a care team member within the specified timeframe after an inpatient discharge from the DSTI hospital during the measurement period
 - ii. Denominator: All HU who have agreed/enrolled in care management who had an inpatient discharge from DSTI hospital during the measurement period
- e. Report percent HU or HU subpopulation who have agreed/enrolled in care management with successful contact (visit or phone call) with a care team member within a specified timeframe after an ED visit at DSTI hospital (e.g., 7 days).
 - i. Numerator: All HU who have agreed/enrolled in care management with successful contact (visit or phone call) with a care team member within the specified timeframe after an ED visit at DSTI hospital during the measurement period
 - ii. Denominator: All HU who have agreed/enrolled in care management with an ED visit at the DSTI hospital during the measurement period
- f. Report percent HU or HU subpopulation who have agreed/enrolled in care management who maintained at least monthly contact/interaction with care manager/care team member during measurement period.

- i. Numerator: All HU who have agreed/enrolled in care management with at least monthly contact/interaction with care manager/care team member during the measurement period.
 - ii. Denominator: All HU who have agreed/enrolled in care management
 - g. Report percent HU or HU subpopulation who have agreed/enrolled in care management who have home visit and/or primary care follow up visit within 7 days of (ED or inpatient) discharge from DSTI hospital
 - h. Documentation of completion: For the options selected, each hospital must provide documentation of the operational referral protocols, care coordination protocols, asset map, and/or reports from *d–g*. Reported percentages should include both numerator and denominator.
6. **Real Time Alerts** – *Demonstrate one or more (must include a)*
- GOAL:** To demonstrate that DSTI hospitals have established or are actively working to establish processes to send and receive real-time alerts for ED and inpatient admissions, discharges and transfers (ADT) for the HU population or subpopulation.
- a. Report summarizing collaboration activities with providers, payers and/or other partners to develop the capability to send and receive real-time alerts to care managers/ coordinators and primary care providers as patients move across the delivery system (e.g., ADT notifications).
 - b. Report summarizing activities on care transitions to facilitate “warm hand-offs” and/or other closed-loop communications between the DSTI hospital and post-acute provider(s).
 - c. For the HU population or subpopulation, develop a pilot for real-time alerts (e.g., email/pager alerts, purchasing ADT technology, use of payer or Commonwealth-supported technology).

XIII. DSTI EVALUATION

33. State Process for Developing an Evaluation of DSTI

A draft design update for the evaluation of DSTI pursuant to STC 52(a)(10) will be included in the draft evaluation design for the 1115 Medicaid Demonstration, to be submitted in accordance with STC section 90. The evaluation design will be refined further after CMS approval of the master DSTI plan and hospital specific plans. The Commonwealth will contract with an independent evaluator to develop an evaluation plan in accordance with STCs 90-94.

The DSTI evaluation will include both process and outcome measures and will draw on both qualitative and quantitative data sources. Content analyses of DSTI project documents, including the master DSTI plan contained in these STCs, will advise the specification of a delivery system theory of change, specific evaluation measures and specifications, and data sources.

**ATTACHMENT K
PUBLIC HOSPITAL TRANSFORMATION AND INCENTIVE INITIATIVE PROTOCOL
Approved October 16, 2015**

I. PREFACE

1. MassHealth Medicaid Section 1115 Demonstration

This Attachment K, Public Hospital Transformation and Incentive Initiatives (PHTII) Protocol, applies to the extension period of the Centers for Medicare & Medicaid Services (CMS) approved section 1115 demonstration, entitled MassHealth (11-W-00030/1) (demonstration) from July 1, 2014 through June 30, 2017 (DY 18 through DY 20), as set forth in Attachment E and STC 50(e).

2. Public Hospital Transformation and Incentive Initiatives (PHTII)

STC 50(e) of the demonstration authorizes the Commonwealth to implement the Public Hospital Transformation and Incentive Initiatives (PHTII) funded through the Safety Net Care Pool (SNCP). PHTII transformation initiatives will include a focus on behavioral health integration initiatives as well as other approved initiatives that support Cambridge Health Alliance's (Public Hospital's) ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations it serves. These initiatives may include:

- a) Behavioral health and physical health integrated care innovations critical to Medicaid and public payer populations;
- b) Community-based innovations for complex patient populations such as those with serious and persistent mental illness and frail homebound elders;
- c) Accountable care outcomes measures and evidence-based practices for population health such as advanced illness and palliative care in the context of rapidly advancing alternative payment models;
- d) Effective care coordination within high value care continuum; and
- e) Community health improvement responsive to public health needs.

PHTII payments are intended to support the public hospital system for improvements in delivery systems and payment models that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

The Public Hospital will be required to develop and implement these initiatives and activities in order to receive the incentive payments. In addition, these initiatives must complement or enhance other federal initiatives in which a hospital may be participating, but they must not duplicate the exact same activities undertaken by a hospital for which that hospital receives specific funding by the U.S Department of Health and Human Services.

PHTII projects are complementary to and not duplicative of the separate portfolio of Delivery System Transformation Initiatives (DSTI). Pursuant to STC 50(e), PHTII payments are not direct reimbursement or payment for services, should not be considered patient care revenue, will not be offset against other Medicaid reimbursements to a hospital system, and will not be counted as payments when calculating hospital-specific cost limits.

3. PHTII Eligibility

STC 50(e) describes the eligibility for PHTII. Cambridge Public Health Commission d/b/a Cambridge Health Alliance (CHA) (hereby referred to as Public Hospital) is the only acute-care Public Hospital in the Commonwealth and is eligible to earn PHTII payments outlined in Attachment E.

4. PHTII Protocol

In accordance with STC 50(e), Attachment K governs PHTII projects, guidelines, structure, and evaluation processes for reporting for payment, as outlined in Section V. This protocol has been developed to comply with relevant DSTI requirements, including carry forward and reclamation provisions, and has several unique provisions outlined in this protocol.

Following approval of the PHTII protocol by CMS and throughout the demonstration renewal period, the Massachusetts Executive Office of Health and Human Services (EOHHS) may propose revisions to the PHTII protocol, in collaboration with the Public Hospital, to reflect modifications to any component of the hospital's final approved plan, including but not limited to projects, measures, metrics, and data sources or to account for other unforeseen circumstances in the implementation of the PHTII program. CMS must render a decision on proposed PHTII protocol revisions within 30 business days of submission by EOHHS. Such revisions must not require a demonstration amendment, provided that they comport with all applicable STC requirements.

II. DESCRIPTION OF PHTII TRANSFORMATION FOCUS AREAS

5. PHTII Focus Areas

PHTII transformation initiatives will include a focus on behavioral health integration initiatives as well as other approved initiatives that support the public hospital system's ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations it serves.

The menu of PHTII projects include the following, which are detailed in the accompanying approved PHTII hospital-specific three-year plan:

- a) Project 1: Expand and Optimize Behavioral Health Integration across CHA's Primary Care System
- b) Project 2: Behavioral Health Home to Manage Needs of Intensive Population
- c) Project 3: Primary Care Addiction Initiative: Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Opioid Abuse Prevention through Improved Prescribing Practices
- d) Project 4: Technology-Enabled Primary Care – Behavioral Health Integration and Tele-Psychiatry
- e) Project 5: Older Adults Integrated Care
- f) Project 6: Advanced Illness and Palliative Care Initiative
- g) Project 7: Referral Management and Specialty Access Improvements
- h) Project 8: Community-Centered Health Home and Community Health Improvement.

High Value, Accountable Care for Public Payer Populations

In recognition that population health management and improvement initiatives are a unifying area of focus for the Public Hospital, an overarching set of accountable care measures is included as part of PHTII. The measures are representative of the culmination these efforts across the demonstration incentive initiatives and separate public payer alternative payment models underway by the Public Hospital.

Focus Area 1: Improving Integrated Behavioral Health Care and Primary Care: A Pathway to Improved Outcomes and Cost-Effective Care

Several PHTII projects (Projects 1 – 4) recognize the importance of addressing the whole health needs of individuals, especially those with complex medical, co-occurring behavioral health, and social services needs within the safety net populations. Research has demonstrated that individuals with serious mental illness have a reduced life expectancy of approximately 25 years compared to

peers without these co-occurring disorders. This significant health disparity has not been linked to suicide or accidents associated with behavioral health symptoms, but rather preventable physical illnesses that have not been identified or treated.¹ The same concerns and outcomes exist for unidentified mental health and substance use treatment needs that contribute to higher costs and poor health outcomes within primary care. A recent publication released by the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that in Massachusetts, only 49.1 percent of adults with any mental illness actually received mental health treatment or counseling within the year prior to being surveyed, and 7.7 percent reported heavy alcohol use within the month prior to being surveyed but only about 1 in 24 (4.2 percent) received treatment for alcohol use within the prior year.^{2,3} Low utilization of necessary treatment has been shown to impact spending in both health care and other public programs. According to a fact sheet released by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), in 2006 the National Institute on Drug Abuse (NIDA) noted that for every dollar spent on addiction treatment programs there is an estimated \$4 to \$7 reduction in the cost of drug related crimes. With outpatient programs, total savings can exceed costs by a ratio of 12:1.⁴ Massachusetts recently declared a public health emergency related to opioid abuse and overdose.

Integrating physical and behavioral health care is an essential direction to address these significant health disparities heavily represented in the Medicaid and safety net populations. Projects may integrate primary care and behavioral health toward overall population health and/or create a behavioral health home for intensive needs populations and those with serious and persistent mental illness by integrating primary care in a specialty behavioral health setting. This important work requires a high degree of professional collaboration to shift from the traditional and often separate practice models of primary care and behavioral health disciplines, and create and implement a shared, collaborative, and integrated approach. This integrated care approach for all patients, whether the predominance of their care is delivered in primary or specialty behavioral health care settings, requires clear policies and protocols, well-defined roles, supportive technology, and shared goals, and approaches within and across clinic settings. Projects may also focus on the deployment of tele-psychoiatry.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and substance use, as a result of an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.⁵ SBIRT was initially developed as a public health model to provide universal screening, secondary prevention (detecting risky or hazardous substance use before the onset of abuse or dependence), early intervention, and treatment for people who have problematic or hazardous alcohol problems within primary care and other health care settings.⁶ SBIRT is unique in its universal screening of all patients regardless of an identified disorder, allowing health care professionals to address the spectrum of such behavioral health problems even when the patient is not actively seeking an intervention or treatment for his or her problems. Consistent with the recommendations of the U.S. Preventive Services Task Force

¹Parks J, Svendsen D, Singer P, Foti M, Mauer B. *Morbidity and mortality in people with serious mental illness*. National Association of State Mental Health Program Directors, 2006. www.nasmhpd.org

²Estimates of age of first use of substances, depression treatment, heavy alcohol use, alcohol use treatment, illicit drug use treatment, mental health treatment/counseling, and the number of persons with any mental illness (AMI) or serious mental illness (SMI) are annual averages based on combined 2008-2012 NSDUH data or combined 2004-2012, 2005-2012, or 2006-2012 NSDUH data where indicated.

³Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Massachusetts, 2013*. HHS Publication No. SMA-13-4796MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

⁴National Association of State Alcohol and Drug Abuse Directors (NASADAD). Fact Sheet: Substance Abuse Prevention and Treatment (SAPT) Block Grant. March 2012. <http://nasadad.org/wp-content/uploads/2012/04/12-March-20-SAPT-Block-Grant-one-pager-FINAL.pdf>

⁵SAMSA - HRSA Center for Integrated Health Solutions. Screening, Brief Intervention, and Referral to Treatment. <http://www.integration.samhsa.gov/clinical-practice/sbirt>

⁶Babor, T. F., Higgins-Biddle J., Dauser, D., Higgins P, & Bureson, J. (2005). Alcohol screening and brief intervention in primary care settings Implementation models and predictors. *Journal on Studies of Alcohol and Drugs*, 66(3), 361-369.

(USPSTF) for adult screening and brief behavioral counseling interventions in primary care to reduce alcohol misuse and improve long-term health outcomes, projects may entail improvements in screening for alcohol and substance use using evidence-based tools (National Institute of Alcohol Abuse and Alcoholism and National Institute on Drug Abuse) and brief interventions.⁷

Focus Area 2: Community-Based Innovations for Integrated Care Models Responsive to Complex Patients Needs

PHTII Project 5 encompasses community-based health innovations that focus on the complex health needs of patient populations such as older adults, including frail homebound elders.

Related projects may include initiatives that integrate medical and behavioral health care along the continuum of care to older adults including those dually eligible for Medicare and Medicaid to improve health outcomes, quality, and the cost-effectiveness of care. The health needs of older adults and those dually eligible for Medicare and Medicaid are often complex due to their multiple medical and mental health challenges. Care for these patients is often delivered in diverse settings and by individual, non-integrated practitioners and is therefore commonly fragmented. Given the unique challenges of this population and aging demographics, strategies that maximize identification of clinical needs and linkages to coordinated services are critical.

Modeled on evidenced-based best practices such as the multi-disciplinary Geriatric Resources for Assessment and Care of Elders (GRACE) and the RAND Corporation's function-based tool for screening community-dwelling older persons to determine risk for health deterioration using the Vulnerable Elders Survey (VES-13), community-based initiatives will integrate primary care and geriatric health care alongside behavioral health and social service needs.^{8,9,10} Project elements may include innovative House Calls home-based primary care services integrated with behavioral health for frail elders and other evidence-based practices. Care improvements may include progress in integrated geriatric assessments for patients, advance care planning, post-hospitalization follow-up care such as medication reconciliation in the outpatient medical record, and influenza immunization during the active flu season. Older adults are much more likely to be hospitalized with these diseases and nearly 90 percent of deaths caused by influenza and its complications occur in this age group.¹¹

Focus Area 3: Evidenced-Based Practices for Population Health in Rapidly Advancing Alternative Payment Model Environment

Responsive to advanced illness and end-of-life care in the context of advancing alternative payment models, projects like Project 6 are geared toward implementation of evidence-based practices that promote palliative care alongside curative care that afford important improvement initiatives to improve the quality of life and care for patients.

⁷ Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: U.S. Preventive Services Task Force Recommendation Statement, Clinical Practice Guideline as published in the Annals of Internal Medicine (www.annals.org) on May 14, 2013.

⁸ Bielaszka-DuVernay, Christina. The "Grace" Model: In-Home Assessments Lead to Better Care for Dual Eligibles. Health Affairs: Mar 2011; 30, 3.

⁹ Saliba, S, Elliott M, Rubenstein LA, Solomon DH, et al. "The Vulnerable Elders Survey (VES-13): A Tool for Identifying Vulnerable Elders in the Community." *Journal of the American Geriatric Society* 2001; 49:1691-9.

¹⁰ Min L, Yoon W, Mariano J, et al. "The vulnerable elders-13 survey predicts 5-year functional decline and mortality outcomes in older ambulatory care patients." *Journal of the American Geriatric Society* 2009 Nov; 57(11):2070-6.

¹¹ Thompson WW, Shay DK, Weintraub E et al. Mortality associated with influenza and respiratory syncytial virus in the United States. *Journal of the American Medical Association*. 2003; 289:179-186.

In a recently published report from the Institute of Medicine, it is noted that the number of frail, older Americans with physical and cognitive disabilities is rapidly growing.¹² The need for responsive, patient-centered care is increasingly recognized, particularly the need for equitable access to such services for culturally diverse groups.¹³ The National Quality Forum has identified palliative care as a national priority for health care improvement, and palliative care services have been identified as an area that should be addressed by health care reform efforts.

A growing body of research is demonstrating the benefits of palliative care. Patients with serious illness often receive care of poor quality, including untreated symptoms, unmet physical and psychosocial needs, family caregiver burden, and low patient and family satisfaction. Palliative care has been associated with improvements in quality of life, patient understanding of the plan of care, enhanced access to home care, emotional and spiritual support, and improvements in well-being and dignity.¹⁴

In addition to improvements in quality of life, palliative care may also contribute to the sustainability of the health care system. In a study involving Medicaid beneficiaries, seriously ill patients that received palliative care had significantly lower costs compared to patients who received usual care.¹⁵

Focus Area 4: Effective Care Coordination within Continuum of the Public Hospital Delivery System

Integral to effective care coordination within a high-value public hospital delivery system, referral management initiatives (Project 7) will advance timely patient access to high-quality specialty care and promote appropriate referrals with emphasis on continuity of care within the public hospital system and community settings. Achieving the Triple Aim of better care, better health, and lower costs depends upon patients accessing the most appropriate care in the most appropriate setting. To accomplish this goal, a highly coordinated care-delivery model is required that provides high quality, timely care in the most cost-effective setting. Breakdowns in coordination can lead to missed or delayed diagnoses and treatments, repeated or unnecessary testing, increased iatrogenic morbidity, and adverse drug reactions.¹⁶ Safety net patients often face barriers to specialty care services, such as shortage specialty areas. Selected specialty access improvement initiative will be implemented and progress measured along domains that may include access, continuity of care through referrals, clinician patient care scheduling improvements, measurable specialty practice improvements, quality measures applicable to the specialty, and/or technology-enabled innovations such as telemedicine.

Referral coordination opportunities are intended to promote access to services in community settings and impact total medical expense. Improvement plans may include several interventions, including the implementation of technology supports, telemedicine for selected services, and a range of clinical practice improvements to foster timely patient access to scheduled appointments and to improve patient and provider communication.

¹² Institute of Medicine (2014). Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.

¹³ Meier, D. E. (2011). Increased access to palliative care and hospice services: Opportunities to improve value in health care. *Millbank Quarterly*, 89(3), 1-19. doi: 10.1111/j.1468-0009.2011.00632.x

¹⁴ Center to Advance Palliative Care. A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A National Quality Forum Consensus Report. Available: capc.org

¹⁵ Morrison, R. S., Dietrich, J., Ladwig, S. Quill, T., Sacco, J., Tangeman, J. & Meier, D. E. (2011). Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs*, 30(3), 454-463. doi: 10.1377/hlthaff.2010.0929

¹⁶ Forrest, Christopher, et al. Coordination of Specialty Referrals and Physician Satisfaction with Referral Care. *Archives of Pediatrics and Adolescent Medicine*. Volume 154 (5). May 2000: 499 – 506.

Focus Area 5: *Community Health Improvement Responsive to Public Health Needs*

The major drivers of personal and population health and cost often reside outside the walls of the healthcare system. McGinnis et al's work on the determinants of health revealed that behavioral issues (40%), personal genomics (30%), and the social determinants of health (15%) were the primary contributors to premature mortality, with access to healthcare contributing only 10%.¹⁷ This finding suggests that to improve health outcomes, we need to substantially transform the health care system so that it is effective in addressing the social, behavioral, and genomic determinants of health, in addition to supporting health care access. Projects (such as Project 8) will include a community health improvement focus, such as the community-centered health home (CCHH) model that effectively integrates prevention and public and community health with primary care. Such efforts also entail implementation of clinically-linked initiatives responsive to priority community health needs (such as opioids and hypertension disparities).

While primary care sits at the intersection between the health care system and the community and public health system, its service delivery model is often separate and distinct from these important resources for health improvement. The CCHH offers a model to integrate public and community health approaches into the design of primary care in order address the important social and behavioral determinants of health more effectively and systematically.^{18,19} Over the next several years, as the call raised by organizations such as the Institute of Medicine and Robert Wood Johnson Foundation intensifies to focus efforts on the integration between the primary care system and public and community health, this is an opportune moment to test models of transformation that redesign the health care system to effectively address social and behavioral determinants of health. Along with this initiative, a measure slate of priority population-wide public health indicators will be monitored and reported.

¹⁷ McGinnis JM, Williams-Russo, P, and Knickman J. "The Case for More Active Policy Attention To Health Promotion." *Health Affairs* March 2002 vol. 21 no. 2 78-93

¹⁸ Cantor J et al. "Community-Centered Health Homes: Bridging the gap between health services and community prevention." *Prevention Institute*, February 2011.

¹⁹ National Research Council. *Primary Care and Public Health: Exploring Integration to Improve Population Health*. Washington, DC: The National Academies Press, 2012. *Primary Care and Public Health: Exploring Integration to Improve Population Health*; www.iom.edu/primarycarepublichealth, retrieved January 19, 2014.

III. KEY ELEMENTS OF PROPOSED PUBLIC HOSPITAL PLAN

6. Public Hospital Transformation and Incentive Initiative Plan

The Public Hospital must implement an individual PHTII plan approved by EOHHS and CMS that meets all requirements pursuant to STC 50(e), and all requirements set forth in Section III.

7. Minimum Number of Projects

The Public Hospital must select a minimum of five projects and no more than ten projects in total for PHTII.

8. Organization of Public Hospital PHTII Plan

- a. Executive Summary: The Executive Summary must provide a summary of the PHTII plan, a summary of the Public Hospital's vision of the initiatives' objectives, and a table of the projects included in the plan, including project titles, brief descriptions of the projects, and three year goals. The Executive Summary must also include a description of key challenges facing the hospital and how the three-year PHTII plan supports the hospital's three-year vision. The Executive Summary should address how the individual projects support the three-year vision, how the individual projects reinforce/support each other, and any challenges and lesson learned from implementation of any relevant transformation plans during DYs 15 – 17.
- b. Background Section: The background section must include, at a minimum, a summary of the Public Hospital's community context, a description of the hospital's patient population, a description of the health system, and a three-year vision. The background section also must include a brief description of any initiatives in which the hospital is participating that are funded by the U.S. Department of Health and Human Services and are directly related to any of the public hospital's PHTII projects.
- c. Sections on Projects
 - i. Project Narrative: The Public Hospital must include a narrative for each project that describes the following elements of the project:
 - (a) Goals: A description of the goal(s) of the project, which describes the challenges of the Public Hospital system and the major solution identified to address those challenges by implementing the particular project;
 - (b) Rationale: A narrative on the Public Hospital's rationale for selecting the project, milestones, and metrics based on relevancy to the hospital system's population and circumstances, community need, and hospital system priority and starting point with available baseline data, as well as a description of how the project represents a new initiative for the hospital system or significantly enhances an existing initiative including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services;
 - (c) Expected Results: A description of the target goal over the demonstration approval period and metrics associated with the project and the significance of that goal to the Public Hospital system and its patients. The goals for the at-risk outcomes and improvement indicators must be developed using the gap-to-goal and improvement measurement methodology, as specified in the approved Public Hospital PHTII plan and described in Section VI, paragraph 14; and

- (d) Relationship to Other Projects: A narrative describing how this project supports, reinforces, enables and is related to other projects and interventions within the Public Hospital PHTII plan.
- d. Milestones and Metrics Table: For each project, the Public Hospital must submit milestones and metrics, referred to as project metrics. In a standardized table format, the hospital must indicate, by demonstration year, when project metrics will be achieved and indicate the appropriate data source that the Public Hospital shall use to support and verify achievement of the project metric.
- e. Outcomes and Improvement Measure Slates:
- i. The PHTII funding at risk for improved performance on outcomes and improvement indicators will be spread among five (5) Measure Slates associated with ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations, each PHTII project, or bundle of projects, as described below. Each Measure Slate is a list of outcomes and improvement indicators for which the Public Hospital must successfully achieve defined metrics for a specified number of the indicators on the list within each specified demonstration year (applicable to DYs 19 and 20).
 - ii. Each Measure Slate (2 – 5) is designed specifically for a project or bundle of projects. Measure Slate 1 is an overarching set of accountable care measures representative of the culmination of population health management and improvement initiatives under the demonstration incentive initiatives and separate public payer alternative payment models underway by the Public Hospital. For the purposes of the at-risk funding for improved performance on outcomes and improvement indicators, the Measure Slates for PHTII projects are as follows:
 - (a) Measure Slate 1 – Accountable Care Initiatives to Effectively Manage Total Medical Expense and Utilization
 - (b) Measure Slate 2 – Project 1: Primary Care and Behavioral Health Integration and Project 2: Behavioral Health Home
 - (c) Measure Slate 3 – Project 3: Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Substance Abuse and Project 4: Tele-Psychiatry
 - (d) Measure Slate 4 – Project 5: Older Adults Integrated Care and Project 6: Advanced Illness/Palliative Care
 - (e) Measure Slate 5 – Project 7: Referral Management Initiative to Promote Continuity of Care and Specialty Access
 - iii. For Measure Slates reflecting a bundle of projects, such projects have a clinical relationship to each other as the basis for the bundling and each of the selected measures has a meaningful clinical purpose for being on its Measure Slate. The Measure Slates include a spectrum of measures reflective of transformation such as accountable care, access, health screening, clinical care improvements, health and quality, cost-effectiveness, and/or workforce development outcomes and improvement indicators.
 - iv. During DY 18, the Public Hospital will report baseline performance on specified measures on Measure Slates 2 – 5, as part of the PHTII projects. The Public Hospital will report all designated outcomes and improvement indicators on Measure Slates 1 – 5 in DYs 19 and 20, some of which will be baseline performance for specified measures as outlined in the Public Hospital plan and Measure Slates. A specified number of outcomes and improvement indicators will need to be achieved in each DY, according to the table below.

The Public Hospital receives payment when a measure is individually achieved and reported, up to the established number of outcomes and improvement indicators assigned funding in given demonstration year. For example in Measure Slate 4 in DY 20, if the Public Hospital achieves 7 indicators (out of the defined number for that year which is set at 8 indicators), the public hospital will be paid for those 7 indicators during that demonstration year. However, if the Public Hospital achieves a greater number than the defined number of improvement indicators established for a given year (for example, 9 indicators compared to the defined number established at 8 indicators), the Public Hospital will only be paid for the first 8 indicators that it achieves on that Measure Slate during that demonstration year.

	Demonstration Year 19	Demonstration Year 20
Measure Slate 1	Report Benchmarks	Achieve 2 of 5 Indicator Goals
Measure Slate 2	Achieve 3 of 5 Indicator Goals	Achieve 9 of 18 Indicator Goals
Measure Slate 3	Achieve 3 of 5 Indicator Goals	Achieve 4 of 7 Indicator Goals
Measure Slate 4	Achieve 3 of 6 Indicator Goals	Achieve 8 of 14 Indicator Goals
Measure Slate 5	Achieve 7 of 20 Indicator Goals	Achieve 11 of 20 Indicator Goals

- v. The Public Hospital is not required to pre-determine which outcomes and improvement indicators will be achieved in terms of performance goals in each year; instead, the Public Hospital must achieve the established performance goals for the specified number of outcomes and improvement indicators applicable to a demonstration year, which are individually payable when an indicator is individually achieved and reported up to the established number of outcomes and improvement indicators assigned funding in that demonstration year. For each of the Measure Slates 2 – 5, at least 2 measures would continue achievement in both DYs 19 and 20; Measure Slate 1 is designed for outcomes improvement in DY 20 with benchmarks developed and reported in DY 19. A description of the funding allocation for the at-risk outcomes and improvement indicators can be found in Section VI, paragraph 13(b). Updates to technical specifications of outcomes and improvement measures in Measures Slates 1 - 6 shall not require a plan modification and can be implemented by the Commonwealth without further approval.

f. Pay-for-Reporting Measure Slate

Measure Slate 6 reflects Population-Wide Public Health Measures associated with Project 8: Community-Centered Health Home (CCHH) and Community Health Improvement. Measure Slate 6 will be Pay-for-Reporting in DYs 19 and 20.

	Demonstration Year 19	Demonstration Year 20
Measure Slate 6	Pay-for-Reporting	Pay-for-Reporting

A description of the funding allocation for the pay-for-reporting measure slate can be found in Section VI, paragraph 13(a).

g. Distribution of Funds

- i. In this section, the Public Hospital must describe how its total potential PHTII funds pursuant to Attachment E will be distributed among the projects and metrics it has selected in its hospital plan. The amount and distribution of funding must be in accordance with the stipulations of Attachment E and Section VI.

IV. NON-FEDERAL SHARE OF PHTII PAYMENTS

9. Identification of Allowable Funding Sources

- a. Allowable Funding Sources: Allowable funding sources for the non-federal share of PHTII payments must include all sources authorized under Title XIX and federal regulations promulgated thereunder.
 - i. The source of non-federal share of DYs 18 – 20 PHTII payments to CHA will be an intergovernmental funds transfer. The Executive Office of Health and Human Services (EOHHS) will issue a request to CHA for an intergovernmental transfer in the amount of the non-federal share of the applicable incentive payment amounts at least 15 days prior to the scheduled date of payment. CHA will make an intergovernmental transfer of its funds to EOHHS in the amount specified by a mutually agreed timeline determined by EOHHS in consultation with CHA, and in accordance with the terms of an executed payment and funding agreement, and all applicable laws. Upon receipt of the intergovernmental transfer, EOHHS will draw the federal funding and pay both the nonfederal and federal shares of the applicable DYs 18 – 20 payment(s) to CHA according to a mutually agreed upon timeline determined by EOHHS in the consultation with CHA, and subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals.
- b. Change in Funding Source: If the source of non-federal share of PHTII payments changes during the renewal period, EOHHS must notify CMS and seek CMS' approval of such change prior to claiming FFP for any payment utilizing such funding source. No demonstration amendment is required, provided that the change is in compliance with the current STCs.

V. PHTII REPORTING AND PAYMENT IN DYs 18 – 20

10. Reporting for Payment in DY 18

In DY 18, the initial payment for PHTII valued at 25% of the annual amount will be payable based on CMS approval of the PHTII plan. EOHHS will schedule the initial payment transaction for the Public Hospital within 30 days following approval by CMS of the public hospital's plan, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals. There shall be one DY 18 reporting period for the balance of the payment. In DY 18, the Public Hospital will report metric progress for payment for metrics achieved during the demonstration period and request for payment due subsequent to CMS approval of the PHTII plan based on metric accomplishment achieved, pursuant to its approved plan. The report must be submitted using the standardized reporting form approved by EOHHS and CMS. The report must include the incentive payment amount being requested for progress achieved on PHTII metrics in accordance with payment mechanics (see Section VI. "Disbursement of PHTII Funds"). The report must include data on progress made for all demonstration year metrics, must provide a narrative description of the progress made, and include the section on lessons learned, challenges faced, and other pertinent findings referenced in paragraph 11(a) for the third report referenced below. The Public Hospital must submit, as an attachment to the report form, a copy or list of the data source identified per metric in the hospital's approved PHTII plan to demonstrate achievement of each PHTII metric for which the hospital is

seeking an incentive payment.²⁰ The reports must contain sufficient data and documentation to allow CMS and the state to determine if the hospital has fully met the specified metric. The Public Hospital system must have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

The report will serve as the basis for authorizing incentive payments to the Public Hospital for achievement of PHTII metrics. The actual payment amounts will be determined by EOHHS based on the achievement of metrics in accordance with the provisions of Section VI. (“Disbursement of PHTII Funds”).

11. Reporting for Payment in DYs 19 – 20

a. Hospital Reporting for Payment

Three times per year, the Public Hospital seeking payment under the PHTII must submit reports to the Commonwealth demonstrating progress on PHTII projects, measured by metrics achieved during the reporting period. The Commonwealth must provide such reports to the assigned independent assessor. The reports must be submitted using the standardized reporting form approved by EOHHS and CMS. The reports must include the incentive payment amount being requested for the progress achieved on PHTII metrics in accordance with payment mechanics (see Section VI. “Disbursement of PHTII Funds”). The report must include data on the progress made for all demonstration year metrics and must provide a narrative description of the progress made; the first two reports each year must furthermore provide a narrative explaining how the hospital will achieve the remaining metrics for each project before the end of the year. The hospital must submit, as an attachment to the report form, a copy or list of the data source as identified per metric in the hospital’s approved PHTII plan to demonstrate achievement of each PHTII metric for which the hospital is seeking an incentive payment.²¹ The reports must contain sufficient data and documentation to allow CMS, the state, and the independent assessor to determine if the hospital has fully met the specific metric. The third report each year will also provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The hospital system must have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- i. Reporting period of July 1 through October 31: the report and request for payment is due November 30.
- ii. Reporting period of November 1 through March 31: the report and request for payment is due April 30.
- iii. Reporting period of April 1 to June 30: the report and request for payment is due July 31. The Commonwealth may permit the reporting for payment of specified outcomes measures, including those on Measure Slate 1, subsequent to the July 31, 2016 and July 31, 2017 reports in recognition that additional time may be needed for necessary data to be available.

²⁰ For non-confidential data sources, the hospital will provide a copy of the data source itself; in the case that a copy of the data itself would compromise confidential patient data, the hospital may alternatively provide a list of the data source(s) used to determine metric achievement.

²¹ For non-confidential data sources, the hospital will provide a copy of the data source itself; in the case that a copy of the data itself would compromise confidential patient data, the hospital may alternatively provide a list of the data source(s) used to determine metric achievement.

These reports will serve as the basis for authorizing incentive payments to the Public Hospital for achievement of PHTII metrics. The actual payment amounts will be determined by EOHHS based on the achievement of metrics in accordance with the provisions of Section VI. (“Disbursement of PHTII Funds”). EOHHS will schedule the payment transaction for the hospital within 30 days following EOHHS approval of the hospital report, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals. The state must inform CMS of the funding of PHTII payments to the provider through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter.

An independent assessor will review the semi-annual reports, ensure accurate reporting of the hospital’s achievement, and make recommendations to the state regarding approvals, denials or recommended changes in order to approve payment. EOHHS will provide final approval of all PHTII payments. The hospital must be allowed an opportunity to respond to, and correct, any recommendation for denial of payment, for a metric that the hospital believes it achieved, through the resubmission of required clarifications and/or data.

c. Mid-Year Assessment

Following submission of the first or second progress report in DYs 19 and 20, the public hospital will meet with the Commonwealth for a formal presentation and assessment of progress made on all PHTII projects. This will provide an opportunity for collaboration and intervention as needed to ensure the hospital’s timely progress on PHTII projects. The Commonwealth will submit a written summary of these assessments to CMS as part of the quarterly operational reports as described in paragraph 11(e) below.

d. Year-end Payment Reconciliation

Based on its review and verification of the Public Hospital’s third annual report for payment, EOHHS will perform reconciliation as an additional check to verify that all PHTII payments made to the hospital based on achievement of the applicable metrics were correct. If, after the reconciliation process EOHHS determines that the hospital was overpaid, the overpayment will be properly credited to the Commonwealth and the federal government or will be withheld from the next PHTII payment for the hospital, as determined by EOHHS. If, after the reconciliation process EOHHS determines that the hospital was underpaid, then subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals, EOHHS will schedule necessary payment transaction(s), or will add the additional amount to the next PHTII payment for the hospital, as determined by EOHHS.

e. Commonwealth Reporting to CMS in DYs 18 – 20

i. PHTII will be a component of the Commonwealth’s quarterly operational reports and annual reports related to the demonstration. These reports will include:

(a) All PHTII payments made to the specific hospital that occurred in the quarter;

(b) Expenditure projections reflecting the expected pace of future disbursements for the participating hospital;

(c) An assessment by summarizing the hospital’s PHTII activities during the given period, including a summary of the mid-year assessments of hospital progress when applicable. This should include an Excel spreadsheet that includes all project metrics – with a crosswalk by hospital regarding whether that metric is “not applicable;” “in progress;” or “to be implemented;” and

(d) Evaluation activities and interim findings of the evaluation design.

f. Claiming Federal Financial Participation

The Commonwealth will claim federal financial participation (FFP) for PHTII incentive payments on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set up exclusively for PHTII payments. FFP will be available only for PHTII payments made in accordance with all pertinent STCs and the stipulations of this master PHTII plan, including Section VI. The Commonwealth and the hospital system receiving PHTII payment must have available for review by CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in the approved hospital PHTII plan.

VI. DISBURSEMENT OF PHTII FUNDS

12. PHTII Incentive Payments

a. Eligibility for PHTII Incentive Payments

PHTII payments for the Public Hospital are contingent on that provider meeting project metrics as defined in the approved hospital plan. As outlined in Sections V and VI of the PHTII protocol, the hospital will be able to receive PHTII incentive payments related to achievement of metrics upon submission and approval of the required reports for payment. PHTII incentive payments may equal but not exceed the allotment outlined in Attachment E.

b. DYs 18 – 20 PHTII Payments

In DYs 18 – 20, PHTII funds will be available as incentive payments to the Public Hospital based on successfully achieving metrics in the approved hospital plan.

c. Funding At Risk for Outcomes and Improvement

The percentage of PHTII funding at risk for improved performance on outcomes and improvement indicators will gradually increase from 0 percent in DY 18 to 15 percent in DY 19 to 30 percent in DY 20 (averaging to 15 percent total over the three-year period).

13. PHTII Funding Allocation Formula

NOTE: The PHTII initiative is distinct from the DSTI pool-wide accountability and funding limitations provisions in Attachment J, the Master DSTI Plan (Paragraph 19(d)), which do not apply to PHTII.

The following chart depicts the percentage and dollar amount of total PHTII funds available per demonstration year for project metrics and the at risk amounts for performance on the outcome and quality indicators.

	DY 18		DY 19		DY 20	
Plan Approval	25%	\$55.0M	0%	\$0M	0%	\$0M
Project Metrics/Measures	75%	\$165.0M	85%	\$187.0M	70%	\$154.0M
At-Risk	0%	\$0M	15%	\$33.0M	30%	\$66.0M
Total:	100%	\$220M	100%	\$220M	100%	\$220M

a. Funding Allocation for PHTII Project Metrics

In DY 18, 75% of total PHTII funds are available as incentive payments for successful achievement of project metrics, as 25% of total PHTII DY 18 funds are payable based on the metric of CMS PHTII plan approval. The funding allocation available for PHTII project metrics changes to 85% in DY 19 and 70% in DY 20, as the at-risk percentage gradually increases from 0% in DY 18 to 15% in DY 19 to 30% in DY 20. Of such annual PHTII funds available for successful achievement of project metrics in DYs 19 and 20, five percent of such annual project metric funding (resulting in DY 19 in 4.25% of total funds and in DY 20 in 3.5% of total funds) is associated with Measure Slate 6 (Population-Wide Public Health Measures associated with Project 8), which is pay-for-reporting in both DY 19 and DY 20.

Each PHTII project has an annual base value that is uniform across all projects. After applying the 5% of total PHTII annual funding for project metrics to Measure Slate 6 (DY 19 and DY 20

only), the annual project base value is calculated by dividing the remaining annual total available amount of PHTII project metric funds by the number of projects (8). The table below specifies the annual base values for PHTII projects.

	DY 18	DY 19	DY 20
Project 1	\$20.625M	\$22.21M	\$18.29M
Project 2	\$20.625M	\$22.21M	\$18.29M
Project 3	\$20.625M	\$22.21M	\$18.29M
Project 4	\$20.625M	\$22.21M	\$18.29M
Project 5	\$20.625M	\$22.21M	\$18.29M
Project 6	\$20.625M	\$22.21M	\$18.29M
Project 7	\$20.625M	\$22.21M	\$18.29M
Project 8	\$20.625M	\$22.21M	\$18.29M
Total PHTII Project Metrics	\$165.0M	\$177.65M	\$146.30M
Measure Slate 6	\$0M	\$9.35M	\$7.7M
Total PHTII Project Metrics and Measure Slate 6	\$165.0M	\$187.0M	\$154.0M

b. Funding Allocation for PHTII At Risk Outcomes and Improvement Indicators

The amount of funding at risk for performance on the outcome and quality indicators will be 0% of the total annual PHTII funding in DY 18, 15% of the total annual PHTII funding in DY 19 and 30% in DY 20. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement using a valid, standardized method, outlined in Section VI, paragraph 14. The defined number of outcome and improvement indicators targeted for achievement in a given demonstration year have an annual base value that is uniform across all indicators within a specific Measure Slate 1 – 5 during a given demonstration year. The annual outcomes and improvement indicator value related to each of the applicable projects (Measure Slates 2 – 5) and the overarching Measure Slate 1 (DY 20 only) is calculated by dividing the annual total available amount of PHTII outcomes and improvement indicator funds by the number of applicable projects in addition to the overarching Measure Slate 1 for the applicable demonstration year. Projects that are combined as a Measure Slate have their annual value combined into the one Measure Slate for two (2) PHTII projects.

	DY 18	DY 19	DY 20
Measure Slate 1	\$0M	\$0M	\$8.25M
Measure Slate 2	\$0M	\$9.43M	\$16.5M
Measure Slate 3	\$0M	\$9.43M	\$16.5M
Measure Slate 4	\$0M	\$9.43M	\$16.5M
Measure Slate 5	\$0M	\$4.71M	\$8.25M
Total	\$0M	\$33.0M	\$66.0M

The PHTII at-risk outcomes and improvement indicator funds will be earned by Measure Slate based on the individual achievement of established performance goals for the specified number of indicators for each respective measure slate in DY 19 and DY 20 respectively, as outlined in Section III, paragraph 8(e). For each Measure Slate, the available funds are divided by the established number of measures specified for achievement during a given demonstration year. Payment will be made to the Public Hospital when a measure is individually achieved and

reported, up to the established number of measures assigned funding in a given demonstration year.

- i. An optional factor at the Public Hospital's option to account for factors such as differences in quality infrastructure, differences in patient populations, differential levels of metric goals, and differences between process metrics and improvement metrics. In the PHTII Plan, if the hospital elects to utilize this adjustment factor, the hospital must provide a rationale for any adjustments made to metric base values. These additional adjustments must be budget neutral for the project, meaning that the total funding allotment for a project may not exceed the total funding allotment derived from the sum of annual metric base values adjusted as described above. A metric adjustment (either up or down) may not exceed more than 20% of the metric base value.

14. Gap-to-Goal and Improvement Measurement Approach

As stated in Section VI, paragraph 13(b) of this attachment, the Public Hospital will report outcomes and improvement indicators related to seven PHTII projects (Measure Slates 2 – 5) and an overarching accountable care Measure Slate 1. In order to receive funding, the Public Hospital must achieve established performance goals for a specified number of indicators which are individually payable when an indicator is individually achieved and reported up to the established number of outcomes and improvement indicators assigned funding in a given demonstration year, as described in Section III, paragraph 8(e). Payment-for-performance on the outcomes and improvement indicators on the Measure Slates will be based on an objective demonstration of improvement over baseline or achievement of established performance thresholds using a valid, standardized method, as described below.

- a. The following is the PHTII payment framework for outcomes and improvement indicators.
 - i. DY 18 – Baselines are reported for specified measures on Measure Slates 2 – 5 as part of the corresponding project metrics. This is pay-for-reporting with established baselines (some measures will have baselines established in DY 19, as noted).
 - ii. DY 19 – This is pay-for-performance for designated measures.
 - (a) The Public Hospital must achieve established performance goals for the specified number of indicators for the demonstration year, as outlined in Section III, paragraph 8(e).
 - iii. DY 20 – This is pay-for-performance.
 - (a) The Public Hospital must achieve established performance goals for the specified number of indicators for the demonstration year, as outlined in Section III, paragraph 8(e).
- b. In the event that the Public Hospital meets the specified performance benchmark in DY 19, the organization must maintain performance at or above the benchmark in DY 20. Variation in performance is acceptable as long as the performance for DY 20 is at or better than benchmark in this case.
- c. The Public Hospital must have a target for outcome and quality improvement indicators in Measure Slates 1 – 5. The specified targets will be used to determine whether or not success is achieved on the associated outcomes or improvement indicator. Measure Slate 6 is pay-for-reporting only on population-wide public health measures (associated with Project 8), and is not included in the at-risk funding for outcomes and improvement indicators, as described in Section VI, paragraph 13(a).

- d. The following is a guiding hierarchy for the selection of improvement benchmarks or targets for outcomes and improvement indicators on Measure Slates 1 – 5. All performance targets will be established during DY 18 for Measure Slates 2 – 5 and will be in place for the entire demonstration period. Benchmarks will be developed and reported in DY 19 for Measure Slate
 - i. Select the latest available 90th percentile National Medicaid data during DY 18. For CMS core inpatient measures and other inpatient measures, utilize available National performance data.
 - ii. If above not available, Select the latest available 90th percentile Massachusetts Medicaid (2014) during DY 18. For CMS core inpatient measures and other inpatient measures, utilize available Massachusetts performance data.
 - iii. If above not available, select other available benchmark (such as other latest available National benchmark) or hospital-defined target during DY 18.
 - iv. If above not available or if the specific measure is more appropriate to improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures), any improvement over DY18/SFY15 hospital baseline will be the improvement measurement method or as specified.
 - v. For the accountable care measures (Measure Slate 1), benchmarks will be developed and reported in DY 19, and these benchmarks may reflect defined trend benchmarks, ACO/payer target, reduction compared to hospital’s baseline, or better performance than the payer’s rest of network.

- e. Outcomes and Improvement Indicators Classifications for Measure Slates 1 – 5
 - i. Outcomes and improvement indicators will be classified into the following groups: (1) Clinical care delivery improvement measures; (2) Clinical outcomes measures; and (3) other delivery/outcomes measures where there is not a standardized benchmark and/or if the specific measure is more appropriate to improvement over hospital baseline.
 - (a) Clinical care delivery improvement measures quantify a performance exhibited by clinical care practices, such as health screenings, and therefore are usually directly observable and can be directly impacted. In general, these metrics fit with a gap-to-goal methodology. All metrics classified as clinical care delivery measures must have an acceptable benchmark. To meet the threshold for success, the Public Hospital must achieve closure of 10% of the difference between the Public Hospital’s baseline performance and the established benchmark or maintain at or above the benchmark. Each subsequent year would continue to be set with a target using the most recent year’s data, unless otherwise specified.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 10\%$$

An example of a clinical care delivery measure is influenza immunization (NQF 0041).

- (b) Clinical outcome measures are metrics influenced by patient case mix, multiple processes, and environmental factors. In general, these metrics fit with a gap-to-goal methodology, depending on the availability of performance benchmarks. Since improvement on outcomes measures requires considerable amounts of resources and time and is dependent on foundational care delivery improvements and patient factors, closure of 10% of the difference between the Public Hospital’s baseline performance and the established benchmark is included. To meet the threshold for success, the Public Hospital must meet the 10% gap to goal, where the Public Hospital must achieve a closure of a minimum of 10% of the difference between the benchmark and

the baseline performance or maintain at or above the benchmark. Each subsequent year would continue to be set with a target using the most recent year's data, unless otherwise specified.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 10\%$$

Examples of clinical outcome measures are Controlling High Blood Pressure (NQF 0018) and Comprehensive Diabetes Care: Hemoglobin A1c Control (NQF 0575).

- (c) Non-standardized benchmark delivery/outcomes measures are metrics that do not have an available or acceptable benchmark and/or are specific measures that are more appropriate for improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures). To meet the threshold for success, for pay-for-performance measures applicable to DY 19, the Public Hospital must show improvement from baseline (DY 18) to performance year (DY 19). To meet the threshold for success, for pay-for-performance measures applicable to DY 20, the Public Hospital must show improvement from baseline (DY 18) to performance year (DY 20) or as specified. For the overarching accountable care measures in Measure Slate 1, benchmarks will be developed and reported in DY 19, and these benchmarks may reflect defined trend benchmarks, ACO/payer target, reduction compared to hospital's baseline, or better performance than the payer's rest of network.

Examples of a non-standardized benchmark delivery/outcomes measure are readmission rates, emergency department utilization rates, and reducing the proportion of out-of-network referrals, thereby improving patient continuity of care. These measures are influenced by many factors (which may include patient case mix, multiple processes, and environmental factors). Given that these measures are not risk-adjusted approach, the use of the Public Hospital's historical performance is a pragmatic approach to PHTII. Other examples of a non-standardized benchmark delivery/outcomes measures are the MassHealth TOB-2a: Tobacco Use Treatment and Depression Response at 6 and 12 Months: Progress Towards Remission (NQF 1884 and 1885). These metrics are relatively new and the benchmark is limited/unavailable.

VII. PLAN MODIFICATION, GRACE PERIODS, AND CARRY-FORWARD & RECLAMATION

15. Plan Modification Process

- a. Consistent with the recognized need to provide the Public Hospital some flexibility to evolve its plans over time and take into account evidence and learning from experience and from the field, as well as for unforeseen circumstances or other good cause, the hospital may request modifications to its plan. The hospital must submit a request for modification to EOHHS. Requests for plan modification must be in writing and must describe the basis for the proposed modification. Updates to technical specifications of outcomes and improvement measures in the Measure Slates (1 - 6) must be approved by the Commonwealth and CMS.
- b. Plan modifications include proposed changes to or replacement of selected milestones, metrics including project metrics and metrics on the improvement and outcome measure slates, and projects. Plan modifications may also address proposed changes in the timeframe for achieving metrics. Acceptable reasons to approve a plan modification request are:

- i. Learning and knowledge acquired from project experience and/or external sources indicate that revising or reorienting project components or metrics would improve and/or enhance the project;
 - ii. Information that was believed to be available to achieve or report on a metric or measure is unavailable or unusable, necessitating a modification to the hospital plan to revise or replace the metric/measure;
 - iii. The hospital identifies superior information to demonstrate achievement of a metric and requests a modification to incorporate that data source;
 - iv. External issues occur outside of the hospital's control that require the hospital to modify or replace a metric, measure, or component of a project;
 - v. New federal or state policies are implemented, or changes in Massachusetts market dynamics occur, that impact a PHTII project and the hospital seeks to update the affected project to reflect the new environment;
 - vi. The hospital encounters an unforeseen operational or budgetary change in circumstances that impacts project components, metrics, and/or timelines;
 - vii. A grace period request that meets the requirements of paragraph 16 below; and
 - viii. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the PHTII program.
- c. With the exception of grace period requests, the Public Hospital may request plan modifications during DYs 18 – 19. Plan modification requests must be submitted to EOHHS a minimum of 75 days prior to the end of the demonstration Year. EOHHS must take action on the plan modification request and submit recommended requests to CMS for approval within 15 days of receiving a modification request. CMS must take action on the plan modification request within 30 days of receipt from EOHHS. Any CMS approved plan modification must be considered an approved modification to the PHTII protocol.
 - d. Plan modifications associated with grace period requests, including EOHHS and CMS review timeframes, are further addressed in paragraph below.

16. Grace Periods

- a. If the Public Hospital needs additional time to achieve a metric beyond the demonstration year, a grace period may be granted for up to 180 days from the end of the demonstration year if it requests and receives approval for a plan modification as described in paragraph 15 above. However, no grace period is available for DY 20 beyond June 30, 2017, with the exception of specified outcomes and improvement measures where there is state and federal approval for a later reporting date in recognition that the data will not be available for reporting until after the July 31, 2017 report for payment. The hospital must have a valid reason, as determined by the Commonwealth and CMS, why it should be granted a grace period and demonstrate that the hospital is able to achieve the metric within the timeframe specified in the request. Acceptable reasons to approve a grace period request include:
 - i. Additional time is needed to collect and prepare data necessary to report on a metric;

- ii. Unexpected delays by third parties outside of hospital's control (e.g., vendors) impact the timing of a metric achievement date;
 - iii. The hospital can show that a metric is near completion (e.g., hospital has completed most of the steps building up to a metric achievement, and needs additional time to finalize the last steps);
 - iv. An approved plan modification delays the timing for completing an approved metric; and
 - v. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the PHTII program.
- b. The Public Hospital is required to submit a grace period request in writing to EOHHS accompanied by a proposed plan modification, pursuant to paragraph 15 above. The hospital must submit the request 75 calendar days prior to the end of the demonstration year for which the grace period is being sought. EOHHS must determine its recommended action on a grace period request and plan modification and submit the request to CMS, with its recommendation, within 15 business days. CMS must take action on the request within 30 business days of receipt from EOHHS. The grace period request and plan modification must be decided by the Commonwealth and CMS 30 business days prior to the end of the demonstration year.
 - c. The Public Hospital that requests a grace period related to a metric is not precluded from alternatively claiming the incentive payment associated with the same metric under the carry-forward policy described in paragraph 17 below.
 - d. If after submitting the grace period request, a hospital achieves the metric before June 30, the hospital may withdraw the grace period request and claim the incentive payment associated with the metric under the regular PHTII reporting process described in Section V.
 - e. Allowable Time Periods for Grace Period Requests: The allowable time period for a grace period is 120 calendar days from June 30 for DYs 18 – 19. No grace period is available for DY 20 beyond June 30, 2017 except as expressly described in paragraph 16(a) above.

17. Carry Forward and Reclamation

The Public Hospital may carry forward unclaimed incentive payments (applicable to both project metrics and outcomes and improvement measure slates) in DYs 18 – 19 for up to 12 months from the end of the demonstration year and be eligible to claim reimbursement for the incentive payment according to the rules below. No carry-forward is available for DY 20.

- a. If the Public Hospital does not achieve a metric that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding associated with that metric for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the corresponding metric associated with the year in which the payment is made. For purposes of carry-forward in this paragraph, a corresponding metric is a metric that is a continuation of a prior year metric and is readily quantifiable. An example of corresponding metrics includes a metric that shows a number or percentage increase in the same specific activity from the previous year.
- b. If there is no corresponding metric associated with the year in which the payment is made, the hospital will be able to carry forward the available incentive funding associated with the missed metric for up to 12 months and receive full payment if EOHHS determines, based on

documentation provided by the hospital, that the hospital meets the missed metric in addition to at least 25 percent of metrics associated with that project in the year in which the payment is made. If at the end of that subsequent demonstration year, an eligible safety net hospital has not fully achieved a metric, it will no longer be able to claim that funding related to its completion of that metric.