DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

OCT 0 1 2013

John Polanowicz
Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Polanowicz:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend Massachusetts' section 1115 demonstration project, entitled MassHealth (Project Number 11-W-00030/1). The amendment is effective as of the date of the approval letter, except as otherwise noted in the attached waiver, expenditure authorities and special terms and conditions (STCs), through the end of this demonstration period, which is June 30, 2014, upon which date unless reauthorized, all waivers and authorities granted to operate this demonstration will expire.

The approval allows the Commonwealth to sustain and improve its ability to provide coverage; affordability and access to health care by making changes to the demonstration that conform to the new coverage opportunities created under the Affordable Care Act. Additionally, these changes will promote continuity of care. The amendment revises the demonstration to reflect that the state is adopting the new adult group in the state plan; accordingly, individuals with incomes at or below 133 percent of the federal poverty limit (FPL) will be in the demonstration for purposes of the delivery system and most individuals previously served in the demonstration with incomes above that amount will be served in the state's Marketplace.

In addition, pursuant to 1902(e)(14)(A) authority, Massachusetts may establish automatic MassHealth eligibility for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled, and Children.

As agreed, we will continue to work with the Commonwealth on its request to implement the Primary Care Payment Reform Initiative.

Our approval of this section 1115 demonstration amendment is subject to the limitations specified in the enclosed approved expenditure and waiver authorities, not applicables, and STCs. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly identified as waived or as not applicable in the waiver and expenditure authorities shall apply to the MassHealth demonstration.

This award letter is also subject to our receipt of your written acceptance of the award, including the waiver and expenditures authorities and STCs, within 30 days of the date of this letter. Your project officer is Ms. Kathleen Engle, who may be reached at (410) 786-5786 and through e-mail at kathleen.engle@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Engle at the following address:

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

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

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

If you have questions regarding this approval, please contact Eliot Fishman, Director of the Children and Adults Health Programs Group in the Center for Medicaid & CHIP Services at (410) 786-5647.

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

Sincerely,

Marilyn Tavenner

cc: Cindy Mann, Director, Center for Medicaid and CHIP Services,
Eliot Fishman, Director, Children and Adults Health Programs Group
Richard McGreal, Associate Regional Administrator, Region I
Kathleen Engle, Children and Adults Health Programs Group
Julie McCarthy, Region I

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 the date of the approval letter, through June 30, 2014, 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 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 the Commonwealth to provide benefits that vary from those specified in the State plan, as specified in Table B of STC 37, 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 determining and redetermining eligibility based on gross income levels and Express Lane eligibility determinations for children, parents and caretaker relatives. This authority for Express Lane eligibility determinations for parents and caretaker relatives is not effective until approval of a Medicaid Express Lane Eligibility state plan amendment applicable to

children, and for children is not effective until expiration of state plan authority for Express Lane eligibility determinations.

4. **Annual Redeterminations** **Section 1902(a)(17)**

To the extent necessary to enable the Commonwealth to extend the eligibility span of enrollees who will need a redetermination between October 1, 2013 and December 15, 2013 to a reasonable date in 2014.

5. **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.

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

To enable Massachusetts 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.

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

To enable Massachusetts to restrict freedom of choice of provider for individuals in the Demonstration, as outlined in Table D, STC 45, 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.

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

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

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

To enable the Commonwealth not to provide retroactive eligibility for up to 3 months prior to the date that the application for assistance is made and instead provide retroactive eligibility as outlined in Table D, STC 45.

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00030/1**

TITLE: **MassHealth Medicaid Section 1115 Demonstration**

AWARDEE: **Massachusetts Executive Office of Health and Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Massachusetts for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension (date of the approval letter through June 30, 2014), 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 extension.

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.

I. Demonstration Population Expenditures

1. **CommonHealth Adults**. Expenditures for health care-related costs for adults aged 19 through 64 who are totally and permanently disabled and not eligible for Standard coverage, but who are:

    a. Employed; or

    b. Not employed and meet a one-time only deductible.

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 Standard coverage.

3. **Family Assistance [e-Family Assistance and e-HIV/FA]**. Effective through December 31, 2013, expenditures for health care-related costs for the following individuals with incomes at or below 200 percent of the FPL:

    a. Individuals who are HIV-positive, if they are age 64 or younger, are not institutionalized, and are not otherwise eligible under the Massachusetts Medicaid state plan. These expenditures include the 60-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 who are not otherwise eligible under the Massachusetts Medicaid state plan due to family income.

4. **Family Assistance [e-Family Assistance and e-HIV/FA]**. Effective January 1, 2014, expenditures for health care-related costs for the following individuals with incomes above 133 through 200 percent of the FPL:

    a. Individuals who are HIV-positive, if they are age 64 or younger, are not institutionalized, and are not otherwise eligible under the Massachusetts Medicaid state plan. These expenditures include 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 who are not otherwise eligible under the Massachusetts Medicaid state plan due to family income.

5. **Breast and Cervical Cancer Treatment Program [BCCTP]**. Effective through December 31, 2013, 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 andhave income at or below 250 percent of the FPL, h. Effective January 1, 2014, 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 andhave income above 133 percent through 250 percent of the FPL

6. **MassHealth Small Business Employee Premium Assistance.** Effective January 1, 2014, expenditure authority to make premium assistance payments available to 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 ESI, and where the member is ineligible for other subsidized coverage through MassHealth or the Health Connector.

7. **Coverage for Non-Disabled Children with Incomes up to 300 Percent of the FPL.** Effective January 1, 2014, expenditure authority to make premium assistance payments available for children ages 1 through 18, whose household income is above 200 and below 300 percent of the FPL and who are insured at the time of application for benefits.

8. **Insurance Partnership [IRP]**. Effective through December 31, 2013, expenditures for the cost of employer-sponsored insurance (ESI) for persons under the age of 65 as follows:

    a. Employee Subsidy. Expenditures for a portion of the employee cost for an ESI plan which meets the basic benefit levels and where the employer contributes at least 50 percent of the cost of health insurance benefits, for individuals (including employees, sole proprietors, and self-employed persons) whose gross family

income is no more than 300 percent of the FPL. This authority expires December 31, 2013.

b. Employer Subsidy. Expenditures for a portion of employer costs of qualified new employer-provided health insurance (insurance not offered prior to January 1, 1999) except that such expenditures are not authorized for sole proprietors and self-employed individuals. This authority expires December 31, 2013.

9. **Basic.** Effective through December 31, 2013, expenditures, for health care-related costs for long-term unemployed childless adults ages 19 through 64 with income at or below 100 percent of the FPL who are receiving Emergency Aid to Elders, Disabled, and Children, or services from the Department of Mental Health. This authority expires December 31, 2013.

10. **Essential.** Effective through December 31, 2013, expenditures for health care-related costs for long-term unemployed childless adults ages 19 through 64 with income at or below 100 percent of the FPL who are not eligible for Basic coverage. This authority expires December 31, 2013.

11. **Medical Security Plan.** Effective through December 31, 2013, expenditures for health care-related costs for individuals with incomes at or below 400 percent of the FPL receiving unemployment benefits from the Division of Unemployment Assistance. This authority expires December 31, 2013.

12. **Commonwealth Care**. Effective through December 31, 2013, expenditures for premium assistance for the purchase of commercial health insurance products for uninsured individuals with income at or below 300 percent of the FPL who are not otherwise eligible under the Massachusetts State plan or any other eligibility category. This authority expires December 31, 2013.

II. Service-Related Expenditures

a. **Premium Assistance**. Expenditures for premium assistance payments to enable individuals enrolled in the CommonHealth (Adults and Children), Family Assistance, Basic and Essential Populations to enroll in private health insurance to the extent the Commonwealth determines that insurance to be cost effective.

b. **Pediatric Asthma Pilot Program.** Pediatric Asthma Pilot Program. Expenditures related to a pilot program, as outlined in STC 39, focused on pediatric asthma that will provide 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 demonstration eligible children, ages 2 through 18 at the time of enrollment in the pilot, who have high-risk asthma. The pilot may include multiple phases, and may include non-traditional services, supplies, and community supports for environmental home mitigation associated

with pediatric asthma. The authority for this pilot program to receive FFP is not effective until CMS approval of the protocols and amendments to such protocols as outlined in STC 39(g) and (h).

c. **Intensive Early Intervention Services for Children with Autism Spectrum Disorder**. Expenditures related to evidence-based intensive early intervention habilitative services to MassHealth-eligible children, ages 0 to three years with a confirmed diagnosis of an autism spectrum disorder (ASD) who have an Individual Family Services Plan (IFSP) that identifies medically necessary Applied Behavioral Analysis-based (ABA) services, and who are not otherwise enrolled through the State's currently approved section 1915(c) home and community-based services (HCBS) waiver, entitled "Children's Autism Spectrum Disorder Waiver," CMS base control number 40207, and because the child has not been determined to meet institutional level of care (LOC) requirements. The authority for this program to receive FFP is not effective until CMS approval of the protocol as outlined in STC 40(h).

d. **Diversionary Behavioral Health Services**. Expenditures for benefits specified in Table C of Section V, STC 38 to the extent not available under the Medicaid state plan.

e. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** Effective January 1, 2014, expenditures to provide full MassHealth Standard plan benefits to presumptively eligible pregnant women with incomes at or below 200 percent of the FPL.

f. **End of Month Coverage for Members Transitioning to Subsidized Qualified Health Plan (QHP) Coverage through the Massachusetts Health Connector.** Effective January 1, 2014, expenditures for individuals who would otherwise lose MassHealth eligibility pending coverage in a QHP, as specified in STC 24A.

g. **Provisional Eligibility for Individuals Pending Verification of Eligibility Factors.** Expenditures for individuals who self-attest to any eligibility factor, except disability as specified in STC 21A.

III. Medicaid Eligibility Quality Control. Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

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

a. Commonwealth Care. Effective through December 31, 2013, expenditures for premium assistance under the Commonwealth Care health insurance program for coverage through December 31, 2013, for individuals ages 21 and over without dependent children with income above 133 percent of the FPL through 300

percent of the FPL. This expenditure authority expires December 31, 2013.

b. 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 through June 30, 2014, as specified in Attachment E of the Special Terms and Conditions.

c. **Health Connector Subsidies**. Effective January 1, 2014, 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 above 133 percent of the FPL through 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; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 300 percent of the FPL.

d. Providers. As described in Attachment E, and limited to the extent permitted under the SNCP limits under STC 49 and STC 50, 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, Commonwealth 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).

e. 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, 2014, for 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 STCs 39 and 41(c). Activities funded under this expenditure authority are not eligible for Delivery System Transformation Initiative (DSTI) incentive payments.

f. Delivery System Transformation Initiatives. Expenditures pursuant to STCs 49(e) and 52 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.

V. Express Lane Eligibility for Parents/Caretaker Relatives Population. Expenditures for parents and caretaker relatives who would not be eligible under either the state plan or other full-benefit demonstration populations, but for Express Lane Eligibility determinations. This authority is not effective until approval of a Medicaid Express Lane Eligibility state plan amendment applicable to children.

VI. Extended Express Lane Eligibility 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 Express Lane Eligibility determinations, for the period after September 30, 2013. This authority is not effective until approval of a Medicaid Express Lane Eligibility state plan amendment applicable to children.

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 programs under demonstration expenditure authority as outlined in Attachment B of the STCs.

2. **Out-of-State Services** — **Section 1902(a)(16)**

   To exempt the state from making payments for otherwise covered services rendered to individuals enrolled in these demonstration programs when such benefits are rendered out-of-state.

In Addition to the Above, the Following Title XIX Requirements Do Not Apply to Expenditures for Family Assistance, IRP, Basic, and Essential Coverage. Expenditure authorities for IRP, Basic, and Essential Coverage programs expire December 31, 2013.

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

   To exempt Massachusetts from furnishing or arranging for EPSDT services for individuals enrolled in these demonstration programs. This authority expires December 31, 2013.

4. **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 these demonstration programs that do not include transportation. This authority expires December

31, 2013.

In Addition to the Above, the Following Title XIX Requirements Do Not Apply to Expenditures for Family Assistance, IRP, Basic, and Essential (non-hypothetical[1] Essential population) Coverage. Expenditure authorities for IRP, Basic, and Essential Coverage programs expire December 31, 2013.

5. **Reasonable Promptness** **Section 1902(a)(8)**

To enable Massachusetts to cap enrollment and maintain waiting lists for these demonstration programs. This authority expires December 31, 2013.

6. **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 these demonstration programs as outlined in Table B of STC 37. This authority expires December 31, 2013.

No Title XIX Requirements are Applicable to Expenditures for the Medical Security Plan, Commonwealth Care, and the Safety Net Care Pool except the Following. Expenditure authority for the Medical Security Plan, and Commonwealth Care programs expire December 31, 2013.

7. **Actuarial Soundness** **42 C.F.R. 438.6(c)**

To enable Massachusetts to require Commonwealth Care providers to be subject to actuarially sound rates. This authority expires December 31, 2013.

[1] See section IV, Eligibility and Enrollment, for an eligibility chart describing hypothetical populations.

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 (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. Amendments to the demonstration as approved in September 2013 are effective January 1, 2014, unless otherwise specified. The demonstration is set to expire on June 30, 2014.
The STCs have been arranged into the following subject areas:

Attachment C. Quarterly Operational Report Content and Format
Attachment D. MassHealth Historical Per Member/Per Month Limits
Attachment E. Safety Net Care Pool Payments
Attachment F. Reserved for Pediatric Asthma Pilot Program Protocols
Attachment G. Reserved for Autism Payment Protocol
Attachment H. Reserved for Safety Net Care Pool Uncompensated Care Cost Protocol
Attachment I. Hospitals Eligible for DSTI
Attachment J. Reserved for Master DSTI Plan and Payment and Funding Protocol

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 for certain categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility was also expanded to certain non-categorically eligible populations, including unemployed adults and non-disabled persons living with Human Immunodeficiency Virus (HIV). Finally, the demonstration also authorized the Insurance Partnership program which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings. However, the Commonwealth's preferred mechanism for achieving coverage has consistently been employer-sponsored insurance, whenever available and cost-effective.

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

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

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

This amendment included:

- 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. With the combination of previous expansions and the recent health reform efforts, the MassHealth Medicaid section 1115 demonstration now covers approximately 1.5 million low-income persons.

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) reclassification of 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 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 most recent extension period, the Commonwealth's goals under the demonstration were:

- Maintain near-universal health care coverage for all citizens 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 is revising its current demonstration and waiver authorities to comply with the provisions of the Affordable Care Act . Additionally, this amendment will support the Commonwealth's ability to sustain and improve its ability to provide coverage, affordability and access to health care under the demonstration. The amendment allows Massachusetts to continue certain programs and realign other programs to comply with the Affordable Care Act provisions that become effective January 1, 2014. For example, the amendment allows Massachusetts to sunset the Commonwealth Care (CommCare) Program, MassHealth Basic, MassHealth Essential, the Medical Security Program and the Insurance Partnership on December 31, 2013. Then, effective January 1, 2014, eligible individuals in these programs with income up to 133 percent of the federal poverty level (FPL) will move to the Medicaid state plan and receive state plan benefits through an approved Medicaid state plan Alternative Benefit Plan (ABP) . Subject to federal approval of its ABP

state plan amendment(s) (SPA), Massachusetts plans to establish two ABPs, one of which (ABP 1) will be identical to MassHealth Standard and will target 19- and 20-year olds as well as certain groups with special health care needs, and the other of which will be a new benefit plan called MassHealth CarePlus. Subject to federal approval, the benefits available under the state's ABP(s) will be effective as of the date specified in the approved SPA(s).

Eligible individuals with income above 133 percent of the FPL will be eligible to purchase insurance through Massachusetts' health insurance Marketplace, the Health Connector. Additionally, some individuals will be eligible for subsidies to help them purchase health insurance through the Health Connector.

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, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must 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.

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.

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 changes to these elements without prior approval by CMS. 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 14 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**

a) 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 9.

b) **Compliance with Transparency Requirements 42 C.F.R. §§ 431.412:** Effective April 27, 2012, as part of the 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 14 as well as include the following supporting documentation:

i. 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.

ii. 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.

iii. 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.

iv. 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.

v. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

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

a) **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state

must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

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

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

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

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

e) **Post Award Forum:** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 58 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 59.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the 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.

11. **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.

12. **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.

13. **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.

14. **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 6, 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.

15. **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.

16. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY AND ENROLLMENT

17. **Eligible Populations.** This demonstration affects mandatory and optional Medicaid state plan populations as well as populations eligible for benefits only through the demonstration.

    The criteria for MassHealth eligibility are outlined in a Table A at the end of section IV of the STCs which 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. .

    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.

18. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance to Table D.

19. **Calculation of Financial Eligibility.** Through December 31, 2013, financial eligibility for demonstration programs is determined by comparing the family group's gross income with the applicable income standard for the specific coverage type. The monthly income standards are determined according to annual Federal Poverty Level (FPL) standard published in the *Federal Register*.

    Effective January 1, 2014, 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. Specifically, MassHealth will apply the five percent income disregard to disabled adults for the purposes of MassHealth Standard eligibility at the 133 percent FPL threshold.

20. **Express Lane Eligibility.** The Medicaid state agency may rely on a finding from an Express lane agency when determining whether a parent or caretaker satisfies one or more components of eligibility derived through the Medicaid state plan or demonstration at the time of redetermination. The authority to provide Express Lane eligibility procedures for parents and caretakers is not effective until the effective date of the companion Medicaid state plan amendment applicable to children. All procedures outlined in the companion

Medicaid Express Lane Eligibility SPA must also apply to Express Lane eligibility determinations for parents and caretakers.

The authority to provide Express Lane eligibility procedures will also remain in effect through the renewal period for children notwithstanding sunset dates for Express Lane Eligibility under title XIX and title XXI applicable to the companion state plan amendments. This authority is subject to approval of the Medicaid Express Lane Eligibility state plan amendment.

21. **Hospital-Determined Presumptive Eligibility effective January 1, 2014**. Effective January 1, 2014, hospitals that elect to do so may make presumptive eligibility determinations for individuals who appear eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan. The hospital-determined presumptive eligibility benefit for pregnant women and unborn children is a full MassHealth Standard benefit.

    Presumptive Eligibility through December 31, 2013. Effective through December 31, 2013, presumptive eligibility is offered to certain children who appear eligible for MassHealth Standard or Family Assistance as well as pregnant women who appear eligible for MassHealth Prenatal program.

    Presumptive eligibility begins 10 calendar days prior to the date the Medical Benefit Request (MBR) is received at the MassHealth Enrollment Center (MEC) or MassHealth outreach site and lasts until MassHealth makes an eligibility determination (but no longer than 60 days). If information necessary to make the eligibility determination is not submitted within 60 days after the begin date, the MBR will be deactivated and presumptive eligibility will end.

    A child may receive presumptive eligibility only once in a 12-month period.

    A presumptively-eligible child receiving services under the Family Assistance program is not assessed a monthly health insurance MassHealth premium.

21A. **Provisional Eligibility.** Effective January 1, 2014, MassHealth will accept self-attestation for all eligibility factors, except for disability status, in order to determine eligibility and may require post-eligibility verification from the applicant (see below for provision of benefits relating to the reasonable opportunity for the verification of immigration and citizenship status). 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 will require further verifications from the applicant. Necessary verifications are required within 90 days of the eligibility determination in order to maintain enrollment. This 90-day period for post-eligibility verification is known as "provisional eligibility. The Commonwealth must not provide retroactive coverage until eligibility during the retroactive period 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) or the newly eligible FMAP for individuals whose eligibility has not been verified within that 90 day provisional eligibility period, but may claim the regular FMAP for those individuals for no longer than a 90 day period of benefits.

Provisional eligibility begins on the date the paper application is received at the MassHealth Enrollment Center (MEC) or MassHealth outreach site, or an electronic application is submitted through the Health Insurance Marketplace online system.

The Commonwealth will continue to follow the rules for the reasonable opportunity to verify immigration and citizen status as required under federal law. The reasonable opportunity period for immigration, citizenship and identity verification will be aligned with the 90 day period, including the ten day retroactive 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 period, 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.

22. **Verification of Breast or Cervical Cancer or Human Immunodeficiency Virus (HIV).** For individuals who indicate on the application that they have breast or cervical cancer or HIV, a determination of eligibility will be made in accordance with the procedures described in STC 21A. 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.

23. **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 STC 49(c), however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP), including the Designated State Health Programs (DSHP).

Individuals 65 years and older (unless a parent or caretaker relative of a child 18 years old or younger or an enrollee in the Medical Security Plan)
Individuals who are institutionalized
Participants in Program of All-Inclusive Care of the Elderly (PACE)
Refugees served through the Refugees Resettlement Program

24. **Enrollment Caps.** The Commonwealth is authorized to impose enrollment caps on populations made eligible solely through the demonstration, except that enrollment caps may

not be imposed for the demonstration expansion population groups listed as "Hypotheticals" in Table A. Setting and implementing specific caps are considered amendments to the demonstration and must be made consistent with section III, STC 7.

24A. **End of Month Coverage for Members Transitioning to Subsidized QHP Coverage through the Massachusetts Health Connector**. Effective January 1, 2014, 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 QHP coverage through the Connector, MassHealth will extend the member's last day of coverage to the end of the month before QHP 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.

24B.**Temporary Authority: Transition to New Programs**

The Commonwealth will extend the eligibility of enrollees who will need a redetermination between October 1, 2013 and December 15, 2013 to a reasonable date in 2014. MassHealth will continue processing change of circumstance requests and periodic data match results during this time.

Table A. MassHealth State Plan Base Populations[1] (See STC 63(f) for terminology)					
Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
AFDC-Poverty Level infants	< Age 1: 0 through 185%	Title XIX	**Base Families**	Standard	Up to 60 days presumptive eligibility for children with unverified income
Medicaid Expansion infants	< Age 1: 185.1 through 200%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted	**1902(r)(2) Children** **1902(r)(2) XXI RO**	Standard	Up to 60 days presumptive eligibility for children with unverified income
AFDC-Poverty Level Children and Independent Foster Care Adolescents	• Age 1 - 5: 0 through 133% • Age 6 - 17: 0 through 114% • Independent Foster Care Adolescents aged out of DCF 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	Title XIX	**Base Families**	Standard	Up to 60 days presumptive eligibility for children with unverified income

[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	• Age 6 - 17: 114.1% through 133% • Age 18: 0 through 133%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted	**Base Families** **Base Families XXI RO**	Standard	Up to 60 days presumptive eligibility for children with unverified income

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%	• 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	**1902(r)(2) Children** **1902(r)(2) XXI RO**	Standard	Up to 60 days presumptive eligibility for children with unverified income
Medicaid Expansion Children II (effective January 1, 2014)	Ages 19 and 20: 133.1 through 150%	Title XIX	**1902(r)(2) Children**	Standard	
CHIP Unborn Children (effective January 1, 2014)	0 through 200%	Title XXI	**n/a**	Standard	
Pregnant women	0 through 185%	Title XIX	**Base Families**	Standard	
Pregnant women ages 19 and older considered presumptively eligible	0 through 185%	Title XIX	**Base Families**	Prenatal	Presumptive eligibility for pregnant women with self-declared income
Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance	0 through 133%	Title XIX	**Base Families**	Standard	
Disabled children under age 19	0 through 150%	Title XIX	**Base Disabled**	Standard	
Disabled adults ages 19 through 64	0 through 114%	Title XIX	**Base Disabled**	Standard	
Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	**Base Disabled**	CommonHealth	Must spend-down to medically needy income standard to become eligible as medically needy
Pregnant women	185.1 through 200%	Title XIX	**1902(r)(2) Children**	Standard	

Pregnant women age 19 and older considered presumptively eligible	185.1 through 200%	Title XIX	**1902(r)(2) Children**	Prenatal	Presumptive eligibility for pregnant women with self-declared income

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	**Base Families** **Base Disabled** **1902(r)(2) Children** **1902(r)(2) Disabled** **New Adult Group** (New Adult Group coverage begins January 1, 2014)	Limited	Member eligible for emergency services only under the state Plan and the demonstration. Members who meet the definition and are determined to have a disability are included in the Base Disabled EG Members who are determined eligible via 1902(r)2 criteria are included in the 1902(r)(2) EG
Disabled adults ages 19 through 64	114.1 through 133%	Title XIX	**1902(r)(2) Disabled**	Standard	
Effective through December 31, 2013, Individuals eligible under the Breast and Cervical Cancer Treatment Program (BCCTP) with income through 250% FPL. Effective January 1, 2014, Individuals eligible under the BCCTP with income above 133% through 250% FPL.	0 through 250% (through December 31, 2013) >133 through 250% (effective January 1, 2014)	Title XIX	**BCCTP**	Standard	

Children eligible under TEFRA section 134, SSA section 1902(e)(3) and 42 U.S.C. 1396a(e)(3) (Kaileigh Mulligan kids)	• Age 0 – 17 • Require hospital or nursing facility level of care • Income < or = to $72.81, or deductible • $0 through $2,000 in assets	Title XIX	**Base Disabled**	Standard	Income and assets of their parents are not considered in determination of eligibility
Children receiving title IV-E adoption assistance	• Age 0 through 18	Title XIX	**Base Families**	Standard	Children placed in subsidized adoption under title IV-E of the Social Security Act

Table 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)	• 0 through 300% SSI Federal Benefits Rate • $0 through $2,000 in assets	Title XIX	**Base Disabled**	Standard	All other participants under age 65 in a HCBW are reflected in other Base Eligibility Groups in this chart.
Affordable Care Act New Adult Group (effective January 1, 2014)	• 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	**Category VIII**	*Subject to approval of Massachusetts' Medicaid Alternative Benefit Plan SPA(s) (effective January 1, 2014)*:	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 (continued)*					
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	• < Age 1: 200.1 through 300% • Ages 1 - 18: 150.1 through 300%	• Title XIX if insured at the time of application or in crowd-out status* • Title XXI via the separate XXI program (Funded through title XIX if title XXI is exhausted)	**CommonHealth** **CommonHealth XXI**	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 and the separate XXI program.
Higher income children with disabilities ages 0 through 18	Above 300%	Title XIX	**CommonHealth**	CommonHealth	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL
Higher income adults with disabilities ages 19 through 64 working 40 hours a month or more	Above 133% (Effective January 1, 2014, above 150% for 19- and 20-year olds)	Title XIX	**CommonHealth**	CommonHealth ("working")	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.
Effective through December 31, 2013, 19 and 20 year olds	0 through 300%	Title XIX	**CommCare-19-20**	Commonwealth Care	
Effective through December 31, 2013, 19 and 20 year olds	0 through 100%	Title XIX	**Essential-19-20**	Essential	
Effective through December 31, 2013, Parents and caretaker relatives eligible per above, except for income	133.1 through 300%	Title XIX	**CommCareParents**	Commonwealth Care	
Effective through December 31, 2013,	At or below 133%	Title XIX	**CommCare-133**	Commonwealth Care	

Low-income adults					

* Crowd out status refers to children made ineligible for CHIP due to the crowd out provisions contained within Title XXI.

Table A. MassHealth Demonstration Expansion Populations (See STC 63(f) 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**
Children ages 1 through 18 (Non-disabled)	150.1 through 200 Above 200 to 300% (effective January 1, 2014)	• Title XIX if insured at the time of application • Title XXI via the separate XXI program if uninsured (Funded through title XIX if title XXI is exhausted)	**e-Family Assistance** **Fam Assist XXI** (if XXI is exhausted)	Family Assistance • Premium Assistance • Direct Coverage 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.	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 XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration and the separate XXI program. Effective January 1, 2014, children ages 1 through 18 from 200-300% FPL who are insured at the time of application are eligible under the 1115 demonstration..
Effective through December 31, 2013, adults under the age of 65 who are not otherwise eligible for medical assistance who work for a qualified small employer and purchase ESI	At or below 300%	Title XIX	**IRP**	Family Assistance/ Insurance Partnership (effective through December 31, 2013)	Enrollment in Family Assistance allows an individual to receive premium assistance through the Insurance Partnership. No additional wraparound is provided. Individuals whose spouse or noncustodial children are receiving MassHealth must enroll in a health plan that provides coverage to the dependents.
Adults under the age of 65 who are not otherwise eligible for medical assistance who work for a small employer and purchase ESI (effective January 1, 2014)	133.1 through 300%	Title XIX	**SEB**	Small Business Employee Premium Assistance (effective January 1, 2014)	Individuals must not be eligible for any other MassHealth coverage or for APTCs. No additional wraparound benefits are provided. 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.

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**
Effective through December 31, 2013, individuals aged 19 through 64 Long-term unemployed individuals or members of a couple and a client of DMH and/or receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC), not otherwise eligible for medical assistance	0 through 100%	Title XIX	**Basic**	Basic	Premium assistance is offered in lieu of direct coverage when qualified cost effective private insurance is available. Wrap around coverage is not provided when premium assistance is paid. Direct Coverage: When there is no qualified cost effective private insurance, direct coverage is furnished through managed care, except that hospice services are covered FFS in community and certain in-patient settings, if requested and the conditions for hospice services are met.
Effective through December 31, 2013, individuals aged 21 through 64 Long-term unemployed individuals or members of a couple, and neither a client of DMH or receiving EAEDC, not otherwise eligible for medical assistance	0 through100%	Title XIX	**Essential**	Essential	Premium assistance is offered in lieu of direct coverage when there is qualified cost effective private insurance is available. Through December 31, 2013, wrap around coverage is not provided when premium assistance is paid. Direct Coverage: When there is no qualified cost effective private insurance, direct coverage is furnished through managed care, except that hospice services are covered FFS in community and certain in-patient settings if requested and the conditions for hospice services are met.
Effective through December 31, 2013, Families receiving unemployment benefits, not otherwise eligible for medical assistance.	At or below 400%	Title XIX	**MSP**	Medical Security Plan	
Effective through December 31, 2013, Individuals with HIV not otherwise eligible for medical assistance with income through 200% FPL.	0 through 200% Above 133 to 200%	Title XIX	**e-HIV/FA**	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.

Effective January 1, 2014, Individuals with HIV not otherwise eligible for medical assistance with income above 133% through 200% FPL.					

Table A. MassHealth Demonstration Expansion Populations					
Populations Made Eligible through the Demonstration (Additional populations)	**Federal Poverty Level (FPL) and other qualifying criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**Massachusetts Demonstration Program**	**Additional comments**
Effective through December 31, 2013, individuals aged 21and older, not otherwise eligible for medical assistance, with no access to ESI, Medicare, or other subsidized health insurance programs, and who are not otherwise eligible under MassHealth or the State plan, including the following groups:[2]* • Low-income adults; • Pregnant women aged 21and older; • Individuals living with HIV; and • Adults working for an employer with 50 or fewer employees who offers no insurance or who contributes < 33% (or < 20% for family coverage) towards insurance costs	• 133.1% through 300%; • 200.1 through 300%; • 200.1 through 300%; • At or below 300%	Title XIX	**SNCP-CommCare**	Commonwealth Care Program	

[2] Through December 31, 2013, parents and caretaker relatives in Commonwealth Care, individuals aged 19 and 20, and low-income adults with income at or below 133 percent of the FPL enrolled in Commonwealth Care are counted as hypothetical base populations and expenditures for these populations are reported under the EGs specified on page 15.

V. DEMONSTRATION PROGRAMS AND BENEFITS

25. **Demonstration Programs.** The demonstration provides health care benefits to eligible individuals and families through the following specific programs. The demonstration program for which an individual is eligible is based on the criteria outlined in Table A of section IV of the STCs. Table B in STC 37, provides a side-by-side analysis of the benefits offered through these MassHealth programs.

26. **MassHealth Standard** Individuals enrolled in Standard receive state plan services including for individuals under age 21, Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. 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 STC 44.

    Beginning January 1, 2014, individuals in the Affordable Care Act New Adult Group (New Adult Group) will be eligible for benefits provided, at minimum, through the state's approved alternative benefit plan (ABP) SPA(s). Benefits will be provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished in coordination with STC 44.
    Subject to federal approval, the benefits available under the state's ABP(s) will be effective as of the date specified in the approved SPA(s).

27. **MassHealth Breast and Cervical Cancer Treatment Program (BCCTP**). The BCCTP 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.

28. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under Standard; individuals under age 21 receive EPSDT services as well. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished in coordination with STC .

29. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under Standard. 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. There are two separate categories of eligibility under Family Assistance:

    a) **Family Assistance-HIV/AIDS**. 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**. Children can be enrolled in Family Assistance if their family's gross income is between 150 percent and 200 percent of the FPL. Beginning January 1, 2014, the upper income threshold will increase to 300 percent of the FPL. Only premium assistance is provided if ESI is available to these children that is cost-effective, meets a basic benefit level (BBL), and for which the employer contributes at least 50 percent of the premium cost. Parents of children eligible for Family Assistance may receive coverage themselves for ESI subsidized by Family Assistance if they work for a qualified employer. However, the premium assistance payment is based on the children's eligibility.Direct coverage is provided for children only during the presumptive/provisional eligibility period and the time span while the Commonwealth is investigating availability of and enrolling the child in ESI. Direct coverage Family Assistance under the separate title XXI program is provided through an MCO or the PCC plan for children without access to ESI.

30. **MassHealth Insurance Partnership (IRP).** Effective through December 31, 2013, the Commonwealth makes premium assistance payments available to certain members (including adults without children) with a gross family income at or below 300 percent of the FPL, who have access to qualifying ESI, and where a qualified small employer contributes at least 50 percent toward the premium. This program will sunset on December 31, 2013.

This design creates an overlap between the Insurance Partnership and premium assistance offered under the Standard, CommonHealth, and Family Assistance programs. The Insurance Partnership program has two components: 1) assisting employers with their health insurance costs through an Insurance Partnership employer payment; and 2) assisting employees with payment of health insurance premiums through a premium assistance payment. The Insurance Partnership employee payment is based on amounts limited by state legislation to the value of the subsidies specified for the Commonwealth Care program.

Qualified employers will receive Insurance Partnership payments for each MassHealth member who receives premium assistance from MassHealth, no matter which MassHealth coverage type the member receives. All premium assistance payments made on behalf of MassHealth eligible members are eligible for FFP at the appropriate federal matching rate as well as IRP payments to employers offering "new" health insurance (insurance not offered prior to January 1, 1999).

In order to provide for a smooth phase-out of the Insurance Partnership program, MassHealth will stop accepting new small businesses as participants in Insurance Partnership as of September 1, 2013.

30A. **MassHealth Small Business Employee (SBE) Premium Assistance.** Effective January 1, 2014, the Commonwealth will make premium assistance payments available to certain individuals whose gross family income is greater than 133 percent of FPL and up 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.

This program offers continuity to members who were previously covered by the Insurance Partnership program. .

31. **MassHealth Basic.** Effective through December 31, 2013 individuals enrolled in Basic are receiving Emergency Aid to Elders, Disabled, and Children (EAEDC) or are Department of Mental Health (DMH) clients who are long-term or chronically unemployed. This demonstration program provides either direct coverage through a managed care plan or premium assistance if qualified cost effective private insurance is available. This demonstration program will sunset on December 31, 2013.

32. **MassHealth Essential**. Effective through December 31, 2013 individuals enrolled in Essential are low-income, long-term unemployed individuals who are not eligible for Basic. This demonstration program provides either direct coverage through a managed care plan or premium assistance if qualified cost effective private insurance is available. This demonstration program will sunset on December 31, 2013.

33. **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. These individuals receive emergency medical services only.

34. **MassHealth Prenatal**. Effective through December 31, 2013, pregnant women are enrolled in Prenatal if they have applied for Standard and are waiting for eligibility approval. These individuals receive short-term outpatient prenatal care (not including labor and delivery). This demonstration program will sunset on December 31, 2013.

35. **Medical Security Plan (MSP).** Effective through December 31, 2013 individuals are enrolled in MSP, a health plan provided by the Division of Unemployment Assistance (DUA), if they are receiving unemployment compensation benefits under the provisions of Chapter 151A of the Massachusetts General Laws. MSP provides health insurance to enrollees through premium assistance and direct coverage. Under premium assistance, partial premiums are paid for continuation of qualified ESI which began while the individual was still employed. Direct coverage is provided by DUA through enrollment in a health plan for an individual who does not have continued ESI available, or if the individual qualifies for a hardship waiver. Premiums are required for those with incomes over 150 percent of the FPL on a sliding scale fee schedule. This demonstration program will sunset on December 31, 2013.

36. **Commonwealth Care (CommCare).** Effective through December 31, 2013, CommCare is a commercial insurance-based premium assistance program administered by the Commonwealth Health Insurance Connector Authority (Connector or Connector Authority), an independent state agency. Premium assistance is offered for the purchase of health benefits from an MCO either licensed under MGL c. 175 by the Massachusetts Division of

Insurance or substantially compliant with licensure requirements, as determined by the Connector Authority. Total payments to the MCO must be actuarially sound, in accordance with the standards outlined in 42 C.F.R. Part 438.6(c). This demonstration program will sunset on December 31, 2013.

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

Table B. MassHealth Direct Coverage Benefits

Benefits	Standard	Common Health	Family Assistance	Basic\ Effective through 12/31/13	Essential Effective through 12/31/13
EPSDT	X	X			
Inpatient Acute Hospital	X	X	X	X	X
Adult Day Health	X	X			
Adult Foster Care**	X	X			
Ambulance (emergency)	X	X	X	X	X
Audiologist Services	X	X	X	X	
Behavioral Health Services (mental health and substance abuse)	X	X	X	X	X
Chapter 766 Home Assessment***	X	X	X		
Chiropractic Care	X	X	X	X	
Chronic Disease and Rehabilitation Hospital Inpatient	X	X	X		
Community Health Center (includes FQHC and RHC services)	X	X	X	X	X
Day Habilitation****	X	X			
Dental Services	X	X	X	X	X
Diversionary Behavioral Health Services	X	X	X	X	X
Durable Medical Equipment and Supplies	X	X	X	X	X
Early Intervention	X	X	X		
Intensive Early Intervention Services for Eligible Children with Autism Spectrum Disorder	X	X	X	X	X
Family Planning	X	X	X	X	X

Benefits	Standard	Common Health	Family Assistance	Basic\ Effective through 12/31/13	Essential Effective through 12/31/13
Hearing Aids	X	X	X	X	
Home Health	X	X	X	X	
Hospice[3]	X	X	X	X	X
Laboratory/X-ray/ Imaging	X	X	X	X	X
Medically Necessary Non-emergency Transport	X	X			
Nurse Midwife Services	X	X	X	X	
Nurse Practitioner Services	X	X	X	X	X
Orthotic Services	X	X	X	X	
Outpatient Hospital	X	X	X	X	X
Outpatient Surgery	X	X	X	X	X
Oxygen and Respiratory Therapy Equipment	X	X	X	X	X
Personal Care	X	X			
Pharmacy	X	X	X	X	X
Physician	X	X	X	X	X
Podiatry	X	X	X	X	X
Private Duty Nursing	X	X			
Prosthetics	X	X	X	X	X
Rehabilitation	X	X	X	X	X
Renal Dialysis Services	X	X	X	X	X
Skilled Nursing Facility	X	X			
Speech and Hearing Services	X	X	X	X	X
Targeted Case Management	X	X			
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X	X
Vision Care	X	X	X	X	Only exam and testing

[3] The MassHealth Basic and Essential program benefit packages include the following hospice services: routine home care (community setting); continuous home care (community setting); inpatient respite care; and general inpatient care.

Benefits	Standard	Common Health	Family Assistance	Basic\ Effective through 12/31/13	Essential Effective through 12/31/13
					services provided by a physician or optometrist

	Chart Notes:
	***Basic and Essential Programs** - The Basic and Essential programs will sunset on December 31, 2013. Beginning January 1, 2014, Medicaid state plan benefits for the new adult group will be provided as specified in the approved ABP benefits state plan amendment(s).
	****Adult Foster Care Services –** These services are State state plan services and the definition of these services may vary contingent upon the approved State 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 state plan services and the definition of these services may vary contingent upon the approved State 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.

38. **Diversionary Behavioral Health Services**. Diversionary behavioral health services are home and community-based mental health services furnished as clinically appropriate alternatives to and diversions from inpatient mental health 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. They 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 Insurance 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

Diversionary Behavioral Health Service	Setting	Definition of Service
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 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

Diversionary Behavioral Health Service	Setting	Definition of Service
		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.
Acute Treatment Services for Substance Abuse	24-hour facility	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.
Clinical Support Services for Substance Abuse	24-hour facility	24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and

Diversionary Behavioral Health Service	Setting	Definition of Service
		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 facility	A clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service.

Diversionary Behavioral Health Service	Setting	Definition of 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.
Program of Assertive Community Treatment	Non-24-hour facility	A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a

Diversionary Behavioral Health Service	Setting	Definition of Service
		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.
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 mileau" 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.		

39. **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 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 is subparagraph (g). For example, pending CMS approval, services may 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).

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 is not available for this pilot program until the protocols and milestones outlined in subparagraph (g) below are approved by CMS. 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 STC 49(d). 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. Before enrolling beneficiaries and claiming FFP under this pilot program, the state must meet the following milestones which require CMS preapproval. These protocols/milestones will be future 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 support 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 STC 84. 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 STCs 58 and 59. 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 STCs 49(d) and 50(b);
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.

40. **Intensive Early Intervention Services for Children with Autism Spectrum Disorder.** The state will provide medically necessary Applied Behavioral Analysis-based (ABA) treatment services to MassHealth eligible children as stipulated below. The early intervention services are highly structured, evidence based, individualized, person-centered treatment programs that address the core symptoms of autism spectrum disorder (ASD). A waiting list is not allowable for this program.

a) Eligibility. The state will limit eligibility to MassHealth eligible children, ages 0 through three years with a confirmed diagnosis of one of the following codes: Autistic Disorder – code 299.00; Childhood Disintegrative Disorder – code 299.10; Asperger's Disorder – code 299.80; Pervasive Development Disorder – code 299.10; Rett's Disorder – code 299.80 according to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or a diagnosis of autism in any updated version of this manual, and must be conferred by a physician or a licensed psychologist; have an Individualized Family Service Plan (IFSP) that identifies medically necessary ABA-based services; and who are not otherwise enrolled in the state's currently approved section 1915(c) HCBS waiver entitled "Children's Autism Spectrum Disorder Waiver," CMS base control number 40207, because the child has not been determined to meet institutional level of care requirements.

b) Individualized Family Service Plan (IFSP). Massachusetts will utilize a universal IFSP form approved by the Massachusetts Department of Public Health that includes the elements required under Part C of the Individuals with Disabilities Education Act (IDEA) and Massachusetts Early Intervention Operational Standards. The form will utilize a child-centered and family-directed planning process intended to identify the strengths, capacities, preferences, needs, and desired outcomes for the child.

The IFSP is a written plan that is developed for each eligible infant and toddler with a disability according to the Part C regulations under the IDEA. The IFSP specifies the child's: service coordinator; present levels of development; and family resources, priorities, and concerns. It also includes measurable results or outcomes and the criteria, procedures, and timelines used to determine the degree to which progress toward

achieving the results or outcomes identified in the IFSP is being made. There is also a statement of the specific early intervention services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family to achieve the results or outcomes identified including: beginning date, length, duration, frequency, intensity, method of delivering, and location of the services. The IFSP will also include a statement that the ABA-based treatment will be provided in the natural environment for that child to the maximum extent appropriate, or a justification as to why the service will not be provided in the natural environment. The IFSP must specify the identification of medical or other services such as ABA-based treatment the child needs or is receiving through other sources, including title XIX. The plan will be reviewed and updated at least annually.

c) Benefits. Participants are eligible to receive ABA-based services. All treatment must be evidence-based, and newer interventions for which there is no evidence of effectiveness may not be employed until such time as there is at least emerging evidence to fully support the intervention's appropriate usage and assure the health and safety of demonstration enrollees. There is no annual maximum benefit.

The following services will be provided as ABA-based treatment:

1) Assessment of child's functional skills across domains impacted by ASD:
2) Development of individualized treatment plan to teach new skills;
3) Direct child instruction to teach new skills;
4) Functional behavioral assessment and support plan to decrease problematic behavior and increase appropriate behavior when indicated;
5) Family training to assist family, extended family, and non-paid caregivers in generalization of skills into the child's natural routines and in management of behavior; and
6) Supervisory session to ensure consistency in instructional practices, data collection accuracy, and to make program adjustments as needed.

d) Delivery System. MassHealth will provide ABA-based treatment services to children through the fee for service delivery system. Children who are enrolled in a contracted managed care organization (MCO) will receive the services as a fee for service "wrap" to the MassHealth covered services.

e) Behavioral Supports and Coordination. Provider specifications for each service specified above are as follows:

1) Board-Certified Behavioral Analyst: hold a doctoral or master's degree and meet certification requirements of the Behavior Analyst Certification Board;
2) Supervising Clinician: hold a master's degree in psychology, education or related field, and any related state licensure for the discipline;
3) Therapist: hold a bachelor's degree and have one year experience with children with autism is preferred; and
4) Specialty Associate: hold an associate degree and have one year experience providing care for a child on the autism spectrum.

f) Provider Participation. All providers must participate in MassHealth. The Department of Public Health shall require that direct care personnel providing the ABA-based treatment will attain provisional certification prior to billing Medicaid for any direct services. Entities or individuals that have responsibility for IFSP development may not provide ABA-based treatment to a demonstration enrollee.

g) Cost-Sharing. MassHealth cost sharing requirements will apply to children who are both eligible for MassHealth, and the ABA-based services. The annual fee assessed by the Massachusetts Department of Public Health for all children enrolled in its general early intervention services program will not apply to MassHealth eligible children. Cost-sharing requirements for MassHealth enrolled children who receive the ABA-based treatment will be the same as the cost-sharing requirements for all other section 1115 demonstration waiver participants as outlined in Attachment B.

h) Payment. Before providing the services outlined in subparagraph (c) and claiming FFP under this component of the demonstration, the state must submit a protocol to CMS for CMS approval that outlines the methodology of the payment rate and the actual rates provided to demonstration participants outlined in subparagraph (c) which are provided by providers specified in subparagraphs (e) and (f). This deliverable will be future Attachment G.

   Proposed rates and any proposed changes to such rates will be subject to public notice. Any changes to the payment protocol are subject to CMS approval as outlined above.

i) Self Direction. Families of children who are eligible to receive the ABA-based services may participate in electing the evidence based intervention treatment model for their child. Parents or other legally responsible relatives will be given the opportunity to interview providers before making the selection of a particular treatment model or provider.

j) Assurances. The state must meet the following requirements:
   1) Assure the CMS that Part C grant funds will not be used as the non-federal share for Medicaid purposes;
   2) Comply with all other requirements of Part 303 of the IDEA, Early Intervention Program for Infants and Toddlers with Disabilities in accordance with the provision of the ABA-based treatment;
   3) Must not permit restraint or seclusion during the course of service delivery; and
   4) Assure that direct service workers accused of abuse or neglect will not provide services to MassHealth enrollees receiving ABA-based treatment until the state's investigation process is completed.

k) Quality Strategy for ABA-Based Treatment Services. The state must implement an overall Quality Assurance and Improvement (QAI) strategy that assures the health and welfare of children receiving the ABA-based services. The strategy will be consistent

with the general quality requirements for Medicaid home and community-based services (HCBS) through other sections of the Act such as sections 1915(c) and 1915(i).

Through an ongoing discovery, remediation and improvement process the state will monitor, at a minimum:

1) IFSP determinations and service delivery;
2) Provider qualifications;
3) Enrollee health and welfare;
4) Financial oversight between the State and Federal programs; and
5) Administrative oversight.

The state must also monitor such items as medical necessity determinations for ABA-based treatment, timeliness of service delivery, improvement and sustainability of functional abilities of enrolled children, effectiveness of treatment type, and staff training. The state will submit its QAI strategy for ABA-based treatment by January 1, 2012. During the time the demonstration is effective, the state assures CMS it will implement the strategy and update it as needed in part based on findings listed in the annual report described below.

l) Annual Report. The state shall provide the CMS with a draft annual HCBS report as part of the annual report requirement for the demonstration as stipulated in STC 59. The first draft HCBS report will be due no later than October 1, 2012. The HCBS report will at a minimum include:

1) An introduction;
2) A description of each ABA-based treatment;
3) An overarching QAI strategy that assures the health and welfare of enrollees receiving HCBS that addresses the: (a) enrollee's person-centered individual service plan development and monitoring, b) specific eligibility criteria for particular HCBS, c) provider qualifications and/or licensure, d) health and safety, d) financial oversight between State and Federal programs, and e) administrative oversight by the State Medicaid Agency;
4) An update on services used by enrollees;
5) The various treatment modalities employed by the state, including any emerging treatments, updated service models, opportunities for self-direction, etc.;
6) Specific examples of how the services have been used to assist demonstration enrollees;
7) A description of the intersection between demonstration ABA-based treatment and any other state programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures; and
8) Other topics of mutual interest between CMS and the state related to the ABA-based treatment.

The annual report may also address workforce development, certification activity, self-direction, and capacity in the state to meet needs of the population receiving the services, and rebalancing goals related to HCBS. Additionally, the annual report will summarize

the outcomes of the state's Quality Strategy for HCBS as outlined above. The state may also choose to provide the CMS with any other information it believes pertinent to the provision of the ABA-based treatment services/HCBS and their inclusion in the demonstration, including innovative practices, cost-effectiveness, and short and long-term outcomes in the annual report.

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 insurance (ESI) when cost effective. These circumstances include the availability of ESI, the employer's contribution level meeting a state-specified minimum, and its cost-effectiveness. MassHealth pays for medical benefits directly (direct coverage) only when no other source of payment is available and cost-effective. Beneficiaries are required, as a condition of eligibility under most coverage types, to obtain or maintain private health insurance when 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 Prenatal and MassHealth Limited have a premium assistance component.

Under MassHealth premium assistance, the Commonwealth provides a contribution through reimbursement to the member or direct payment to the insurer, toward an employed individual's share of the premium for an ESI plan of which the individual is a beneficiary or covered dependent, and 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 ESI plan is measured against the BBL, and a determination is then made regarding the cost-effectiveness of providing premium assistance rather than direct coverage. Premium assistance is the provided benefit under the Commonwealth Care for the purchase of a commercial health insurance product.

MassHealth benefits provided through direct coverage are delivered both on a fee for service (FFS) and capitated basis under the demonstration. See Table D within STC 45 for details on the Delivery System and Coverage for MassHealth Administered Programs. As described below in Table D, MassHealth may require members eligible for direct coverage under Standard, an ABP SPA, Family Assistance, CommonHealth, Basic and Essential to enroll in managed care. Most members of Standard, ABP 1 (subject to approval of the Commonwealth's ABP SPA), and Family Assistance can elect to receive services either through the statewide Primary Care Clinician (PCC) Plan or from a MassHealth-contracted managed care organization (MCO). Subject to approval of the Commonwealth's ABP SPA entitled "CarePlus," CarePlus members will be required to enroll with a MassHealth-contracted CarePlus MCO, provided that there are at least two CarePlus MCOs available in the member's service area; if there are fewer than two available CarePlus MCOs in a particular region, CarePlus members in that region must enroll in the PCC Plan or a CarePlus 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.

41. **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) 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). The PCC Plan members are guaranteed freedom of choice of provider for family planning services and are able to obtain these services from any participating Medicaid provider without consulting their PCC or obtaining MassHealth's prior approval.

    b) 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.

    c) 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®-PCMH™) 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 49(d). 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 84.

d) MCO**.** 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. MassHealth Standard/ABP 1, CommonHealth and Family Assistance members who either choose or are assigned to a health plan may transfer to another available health plan in their geographic service area at any time for any reason. Subject to approval of the Commonwealth's ABP SPA entitled "CarePlus," MassHealth CarePlus members may transfer to another available health plan in their geographic service area for any reason, effective on the first of the month following the request to transfer; provided, however, that transfers for cause are effective immediately.

42. **Exclusions from Managed Care Enrollment**. MassHealth may exclude the following individuals 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/ABP 1 and CommonHealth, for whom MassHealth is a secondary payer, to enroll with the behavioral health contractor for behavioral health services;

b) Individuals who are receiving MassHealth Standard/ABP 1, CommonHealth, Family Assistance, or CarePlus (subject to approval of the Commonwealth's ABP SPA(s)) 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 Prenatal and Limited coverage;

d) Individuals receiving Standard coverage who are 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.

43. **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 contract is set at the same rate for both public and private providers. This requirement does not apply to contracts under the SNCP as outlined in STC 49(c) and STC 49(e) except as implemented by STC 50(f).

c) Selective Contracting. Procurement 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.

44. **MassHealth Standard and CommonHealth Premium Assistance.** iIf available and cost effective, the Commonwealth will purchase private health insurance on behalf of individuals eligible for Standard or CommonHealth 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, 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. Effective January 1, 2014, these premium assistance provisions would also apply to individuals in the New Adult Group.

45. **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 D. Delivery System and Coverage for MassHealth Demonstration Programs

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Standard and Alternative Benefit Plan(s)*					
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
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	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, PCCP 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
Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF	All services are offered via MCO, PCC Plan or FFS,	x	x	x	Start date of state custody

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
	with the exception of behavioral health which is provided via mandatory enrollment in BHP PIHP unless a child is enrolled in an MCO (in which case, behavioral health is provided through the MCO).				
Presumptive children, for an up to 60-day period, before self-declared family income is verified	FFS			x	10 days prior to date of application
Individuals in the Breast and Cervical Cancer Treatment Program	MCO or PCC Plan	x			10 days prior to date of application
CommonHealth*					
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	Premium assistance			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
	with wrap				
Family Assistance for HIV/AIDS*					
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
Individuals with qualifying ESI	Premium assistance with wrap			x	10 days prior to date of application
Family Assistance for Children***					
Individuals with no TPL	MCO or PCC Plan**	x			10 days prior to date of application
Individuals with qualifying ESI	Premium assistance with wrap			x	10 days prior to date of application
Insurance Partnership					
Individuals with qualifying ESI	Premium assistance for employees and incentive payments for employers			N/A	First month's premium payment following determination of eligibility
Small Business Employee Premium Assistance					
Individuals with qualifying ESI	Premium assistance for employees			N/A	First month's premium payment following determination of eligibility
Basic					
Individuals with no TPL	MCO or PCC Plan	x			Coverage starts when managed care enrollment is effective, there is no retroactive coverage. Hospice benefits are provided FFS from date of authorization.
Individuals with TPL	Premium assistance only, no			N/A	First month's premium payment following determination of eligibility.

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
	benefit wrap through 12/31/2013.				
Essential					
Individuals with no TPL	MCO or PCC Plan	x			Coverage starts when managed care enrollment is effective, there is no retroactive coverage. Hospice benefits are provided FFS from date of authorization.
Individuals with TPL	Premium assistance only, no benefit wrap through 12/31/2013.			N/A	First month's premium payment following determination of eligibility.
Limited					
Individuals receiving emergency services only	FFS			x	10 days prior to date of application
Prenatal	FFS			x	10 days prior to date of application
Home and Community-Based Waiver, under age 65	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.
Medical Security Plan					
Direct Coverage	MCO	x			Start date of unemployment benefits
Premium Assistance	Premium assistance only			N/A	Start date of unemployment benefits
Commonwealth Care Premium Assistance	MCO	x			First day of month following enrollment

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Chart Notes					
*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, subject to approval of the Commonwealth's ABP SPA entitled "CarePlus."					
***Presumptive and time-limited during health insurance investigation					
****All retroactive eligibility is made on a FFS basis					

VII. COST SHARING

46. **Overview.** Cost-sharing imposed upon individuals enrolled in 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 Commonwealth Care, Medical Security Plan, and 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)

47. **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.

48. **SNCP 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 the SNCP are effective for dates of services beginning on the date of the approval letter through June 30, 2014. For the period operating under temporary extension from July 1, 2011, 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 2012, with the exception of Commonwealth Care which was funded through budget neutrality savings. The aggregate SNCP cap must be reduced by Commonwealth Care expenditures for the temporary

extension period to reflect this exception.

Additional expenditures authorized through the approved September 2013 demonstration amendment are for dates of service from January 1, 2014, to June 30, 2014.

49. **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 50, 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.

    a) Commonwealth Care. For dates of services through December 31, 2013, the Commonwealth may claim as allowable expenditures under the demonstration to the extent permitted under the SNCP limits under STC 50 premium assistance under the Commonwealth Care health insurance program for individuals ages 21 and older without dependent children with income above 133 percent of the FPL through 300 percent of the FPL.

    b) Designated State Health Programs (DSHP). For dates of service through December 31, 2013, the Commonwealth may claim as allowable expenditures under the demonstration to the extent permitted under the SNCP limits under STC 50 DSHP, which are otherwise state-funded programs that provide health services. For dates of service January 1 through March 31, 2014, the Commonwealth may claim as allowable expenditures under the demonstration costs of an orderly closeout of the Commonwealth Care premium assistance program, as described in Attachment E, chart A, line 7b. For dates of service January 1 through June 30, 2014, the Commonwealth may claim as allowable expenditures under the demonstration Health Connector subsidies as described below.

    Beginning January 1, 2014, 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 above 133 percent of the FPL through 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; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 300 percent of the FPL. Federal financial participation for the premium assistance portion of Health Connector subsidies for citizens and eligible qualified aliens will be provided through the Designated State Health Programs authority under the Safety Net Care Pool pursuant to this STC.

    c) Providers. 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 50, 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, Commonwealth 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).

d) Infrastructure and capacity-building. The Commonwealth may claim as allowable expenditures under the demonstration to the extent permitted under the SNCP limits under STC 50 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 STCs 39 and 41(c). 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 STC 59, the Commonwealth must provide the actual amount, purpose and the entity each associated payment was made to for this component of the SNCP.

e) 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 50, incentive payments to providers for the development and implementation of a program 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 the development of payment reform strategies and models.

1) 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 Medicaid payer mix more than one standard deviation above average and a commercial payer mix more than one standard deviation below average based on FY 2009 cost report data. The hospitals eligible for incentive payments, over this demonstration period, based on this criterion, are listed in Attachment I.

2) Master DSTI Plan. The Commonwealth must develop and submit to CMS for approval a "master" DSTI plan. CMS shall render a decision on the master DSTI plan within 45 days of the Commonwealth's submission of the plan to CMS. 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.

3) Hospital-specific Plans. Upon CMS approval of the Commonwealth's master DSTI plan, each participating hospital must submit an individual DSTI plan 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 within 45 days of the Commonwealth's submission of the hospital's plan to CMS for final approval 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 52(a)(2) and STC 52(a)(3) 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 (6) and the submission of required progress reports outlined in STC 53(c)(1).

4) 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. Metrics may vary across participating providers, but should be consistent within projects developed in the DSTI master plan to facilitate evaluation.

5) 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 that the objectives/projects must result in learning, adaptation and progress toward the desired impact. 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.

6) 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 (7) below, the final master DSTI plan and payment and funding protocol as required by STC 52 must include an incentive payment formula. Within this formula, approval of the hospital-specific plans may be considered an appropriate metric for the first incentive payment of the initiative in DY 15, and may equal up to 50 percent of the DY 15 total annual amount of DSTI funding a hospital may be eligible for based upon incentive payments. Payment cycles to providers will be described in final approved DSTI funding protocol but 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 dispersed 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.

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.

7) Distribution of DSTI Funds among Hospitals: Attachment I specifies the hospitals eligible for DSTI over the Demonstration approval period and outlines the initial proportional allowance of available DSTI funds for participating providers to earn through DSTI incentive payments for SFY2012-2014. This initial proportional allowance is based upon a foundational amount of funding of $4 million for each hospital over the demonstration approval period that is necessary for hospitals to undertake transformation initiatives, regardless of hospital size. Beyond this foundational amount, the initial allotment of available funds is based on the relative size of each hospital's Medicaid and low-income public payer patient population, as measured by each hospital's patient services charges as indicated in the Medicaid and Low-Income Public Payer Gross Patient Services Revenue (GPSR), published in the SFY 2009 Massachusetts 403 acute hospital cost reports filed with the Division of Health Care Finance and Policy. "Public payers" in this instance include Medicaid, Medicaid managed care, Commonwealth Care and the Health Safety Net. The public payers and base year data are consistent with the eligibility criteria for participating providers.

   The final 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 49(e)(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.

8) FFP. FFP is not available for DSTI payments to a participating provider until the DSTI master plan, the individual provider's plan and the funding protocol outlined in STC 52 are 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.

50. **Expenditure Limits under the SNCP.**

a) Aggregate SNCP Cap. From the date of the approval letter through June 30, 2014 (SNCP extension period), the SNCP will be subject to an aggregate cap of $4.674 billion, as well as the overall budget neutrality limit established in section XI of the STCs. Because the aggregate SNCP cap is based in part on an amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment, any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate SNCP cap, and a

corresponding change to the provider cap as described in subparagraph (c). Such a change shall be reflected in STCs 50(a) and 50(c), and shall not require a demonstration amendment. The aggregate SNCP cap of $4.674 billion is based on an annual DSH allotment of $624,691,018 (Total Computable), the Commonwealth's projected annual DSH allotment for FFY 2012 and budget neutrality savings. For the period operating under temporary extension from July 1, 2011, 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 2012, with the exception of Commonwealth Care which was funded through budget neutrality savings. The aggregate SNCP cap was reduced by Commonwealth Care expenditures for the temporary extension period to reflect this exception.

b) 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 STC 49(d). 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 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 STCs 58 and 59, respectively. Infrastructure projects for which FFP is claimed under this expenditure authority are not eligible for DSTI incentive payments.

c) Provider Cap. The Commonwealth may expend an amount for purposes specified in STC 49(c) 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 provider cap. Such change shall not require a demonstration amendment. The provider cap is based on an annual DSH allotment of $624,691,018 (total computable), the Commonwealth's projected annual DSH allotment for SFY 2012.

d) DSHP Cap. Expenditure authority for DSHP is limited to $360 million in SFY 2012, $310 million in SFY 2013 and $130 million in SFY 2014 through December 31, 2013. For dates of service January 1 through June 30, 2014, expenditure authority for the Health Connector subsidies under DSHP, as described in STC 49(b), is limited by the overall SNCP cap described in STC 50(a). For dates of service January 1 through March 31, 2014, expenditure authority for the orderly closeout of the Commonwealth Care premium assistance program, as described in Attachment E, chart A, line 7b, is limited by the overall SNCP cap described in STC 50(a). Total computable expenditures for DSHP through December 31, 2013, shall be reduced by a fixed amount of 5.3 percent annually

to determine allowable DSHP expenditures under the demonstration to account for the unknown immigration status of certain program recipients.

e) 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, STC 80. In that event, the Commonwealth must reduce expenditures for items 1 through 7 and 9 in chart A of Attachment E before reducing expenditures to item 8, Commonwealth Care.

f) Transition to Cost for Uncompensated Care. The SNCP payments pursuant to STC 49(c) support providers for furnishing uncompensated care. Currently these payments are not limited to the documented cost of providing such care. Over this extension period, CMS will work with the Commonwealth to develop a cost protocol, to be approved by CMS and included as future Attachment H. This protocol will ensure that beginning on July 1, 2014 all provider payments for uncompensated care pursuant to STC 49(c) 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. The DSH audit rule definition of allowable inpatient and outpatient services and allowable uninsured costs and revenues will serve at the initial framework for discussions on the cost protocol. Any additional costs to be included as allowable as uncompensated care must be identified and included in the resulting approved cost protocol.

Therefore, over this extension period, the following milestones outlined in subparagraph (a) must be completed to develop and receive CMS approval for a cost protocol. If there is no approved protocol in place by October 1, 2013, then default cost limit methodologies pursuant to subparagraph (b) will be applied to all provider payments under STC 49(c) for uncompensated Medicaid or uninsured services beginning on July 1, 2014 through any extension of the Demonstration.

a. Protocol Development
    i. By January 1, 2012 CMS will provide sample cost report protocols to the Commonwealth for physician, clinic and hospital services as well as any other provider receiving payments for services under the SNCP provider payments for uncompensated care.
    ii. By March 30, 2012, the Commonwealth must provide CMS for CMS approval a cost protocol development tool that includes a description of all specific data including data sources it proposes to include in the cost-limit protocol, including the scope of services and costs for each provider type (e.g. inpatient, outpatient, physician services, clinic services, non-hospital services, etc.). Massachusetts must use the same definition for inpatient and outpatient services as described in its approved Medicaid State plan for an initial framework and identify other uncompensated care costs that

are not included in the State plan definitions. The Commonwealth must also identify any costs that would not be captured using Medicare cost principles but for which it will seek reimbursement under the SNCP (an example would be unreimbursed translation services associated with Medicaid or uninsured individuals).

iii. By May 31, 2012, CMS will approve this cost protocol development tool. This approval will inform the scope of services and costs in subparagraph (iv) below and in the final protocol.

iv. By July 1, 2012, the Commonwealth must develop an impact analysis of the cost limit protocol (will require hospitals to report necessary data on a preliminary basis). This impact analysis must identify the sources of data used, the dates associated with the available data and any adjustments or modifications that have been made to the data along with the methodology and rationale.

v. By August 30, 2012, CMS will provide comments on the cost-limit impact analysis.

vi. By December 1, 2012, the Commonwealth must submit to CMS a draft cost protocol for each provider type receiving SNCP payments under STC 49(c) that describes the methodology to calculate the annual cost of uncompensated care for Medicaid and uninsured populations for all services provided beginning on July 1, 2014 through any extension of the demonstration. Payments to providers under STC 49(c) will be limited by this annual provider specific cost limit beginning July 1, 2014 through any extension of the demonstration.

vii. CMS will review and submit initial comments and questions on the draft protocol by January 1, 2013.

viii. The Commonwealth will work with CMS to finalize the cost protocol by October 1, 2013.

ix. Hospitals will be required to certify and report necessary data to the Commonwealth by January 1, 2014.

x. Hospital-specific cost limits for SNCP Provider Cap payments will be implemented for all services provided beginning on July 1, 2014 through any extension of the demonstration.

b. <u>Default Cost Limit Methodologies</u>

i. If there is no approved protocol pursuant to subparagraph (a) above by October 1, 2013, then the following default cost limit methodologies will apply based on provider type for all providers receiving payments for uncompensated Medicaid or uninsured services under STC 49(c) provided beginning July 1, 2014 through any extension of the demonstration:

1. Hospitals will be limited to unreimbursed cost as determined using a cost-to-charge ratio utilizing the most recent Medicare cost report data by cost-center available through the CMS Medicare reporting system (HCRIS);

2. Physician uncompensated care payments will be limited to the amount Medicare would have paid for the services based on the Medicare fee schedule in effect when the services were rendered; and
3. Clinics will be limited to the amount of uncompensated care demonstrated using the HRSA 330 grantees cost-reports.

ii. The default methodologies pursuant to subparagraph (i) above do not include any additional costs not identified in the standard reports gathered by Medicare or HRSA.

51. **Priority Expenditures under the SNCP through December 31, 2013.** The Commonwealth must support expenditures for premium assistance under Commonwealth Care as its first priority.

52. **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 develop an overarching master DSTI plan to be submitted to CMS for approval. The master plan will be future Attachment J and 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 STC 49(e)(4),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 STC 49(e)(3) and STC 52(b);

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 issues 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 STC 84. 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 STCs 52(b) and 53(c).

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;

3) Sections on each of the four categories as specified in the STC 47(e)(4), and include:
    i. For Categories 1, 2 and 3 –
        1. Each hospital must select a minimum number of projects, with associated metrics, milestones and data sources in accordance with the master DSTI plan.
        2. For each project selected, the hospital at a minimum must include:

a. 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;
b. 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;
c. 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;
d. A narrative describing how this project supports, reinforces, enables and is related to other projects and interventions within the hospital system plan; and
e. Any other hospital reporting guidelines stipulated in the master DSTI Plan.

ii. In addition to requirements addressed in the above subparagraph (i), Category 2 must also include:
   a. 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.

iii. Category 4 – Population-Focused Improvements
   a. 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. The projects must be hospital-specific and need not be uniform across all the hospitals, but must be uniform across projects that are selected by multiple hospitals.

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 approved by CMS. The following principles must also be incorporated into the funding protocol that will be incorporated in future 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 STC 51(c).

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 STC 50(a)(6). 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 effect each hospitals maximum allowable payment.

4) Carry-Forward/Reclamation. The 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 associate 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, 2014.
    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 STC 50(a)(9) above. 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 STCs 50 and 51(c). 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 STC 52(a)(9).
    iii. Projects that focus primarily on infrastructure will have further limited rollover ability as defined in the master DSTI plan.

53. **SNCP Additional Reporting Requirements**. All SNCP expenditures must be reported as specified in section X, STC 63. 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 Year (SFY) 2012-2014 and identify the non-federal share for each line item, no later than 45 days after enactment of the State budget for each SFY. CMS shall approve the Commonwealth's projected SNCP payments and expenditures within 30 days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 50.

The Commonwealth must notify CMS and receive CMS approval, before it can claim FFP, for any SNCP payments and expenditures outlined in Charts A-B of Attachment E that are in excess of the approved projected SNCP payments and expenditures by a variance greater than 10 percent. Any variance in SNCP payments and expenditures must adhere to the SNCP expenditure limits pursuant to STC 50. 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 days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 50.

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 days after the close of the SFY. CMS shall approve the Commonwealth's actual SNCP expenditures within 45 days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in STC 50.

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 days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable limits specified in STC 50.

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 Public Service Hospital Safety Net Care.

b) DSHP. The Commonwealth must submit to CMS for approval a table of projected DSHP spending by approved program, no later than 45 days after enactment of the state budget for each SFY. CMS must approve the Commonwealth's projected DSHP expenditures within 15 days of the Commonwealth's submission of the update, provided that all DSHP projections are within the applicable SNCP limits specified in STC 50.

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 days after the close of the SFY. CMS must approve the Commonwealth's actual DSHP expenditures within 45 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 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 STC 50(d). The Commonwealth is required to amend the demonstration in order to add to the list of DSHP programs in Chart C of Attachment E.

Additional DSHP Reporting for ConnectorCare. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 59. This data must, at a minimum, include:

i. The number of individuals served by the program;
ii. The size of the subsidies; and
iii. A comparison of projected costs with actual costs.

c) DSTI Reporting. The participating providers and the state must report the following:

1) Hospital Reporting. The reporting protocol within the master DSTI must outline the hospitals' reporting requirements, process and timelines that 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 plans. The required hospital reporting requirements, process and timeline are pursuant to the reporting protocol, state review process and funding protocol as outlined in STC 52(a)(7) and STC 52(a)(8) and STC 52(c) and must be consistent with the following principles:
        1. The hospital reports must be submitted using a 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. STC 58 and 59 require 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 STC 84.

IX. GENERAL REPORTING REQUIREMENTS

54. **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.

55. **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.

56. **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.

57. **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.

58. **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, 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
        - Total number of Medicaid/CHIP applicants for the specified quarter
        - Total number Medicaid/CHIP applicants with identified income inconsistencies for the specified quarter
        - Average number of days to resolve inconsistency
        - Number of Medicaid CHIP applicants disenrolled due to income ineligibility identified
        - Basis for ineligibility
        - Quality of initial data
        - Expenditures for ineligible individuals

    h) Evaluation activities and interim findings.

59. **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 STC 58 in addition to the annual HCBS report as stipulated in STC 40(l). The Commonwealth must submit the draft annual report no later than October 1st of each year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

60. **Transition Plan**. On or before July 1, 2012, the state is required to submit a draft and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs (a)-(e) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

    a) Required Authorities. The state must conduct an assessment of which demonstration authorities outlined in the waivers and expenditure authorities should expire on December 31, 2013 consistent with the provisions of the Affordable Care Act and submit a plan outlining the process for submission of any necessary demonstration amendment(s). For example, this may include authorities related to specific demonstration populations (e.g. Commonwealth Care, hypothetical populations, etc.) in addition to processes and activities such as eligibility procedures and standards, financial responsibility/deeming, retroactive eligibility, cost sharing, etc.

    b) Seamless Transitions. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the state must:
        i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in section 1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
        ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
        iii. Implement a process for considering, reviewing, and making preliminarily

determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the state identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

c) Access to Care and Provider Payments and System Development or Remediation. The state should assure adequate provider supply for the state plan and demonstration populations affected by the demonstration on December 31, 2013. Additionally, the Transition Plan for the demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation.

d) Progress Updates. After submitting the initial Transition Plan for CMS approval, the state must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e) Implementation.

i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Marketplace or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

61. **Final Report.** Within 120 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

62. **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.

63. **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. The Commonwealth may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

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 dDemonstration 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.

vi. 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.

vii. 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.

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.

i.	**Base Families:**	Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only)
ii.	**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)
iii.	**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)
iv.	**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)
v.	**BCCTP:**	Individuals eligible under the Breast and Cervical Cancer Treatment Program who are enrolled in Standard
vi.	**CommonHealth:**	Higher income working adults and children with disabilities enrolled in CommonHealth
vii.	**e-Family Assistance:**	Eligible children receiving premium assistance or direct coverage through 200 percent of the FPL enrolled in Family

		Assistance
viii.	**CommCare-19-20:**	19 and 20 year olds receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority
ix.	**Essential-19-20:**	Eligible 19 and 20 year olds who are long-term unemployed and not receiving EAEDC or a client of DMH
x.	**CommCareParents:**	Parents receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority
xi.	**CommCare-133:**	Individuals 21 years old and over without dependent children with income at or below 133 percent of the FPL receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority
xii.	**Base Fam XXI RO:**	Title XXI-eligible AFDC children enrolled in Standard after allotment is exhausted
xiii.	**1902 (r)(2) XXI RO:**	Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted
xiv.	**CommonHealth XXI:**	Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted
xv.	**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

xvi.	**e-HIV/FA:**	Effective through December 31, 2013, eligible individuals with HIV/AIDS through 200 percent of the FPL who are enrolled in Family Assistance. Effective January 1, 2014 eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance.
xvii.	**IRP:**	Effective through December 31, 2013 Subsidies or reimbursement for ESI made to eligible individuals and/or eligible employers, not including subsidies for individuals in other eligible groups
xviii.	**SBE:**	Subsidies or reimbursement for ESI made to eligible individuals
xix.	**Basic:**	Effective through December 31, 2013 Eligible individuals who are long-term unemployed receiving EAEDC and/or a client of DMH
xx.	**Essential:**	Effective through December 31, 2013 Eligible individuals who are long-term unemployed and not receiving EAEDC or a client of DMH
xxi.	**MSP:**	Effective through December 31, 2013 Eligible individuals receiving unemployment benefits from the DUA
xxii.	**SNCP-CommCare:**	Effective through December 31, 2013 Individuals ages 21 and over with income above 133 percent of the FPL receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority
xxiii.	**SNCP-HSNTF:**	Expenditures authorized under the demonstration for payments held to the provider sub-cap to support uncompensated care

xxiv.	**SNCP-DSHP:**	Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP)
xxv.	**SNCP-DSTI:**	Expenditures authorized under the demonstration for Delivery System Transformation Initiatives (DSTI)
xxvi.	**SNCP-OTHER:**	All other expenditures authorized under the SNCP
xxvii.	**Asthma**:	All expenditures authorized through the pediatric asthma bundled pilot program
xxviii.	**Autism:**	All expenditures authorized for early intervention services for children with autism
xxix.	**New Adult Group:**	Effective January 1, 2014, 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
xxx.	**Marketplace Subsidy:**	Effective January 1, 2014, expenditures for subsidies described in STC 49(b)
xxxi.	**Provisional Eligibility**:	Effective January 1, 2014, expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority

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

demonstration apply:

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

a) Exhaustion of Title XXI Funds. If the Commonwealth has exhausted title XXI funds, expenditures for these optional targeted low-income children may be claimed as title XIX expenditures as approved in the Medicaid state plan. The Commonwealth shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 63 (Reporting Expenditures Under the Demonstration).

b) Exhaustion of Title XXI Funds Notification. The Commonwealth must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures.

c) If the Commonwealth chooses to claim expenditures for **Base Families XXI RO, 1902(r)(2) RO, and CommonHealth XXI** groups under title XIX, the expenditures and caseload attributable to these EGs will:

   i. Count toward the budget neutrality expenditure limit calculated under section XI, STC 80 (Budget Neutrality Annual Expenditure Limit); and

   ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 80, so that the Commonwealth is not at risk for caseload while claiming title XIX federal matching funds when title XXI funds are exhausted.

d) If the Commonwealth chooses to claim expenditures for **Fam Assist XXI** under title XIX, the expenditures and caseload attributable to this EG will be considered expenditures subject to the budget neutrality agreement as defined in STC 80. 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.

65. **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.

66. **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.

67. **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.

68. **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.

69. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

    a) For the purpose of calculating the budget neutrality agreement and for other purposes, the Commonwealth must provide to CMS, as part of the quarterly report required under STC 58, the actual number of eligible member months for the EGs i-xxi and EGs xxvi and xxvii defined in STC 63(f). 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.

70. **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.

71. **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.

72. **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) The 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.

73. **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.

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

75. **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

76. **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, 2011.

77. **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, STC 63. 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.

78. **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.

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

    a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on behalf of enrollees under age 65 who are institutionalized in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded, or a state psychiatric hospital for other than a short-term rehabilitative stay;

    b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient, and home and community-based waiver services, except pursuant to STC 40;

        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.

80. **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, STC 69 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 2012-2014;

iii. Starting in SFY 2009, actual expenditures for the CommCare-19-20, Essential-19-20 and CommCare Parents EGs will be included in the expenditure limit for the Commonwealth for dates of service through December 31, 2013. Starting April 1, 2010, actual expenditures for the CommCare-133 EG will be included in the expenditure limit for the Commonwealth for dates of service through December 31, 2013. The amount of actual expenditures to be included will be the lower of the trended baseline costs, or actual per member per most cost experience for these groups in SFYs 2012-2014;

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 15 PMPM	DY 16 PMPM	DY 17 PMPM
Mandatory and Optional State Plan Groups				
Base Families	5.3 percent	$562.02	$591.81	$623.17
Base Disabled	6.0 percent	$1,224.88	$1,298.38	$1,376.28
BCCTP	5.3 percent	$3,674.67	$3,869.43	$4,074.51
1902(r)2 Children	4.9 percent	$457.59	$480.02	$503.54
1902(r)2 Disabled	6.0 percent	$959.04	$1,016.59	$1,077.58
Essential**	5.3 percent	$351.85	$370.50	$390.14
Hypothetical Populations*				
CommonHealth	6.0 percent	$563.46	$597.27	$633.11
CommCare-19 and 20 year olds**	5.3 percent	$447.13	$470.83	$495.78
CommCare Parents**	5.3 percent	$498.35	$524.77	$552.58
Essential-19 and 20 year olds**	5.3 percent	$378.31	$398.36	$419.47
CommCare-133**	5.3 percent	$498.36	$524.77	$552.58

* "These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical

populations on the overall expenditure limit, according to the process listed in STC 80(a) (ii) and (iii)."
** Expenditures for these EGs will only be reported for dates of service through December 31, 2013, after which time these EGs will be discontinued.

Supplemental Budget Neutrality Test: New Adult Group 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 15 PMPM	DY 16 PMPM	DY 17 PMPM
New Adult Group	5.1 percent	N/A	N/A	$461.23

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 above 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..

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 New Adult Group.

e. If total FFP for the New Adult Group should exceed the federal share of the Supplemental Budget Neutrality Test after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in STC 80.

b) Limit B. The Commonwealth's annual DSH allotment.

c) The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure limits. The federal share of the overall budget neutrality expenditure limit represents the maximum amount

of FFP that the Commonwealth may receive for expenditures on behalf of demonstration populations as well as demonstration services described in Table B in STC 37 during the demonstration period.

d) 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.

81. **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.

82. **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 15	Cumulative budget neutrality limit plus:	1 percent
DY 15 through DY 16	Cumulative budget neutrality limit plus:	0.5 percent
DY 15 through DY 17	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.

83. **Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 82, 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.

XII. EVALUATION OF THE DEMONSTRATION

84. **Submission of a Draft Evaluation Design.** The Commonwealth must submit to CMS for approval a draft evaluation design no later than 120 days after CMS' approval of the demonstration.

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. 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.

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.
    - The number of uninsured in the Commonwealth;
    - The number of demonstration eligibles accessing ESI;
    - Growth in the Commonwealth Care Program;
    - Decrease in uncompensated care and supplemental payments to hospitals;
    - The number of individuals accessing the Health Safety Net Trust Fund;
    - The impact of DSTI payments to participating providers on the Commonwealth's goals and objectives outlined in its master plan including:
        - 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 as discussed in STC 49(e)(4) and pursuant to STC 52?
        - Were the participating hospitals able to show improvements on measures within Category 4 related to the goals of the three-part aim as discussed in STC 49(e)(4) and pursuant to STC 52?
        - What is the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers?
        - What is the impact of the payment redesign and infrastructure investments to improve cost efficiency?
        - What is the impact of DSTI on managing short and long term per-capita costs of health care?
        - How did the amount paid in incentives compare with the amount of improvement achieved?
    - The benefits, savings, and design viability of the Pediatric Asthma Pilot Program;
    - The benefits, cost and savings of providing early intervention services for demonstration eligible children with autism;
    - The impact of utilization of Express Lane Eligibility procedures for parents and caretakers; and
    - Availability of access to primary care providers.

b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative 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 X of the STCs. From these, 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 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. Levels of Analysis: The evaluation designs proposed for each 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.

85. **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.

86. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in STC 84 within 60 days of receipt, and the Commonwealth shall submit a final design within 60 days after receipt of CMS comments. The Commonwealth must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The Commonwealth must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The Commonwealth must submit the final evaluation report within 60 days after receipt of CMS comments.

87. **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 120 days from the award of the demonstration	Draft Evaluation Design	Section XII, STC 84
Within 60 days of receipt of CMS comments	Final Evaluation Design and Implementation	Section XII, STC 86
January 1, 2012	Sample Cost Report Protocols	Section VIII, STC 50(f)
March 30, 2012	Cost Protocol Development Tool	Section VIII, STC 50(f)
July 1, 2012	Impact Analysis of the Cost Limit Protocol	Section VIII, STC 50(f)
December 1, 2012	Draft Cost Protocol	Section VIII, STC 50(f)
July 1, 2012	Draft Transition Plan	Section IX, STC 60
October 1, 2013	Final Cost Limit Protocol	Section VIII, STC 50(f)
Within 180 days after the expiration of the demonstration	Final Report	Section IX, STC 61
Annually		
October 1st	Draft Annual Report, including HCBS report beginning in 2012	Section IX, STC 59 Section V, STC 41
30 days of the receipt of CMS comments	Final Annual Report, including DSTI reporting, and HCBS report beginning in 2012	Section IX, STC 59 Section VIII, STC 53(c) Section V, STC 41
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, STC 53(a)
No later than 45 days after enactment of the state budget for each SFY	Projected annual DSHP expenditures	Section VIII, STC 53(b)
180 days after the close of the SFY (December 31st)	Updates to Charts A-B of Attachment E that reflect actual SNCP payments and expenditures	Section VIII, STC 53(a)
At Least Semi-Annually		
	DSTI Hospital Reporting	Section VIII, STC 53(c)
Quarterly		
60 days following the end of the quarter	Quarterly Operational Reports, including DSTI reporting and eligible member months	Section IX, STC 58 Section VIII, STC 53(c) Section X, STC 69
	Quarterly Expenditure Reports	Section X, STC 62

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Unborn Targeted Low Income Child	0 through 200%	Uninsured	No (through December 31, 2013) Yes (effective January 1, 2014)	Separate XXI		Healthy Start (through December 31, 2013 Standard (effective January 1, 2014)	
Newborn Children Under age 1	AFDC-Poverty Level Infants 0 through 185%	Any	Yes	XIX via Medicaid state plan	**Base Families** *Without Waiver*	Standard	
	185.1 through 200%	Insured	Yes	XIX via Medicaid state plan	**1902(r)(2) Children** *Without Waiver*	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI Medicaid Expansion (via Medicaid state plan and XXI state plan) Funded through title XIX if XXI is exhausted	**1902(r)(2) XXI RO** *Without Waiver* (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	
	200.1 through 300%	Insured or in crowd-out status*	Yes	XIX via demonstration authority only	E-Family Assistance	Family Assistance Premium Assistance	No additional wraparound benefit is

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY 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
							provided
		Uninsured at the time of application	No	Separate XXI		Family Assistance	

This chart is provided for informational purposes only.
*Crowd out status refers to children made ineligible for CHIP due to the crowd out provisions contained within title XXI.

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Newborn Children Under Age 1 and Disabled	200.1-300%	Insured	Yes	XIX via demonstration authority only	**CommonHealth** *Hypothetical*	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	**CommonHealth XXI** *Hypothetical* (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 title XXI

							state plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate title XXI program but expenditures are claimed under title XXI until the title XXI allotment is exhausted.
Population	**Federal Poverty Level (FPL) and/or Other qualifying Criteria**	**Insurance Status upon application**	**Part of MassHealth Demonstration?**	**Funding Stream title XIX/XXI**	**Budget Neutrality Expenditure Eligibility Group (EG) Reporting**	**Demonstration Program**	**Comments**
Newborn Children Under Age 1 and Disabled (continued)	Above 300%	Any	Yes	XIX via demonstration authority only	**CommonHealth** *Hypothetical*	CommonHealth or CommonHealth Premium Assistance With wraparound to direct coverage CommonHealth	
Children Ages 1 through 18 Non-disabled	AFDC-Poverty Level Children Age 1-5: 0 through 133% FPL Age 6 through 17: 0 through 114% Independent Foster	Any	Yes	XIX	**Base Families** *Without waiver*	Standard	

	Care Adolescents aged out of DCF until the age of 21 without regard to income or assets						
	AFDC-Poverty Level Children Age 6 through 17: 114.1% through 133% Age 18: 0 through 133%	Insured	Yes	XIX	**Base Families** *Without waiver*	Standard	
		Uninsured	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	**Base Fam XXI** (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 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)	Medicaid Expansion Children Ages 1 through 18: 133.1 through 150%	Insured	Yes	XIX	**1902(r)(2) Children** *Without waiver*	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	**1902(r)(2) Children RO** (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	
	All children Age 1 through 18: 150.1 through 200%	Insured	Yes	XIX via demonstration authority only	**E-Family Assistance**	Family Assistance Premium Assistance Direct Coverage	No additional wraparound is provided to ESI

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Ages 1 through 18 Non-disabled (continued)	All children Age 1 through 18: 150.1 through 200% (continued)	Uninsured at the time of application	Yes	Separate XXI Funded through XIX if XXI is exhausted	**Fam Assist XXI RO** (member months and expenditures for these children are only reported if XXI funds are exhausted)	Family Assistance Premium Assistance Direct Coverage	No additional wrap is provided to ESI Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children's Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the title XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under the 1115 demonstration and as authorized under the separate title XXI program, but expenditures are claimed under title XXI until the title XXI allotment is exhausted.

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

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

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Aged 1 through 18 and Disabled (continued)	150.1 through 300% (continued)	Uninsured at the time of application	Yes	Separate XXI Funded through XIX if XXI is exhausted	**CommonHealth XXI** *Hypothetical* (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 claimed under title XXI until the title XXI allotment is exhausted.
Children Aged 1 through 18 and Disabled	Above 300%	Any	Yes	XXI via demonstration authority only	**CommonHealth** *Hypothetical*	CommonHealth/ Premium Assistance With wraparound to direct coverage	

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

Demonstration Program	Premiums (only for persons with family income above 150 percent of the FPL)	Co-payments
MassHealth Standard/ABP	$0	All co-payments and co-payment caps are specified in the Medicaid state plan.
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
MassHealth Family Assistance: Direct Coverage	$12 per child, $36 max per family group	Children only-no copayments.
MassHealth Basic and Essential	$0	MassHealth Standard co-payments apply

ATTACHMENT B
COST SHARING

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

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

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

CommonHealth Supplemental Premium Schedule	
% of FPL	**Premium requirement**
Above 150% to 200%	60% of full premium per listed premium costs above
Above 200% to 400%	65% per above
Above 400% to 600%	70% per above
Above 600% to 800%	75% per above
Above 800% to 1000%	80% per above
Above 1000%	85% per above

ATTACHMENT B
COST SHARING

Insurance Partnership: Employer Subsidy	Tier of Coverage	Monthly Employer Subsidy
The insurance partnership also provides a monthly subsidy to qualified small employers	Individual	$33.33
	Couple	$66.66
	One adult, one child	$66.66
	Family	$86.33

Insurance Partnership: Employee Contribution	% of FPL	Premium Requirement for Individual	Premium Requirement for Couples
Family Assistance via the Insurance Partnership The Insurance Partnership provides premium assistance (via the Family Assistance program) to certain employees who work for a small employer	Above 150% to 200%	$27.00	$54.00
	Above 200% to 250%	$53.00	$106.00
	Above 250% to 300%	$80.00	$160.00

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, STC 58, 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: 16 (7/1/2012 – 6/30/2013)
Quarter 1: (7/12 – 09/12)

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.

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

Eligibility Group	Current Enrollees (to date)
(CarePlus)	
BCCTP	
CommonHealth	
Essential 19-20	
CommCare 19-20	
CommCareParents	
CommCare-133	
e-Family Assistance	
e-HIV/FA	
SBE/IRP	
Basic	
Essential	
MSP	
SNCP-CommCare	
Base Fam XXI RO	
1902(r)(2) XXI RO	
CommonHealth XXI	
Fam Assist XXI	
Asthma	
Autism	
Total Demonstration	

Enrollment in Managed Care Organizations and Primary Care Clinician Plan

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

Delivery System for MassHealth-Administered Demonstration Populations

Plan Type	June 30, 2008	September 30, 2008	Difference
MCO			
PCC			
MBHP			
FFS			
PA			

Enrollment in Premium Assistance, Insurance Partnership Program, 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 impacting demonstration population and/or undertaken in relation to the SNCP. As per STC 58, 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 STCs 50 and 53.

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				
BCCTP				
CommonHealth				
Essential 19-20				

CommCare 19-20				
CommCareParents				
CommCare133				

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				
IRP				
Small Business Employee Premium Assistance				
Basic				
Essential				
MSP				
SNCP-CommCare				
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 C
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

ATTACHMENT D
MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS

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

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

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

DY	Time Period	Families		Disabled		MCB		1902(r)(2) Children		1902(r)(2) Disabled	
		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		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
6	SFY 2003	$288.58	7.71%	$677.56	10.0%	$236.98	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		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
12	SFY 2009	$466.84	6.95%	$1,011.95	6.86%	$382.45	6.95%	$791.46	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%	$1,1155.55	6.86%	$436.22	6.95%	$904.76	6.86%	$3,489.72	6.86%

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, 2014, unless otherwise specified in STCs 48 and 49, 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, 2014, unless otherwise specified in STCs 48 and 49(projected and rounded)

#	Type	Applicable caps	State law or regulation	Eligible providers	Total SNCP Payments per SFY			Total	Applicable footnotes
					SFY 2012	SFY 2013	SFY 2014		
1	Public Service Hospital Safety Net Care Payment	Provider		Boston Medical Center Cambridge Health Alliance	$332.0	$332.0	$332.0	$996.0	(1)
2	Health Safety Net Trust Fund Safety Net Care Payment	Provider	114.6 CMR 13.00, 14.00	All acute hospitals	$77.74	$159.4	$156.3	$393.4	(2)
3	Institutions for Mental Disease (IMD)	Provider	130 CMR 425.408, 114.3 CMR 46.04	Psychiatric inpatient hospitals Community-based detoxification centers	$9.9	$22.0	$24.0	$55.8	(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	$40.0	$43.0	$45.0	$128.0	(4)
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	Provider		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Lindemann Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester State Hospital	$70.0	$74.0	$77.0	$221.0	
6	Delivery System Transformation Initiatives	n/a		Eligible hospitals outlined in Attachment I	$209.3	$209.3	$209.3	$627.9	(5)
7	Designated State Health Programs	DSHP		n/a	$360.0	$310.0	$130.0	$800.0	
7a	DSHP Health Connector subsidies	Overall SNCP cap		n/a	n/a	n/a	$55.0	$55.0	(6)
7b	DSHP Commonwealth Care Transition	Overall SNCP cap		n/a	n/a	n/a	$8	$8	
8	Commonwealth Care	n/a	C. 58 (2006)	n/a	$305.1	$303.1	$152.5.	$760.7	(7)

9	Infrastructure and Capacity-Building	Infrastructure		Hospitals and CHCs	$3.0	$14.5	$26.0	$43.5	(8)
	Total							$4,089.4	

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

The following notes are incorporated by reference into chart A

(1) The provider-specific Public Service Hospital Safety Net Care payments approved by CMS are as follows:
For dates of service in SFY 2012: BMC, $52,000,000; CHA, $154,500,000. An additional $125,500,000 for CHA was authorized through a demonstration amendment approved on August 17, 2011.
For dates of service in SFY 2013: BMC, $52,000,000; CHA, $280,000,000.
For dates of service in SFY 2014: BMC, $52,000,000; CHA, $280,000,000
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. 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. 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. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth.

(5) Delivery System Transformation Initiative funds will be distributed to participating hospitals pursuant to STCs 49(e) and 52.

(6) Expenditures for DSHP Health Connector Subsidies are based on actual enrollment and premium assistance costs. Consequently, the amount of total expenditures for SFY14 may vary.

(7) Expenditures for Commonwealth Care Premium Assistance are based on actual enrollment, capitation rates, and expected enrollee contributions, and are approved by CMS on an aggregate basis. Consequently, the amount for each year may vary. Expenditures for Commonwealth Care Premium Assistance for Hypothetical populations (CommCare-19-20, CommCareParents, and CommCare-133 EGs) are excluded from the SNCP. For the period operating under temporary extension from July 1, 2011, Commonwealth Care expenditures were funded through budget neutrality savings rather than through the SNCP expenditure authority. Therefore, the aggregate SNCP cap must be reduced by Commonwealth Care expenditures for the temporary extension period to reflect this exception.

(8) Infrastructure and Capacity-Building (ICB) funds support Commonwealth-defined health systems improvement projects, and are approved by CMS pursuant to STCs 49(d) and 50(b). Participating providers (including hospitals, community health centers, primary care practices and physicians) and provider-specific amounts are determined based on a formal request for responses (RFR) process. Spending for ICB is subject to the limit described in STC 50(b).

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2014, unless otherwise specified in STCs 48 and 49 (projected and rounded)

#	Type	State law or regulation	Eligible providers	Total SNCP payments per SFY					
				SFY 2012	Source of Non-federal share	SFY 2013	Source of Non-federal share	SFY 2014	Source of Non-federal share
1	Public Service Hospital Safety Net Care Payment		Boston Medical Center Cambridge Health Alliance	$332.0		$332.0		$332.0	
2	Health Safety Net Trust Fund Safety Net Care Payment	114.6 CMR 13.00, 14.00	All acute hospitals	$77.7		$159.4		$156.3	
3	Institutions for Mental Disease (IMD)	130 CMR 425.408, 114.3 CMR 46.04	Psychiatric inpatient hospitals Community-based detoxification centers	$9.9		$22.0		$24.0	
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$40.0		$43.0		$45.0	
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Lindemann Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester State Hospital	$70.0		$74.0		$77.0	
6	Delivery System Transformation Initiatives		Eligible hospitals outlined in Attachment I	$209.3		$209.3		$209.3	
7	Designated State Health Programs		n/a	$360.0		$310.0		$130.0	
7a	DSHP – Health Connector susbsidies		n/a	n/a		n/a		$55.0	
7b	DSHP – Commonwealth Care Transition		n/a	n/a		n/a		$8	
8	Commonwealth Care	C. 58 (2006)	n/a	$305.1.9		$303.1		$152.5	
9	Infrastructure and Capacity-Building for Hospitals and		Hospitals, community health centers, primary care practices	$30.0		$30.0		$30.0	

	Community Health Centers		and physicians						
	Total								

Designated State Health Programs (DSHP). The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. Any changes to the list of programs will require an amendment pursuant to the process outlined in STC 7. This chart shall be updated pursuant to the process described in STC 53(b).

Chart C: Approved Designated State Health Programs (DSHP)

Dates of service July 1, 2012, through December 31, 2013

Agency	Program Name
DMH	Recreational therapy services
DMH	Occupational therapy services
DMH	Individual support
DMH	Community Mental Health Center (CMHC) continuing care (non-inpatient)
DMH	Homeless support services
DMH	Individual and family flexible support
DMH	Comprehensive psychiatric services
DMH	Day services
DMH	Child/adolescent respite care services
DMH	Day Rehabilitation
DMH	Community rehabilitative support
DMH	Adult respite care services
DOC	Department of Corrections - DPH/Shattuck Hospital Services
DPH	Community Health Centers
DPH	CenterCare
DPH	Renal Disease
DPH	SANE program
DPH	Growth and nutrition programs
DPH	Prostate Cancer Prevention - Screening component
DPH	Hepatitis C
DPH	Multiple Sclerosis
DPH	Stroke Education and Public Awareness
DPH	Ovarian Cancer Screening, Education, and Prevention
DPH	Diabetes Screening and Outreach
DPH	Breast Cancer Prevention
DPH	Universal Immunization Program
DPH	Pediatric Palliative Care
EHS	Children's Medical Security Plan
ELD	Prescription Advantage
ELD	Enhanced Community Options (ECOP)
ELD	Home Care Services
ELD	Home Care Case Mgmt and Admin
ELD	Grants to Councils on Aging
HCF	Fisherman's Partnership
HCF	Community Health Center Uncompensated Care Payments
MCB	Turning 22 Program - personal vocational adjustment
MCB	Turning 22 Program – respite

Agency	Program Name
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
MCB	Turning 22 Program - medical evaluations
MRC	Turning 22 Services
MRC	Head Injured Programs
VET	Veterans' Benefits

Dates of service January 1, 2014 through March 31, 2014

This DSHP is subject to the overall SNCP cap.

Agency	Program Name
HealthConnector	Commonwealth Care Transition

Dates of service January 1, 2014 through June 30, 2013

This DSHP is subject to the overall SNCP cap.

Agency	Program Name
HealthConnector	Health Connector Subsidies

Attachment H
Massachusetts MassHealth Section 1115 Demonstration
Safety Net Care Pool Uncompensated Care Cost Protocol Development Tool

Introduction

Under the Safety Net Care Pool (SNCP), the current MassHealth section 1115 Medicaid demonstration [state fiscal year (SFY) 12-SFY 14)] authorizes the Commonwealth to make certain 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 fee-for-service (FFS), Medicaid managed care, Commonwealth Care, and low-income uninsured individuals. The Commonwealth may also claim as an allowable expenditure payments not otherwise eligible for federal financial participation (FFP) that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Diseases (IMD)."[1] These payments currently include:

1) Public Service Hospital Safety Net Care Payments;
2) Health Safety Net Trust Fund Safety Net Care Payments (HSN Payments);
3) Payments to Institutions for Mental Disease;
4) Payments to Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health;
5) Payments to State-Owned Non-Acute Hospitals operated by the Department of Mental Health.

These Safety Net Care Pool (SNCP) payments authorized under STC 49(c) are currently limited on an aggregate basis by a Provider Cap pursuant to STC 50(c).[2] If this demonstration is renewed, effective July 1, 2014, SNCP payment limits defined by STC 50(c) will be further limited on a provider-specific basis to the documented costs of uncompensated care for Medicaid-eligible and uninsured individuals. To accomplish this, Massachusetts must establish a CMS-approved method for measuring the costs of care provided to such patients by providers that receive SNCP payments that are subject to the Provider Cap.

According to STC 50(f), the Commonwealth will develop a protocol, subject to CMS approval, that reflects the costs of providing uncompensated care. Consistent with STC 50(f), MassHealth includes Medicaid eligible and uninsured individuals as the applicable populations when counting the allowable uncompensated costs of care. 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.

Lastly MassHealth proposes that "uninsured individuals" for whom uncompensated care costs

[1] STC 49(c)
[2] Other SNCP expenditures, including Commonwealth Care, Delivery System Transformation Initiatives (DSTI), Infrastructure and Capacity Building Grants, and Designated State Health Programs (DSHP) are not subject to the provider cap and are therefore not subject to the cost limit requirement.

are allowable includes the population for which HSN payments are made. HSN Primary is available to low-income Massachusetts residents who have no other source of insurance. HSN Secondary differs from HSN primary in that HSN Secondary pays for certain services not covered by the primary payer provided to residents who are enrolled in private health insurance, Medicare, MassHealth, or Commonwealth Care.

This protocol will meet the required protocol specifications pursuant to 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.
3) All Medicaid fee-for-service payments for services and managed care payments, including any supplemental or enhanced Medicaid payments made under the State plan [3], 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. To the extent that 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 may include performance- and incentive-based payments and grants and awards both currently in existence or those that may be implemented during future demonstration renewal periods, such as those listed below.

    a. 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;
        vi. Medicaid EHR incentive payments, including eligible provider and hospital Electronic Health Record (Her) incentive payments, made in

[3] 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.

accordance with the CMS-approved state Medicaid Plan and CMS regulations.

b. 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.

Allowable Costs by Provider Type.

I.1. Determination of Allowable Medicaid Costs: Acute Inpatient and Outpatient Hospitals

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 under the protocol varies from the Medicaid DSH requirements, the process must be approved in this document, including the Appendix, and the final protocols.

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.

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 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 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 the cost protocol (see Section I. subsections c., d., and e. below).

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 Appendix. 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 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 Appendix A.

f. Additional Allowable Costs – Allowable costs are defined in Appendix A.

I.2. Determination of Allowable Medicaid Acute Hospital Revenue

a. All revenue received by the provider by or on behalf of the patient for the specific service/eligible cost included in the uncompensated care cost (UCC) calculation must be offset against a hospital's cost limit. Revenues include, but are not limited to, the following:

i. MassHealth and HSN payments for services provided to Medicaid eligible individuals and the uninsured, including the HSN population;

ii. Cost-sharing from Medicaid-eligible patients, regardless of insurance type;

iii. Any third party liability (TPL) payments for services;

b. Revenues that are not associated with the eligible costs are not required to be offset against an acute hospital's cost limit.

I.3. Data Sources

a. Medicare 2552 cost report

i. For hospitals that file the **Medicare 2552 cost report**, the basis of the model will be the cost methodology prescribed by the DSH final rule (CMS 2198-F) and associated guidance. The cost methodology will rely on the Medicare 2552 and the cost center-specific apportionment method to compute Medicaid and uninsured cost.

b. Uniform Medicaid and Low-Income Uncompensated Care Cost & Charge Report (UCCR)

i. The Commonwealth will only use the UCCR to determine costs when the provider does not file the CMS-2552 or when costs approved in the protocol are not included in the CMS-2552. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol may file the Uniform Medicaid and Low-Income Uncompensated Care Cost & Charge Report (UCCR). The UCCR report includes cost-center specific data and captures "uncompensated costs" that safety net providers incur from supporting a large proportion of MassHealth members. 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 low-income patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc.) The UCCR report is filed on a provisional, interim, and final

basis.

1. Schedule A. Schedule A calculates the MassHealth FFS costs for inpatient and outpatient services.
2. Schedule B. Schedule B calculates the payer-specific routine costs. Payer-specific routine costs are calculated by multiplying the routine per diem by the number of payer-specific days by cost center.
3. Schedule C. Schedule C calculates the Medicaid MCO, and Low-income uncompensated care costs for inpatient and outpatient services.
4. Schedule D. Schedule D calculates allowable hospital-based physician costs for MassHealth FFS, Medicaid MCO, and Low-income Uninsured patients.
5. Schedule E. Schedule E itemizes safety net-related expenses incurred by providers and health care systems. Items included in this Schedule shall be deemed allowable at the discretion of EOHHS and consistent with the CMS-approved protocol, and shall not be duplicative of costs reported elsewhere on the UCCR. See **Section I.e.** for the list of Safety Net allowable costs that will be reported on Schedule E.

II.1. Determination of Allowable Medicaid Costs: Chronic Disease and Rehabilitation Inpatient and Outpatient Hospitals

a. DSH Allowable Costs

i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable chronic disease and rehabilitation 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 cost under the protocol varies from the Medicaid DSH requirements, the process must be approved in this document, including the Appendix, and the final protocol.

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.

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 chronic disease and rehabilitation 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 chronic disease and rehabilitation inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the State plan definitions to be included as allowable uncompensated care costs in the cost protocol (see Section I. subsections c., d., and e. below).

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 are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
2. **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.

c. 1115 Demonstration Allowable Costs

i. **1115 Demonstration Expenditures**: Costs incurred by 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 Medicaid state plan and are provided by chronic disease and rehabilitation hospitals under the section 1115 demonstration include the following 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). Allowable costs are defined in Appendix A.

d. Medicaid Managed Care Costs: Costs incurred by 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.

e. Other Allowable Costs, Approved 1915(c) Waivers – The list of additional services is contained in Attachment A.

f. Additional Allowable Costs - The list of additional services is contained in Attachment A.

II.2. Determination of Allowable Medicaid Chronic Disease and Rehabilitation Hospital Revenue

a. All revenue received by the provider by or on behalf of the patient for the specific service/eligible cost included in the UCC calculation must be offset against a chronic disease and rehabilitation hospital's cost limit. Revenues include, but are not limited to, the following:

i. MassHealth and HSN payments for services provided to Medicaid eligible individuals and the uninsured, including the HSN population;

ii. Cost-sharing from Medicaid-eligible patients, regardless of insurance type;

iii. Any third party liability (TPL) payments for services;

b. Revenues that are not associated with the eligible costs are not required to be offset against a chronic disease and rehabilitation hospital's cost limit.

II.3. Data Sources

a. Medicare 2552 cost report

i. For hospitals that file the Medicare 2552 cost report, the basis of the model will be the cost methodology prescribed by the DSH final rule (CMS 2198-F) and associated guidance. The cost methodology will rely on the Medicare 2552 and the cost center-specific apportionment method to compute Medicaid and uninsured cost.

ii. Uniform Medicaid and Low-Income Uncompensated Care Cost & Charge Report (UCCR)

iii. The Commonwealth will only use the UCCR to determine costs when the provider does not file the CMS-2552 or when costs approved in the protocol are not included in the CMS-2552. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol may file the Uniform Medicaid and Low-Income Uncompensated Care Cost & Charge Report (UCCR). The UCCR report includes cost-center specific data and captures "uncompensated costs" that safety net providers incur from supporting a large proportion of MassHealth members. 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 low-income patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc.). The UCCR report is filed on a provisional, interim, and final basis.

1. Schedule A. Schedule A calculates the MassHealth FFS costs for inpatient and outpatient services.

2. Schedule B. Schedule B calculates the payer-specific routine costs. Payer-specific routine costs are calculated by multiplying the

routine per diem by the number of payer-specific days by cost center.

3. Schedule C. Schedule C calculates the Medicaid MCO, , and Low-income uncompensated care costs for inpatient and outpatient services.
4. Schedule D. Schedule D calculates allowable hospital-based physician costs for MassHealth FFS, Medicaid MCO, , and Low-income Uninsured patients.
5. Schedule E. Schedule E itemizes safety net-related expenses incurred by providers and health care systems. Items included in this Schedule shall be deemed allowable at the discretion of EOHHS and consistent with the CMS-approved protocol, and shall not be duplicative of costs reported elsewhere on the UCCR. See **Section I.e.** for the list of Safety Net allowable costs that will be reported on Schedule E.

III.1. Determination of Allowable Medicaid Costs: Institutions for Mental Diseases - Psychiatric Hospitals and Community Based Detoxification Centers (CBDC)

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 cost under the protocol varies from the Medicaid DSH requirements, the process must be approved in this document, including the Appendix, and the final protocol.

ii. Pharmacy service costs are separately identified on the Medicare 2552–96 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.

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 institutions for mental disease. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the State plan definitions to be included as allowable uncompensated care costs in the cost protocol (see Section I. subsections c., d., and e. below).

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 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 inpatient 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 inpatient 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 Attachment A.

c. Medicaid Managed Care Costs: Costs incurred by Institutions for Mental Disease 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 Appendix A.

e. Additional Allowable Costs – The list of allowable services is contained in Appendix A.

III.2. Determination of Allowable Medicaid Psychiatric Inpatient Hospital and CBDC Revenue

a. All revenue received by the provider by or on behalf of the patient for the specific service/eligible cost included in the UCC calculation must be offset against a hospital's cost limit. Revenues include, but are not limited to, the following:

i. MassHealth and HSN payments for services provided to Medicaid eligible individuals and the uninsured, including the HSN population;

ii. Cost-sharing from patients, regardless of insurance type;

iii. Any third party liability (TPL) payments for services;

b. Revenues that are not associated with the eligible costs are not required to be offset against a psychiatric inpatient hospital's or CBDC's cost limit.

III.3. Data Sources

a. Medicare 2552 cost report

i. For psychiatric hospitals that file the **Medicare 2552 cost report**, the basis of the model will be the cost methodology prescribed by the DSH final rule (CMS 2198-F) and associated guidance. The cost methodology will rely on the Medicare 2552 and the cost center-specific apportionment method to compute Medicaid and uninsured cost.

b. Community Based Detoxification Centers ONLY: Uniform Financial Report (UFR)

i. CBDCs are human and social services contractors that do not file a 2552 cost report and, therefore, if subject to the cost protocol may submit the Massachusetts **Uniform Financial Statements and Independent Auditor's Report (UFR)** to supplement the Medicare 2552 cost report. The UFR is the set of financial statements and schedules required of human and social service contracting with state departments. The reports are filed with the Massachusetts Operational Services Division on an annual basis.

ii. 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

iii. The UFR allows for revenue to be reported from Medicaid Direct Payments, Medicaid MBHP Subcontracts, Department of Mental Health, Department of Public Health, and other human and social service agencies.

iv. The contracting entity'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

c. Uniform Medicaid and Low-Income Uncompensated Care Cost & Charge Report (UCCR)

i. The Commonwealth will only use the UCCR to determine costs when the provider does not file the CMS-2552 or when costs approved in the protocol are not included in the CMS-2552. To supplement the Medicare

2552 cost report, hospitals and CBDCs subject to the cost protocol may file the **Uniform Medicaid and Low-Income Uncompensated Care Cost & Charge Report (UCCR)**. The UCCR report includes cost-center specific data and captures "uncompensated costs" that safety net providers incur from supporting a large proportion of MassHealth members. 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 low-income patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc.) The UCCR report is filed on a provisional, interim, and final basis.

1. Schedule A. Schedule A calculates the MassHealth FFS costs for inpatient and outpatient services.
2. Schedule B. Schedule B calculates the payer-specific routine costs. Payer-specific routine costs are calculated by multiplying the routine per diem by the number of payer-specific days by cost center.
3. Schedule C. Schedule C calculates the Medicaid MCO, , and Low-income uncompensated care costs for inpatient and outpatient services.
4. Schedule D. Schedule D calculates allowable hospital-based physician costs for MassHealth FFS, Medicaid MCO, , and Low-income Uninsured patients.
5. Schedule E. Schedule E itemizes safety net-related expenses incurred by providers and health care systems. Items included in this Schedule shall be deemed allowable at the discretion of EOHHS and consistent with the CMS-approved protocol, and shall not be duplicative of costs reported elsewhere on the UCCR. See **Section I.e.** for the list of Safety Net allowable costs that will be reported on Schedule E.

MassHealth Cost Protocol Development Tool Appendix A
Table 1. Crosswalk of Additional Allowable Services by Provider Type

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		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X

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
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services		X		X		X		X
Community Psychiatric Support and Treatment		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						

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						
Diversionary Behavioral Health Services	X	X	X	X	X	X		
Public Hospital Pensions and Retiree Benefits	X	X						

Additional detail regarding some of these services is below for reference.

- **Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing.**

  Acute Hospitals incur unreimbursed costs for services provided by employed and contracted physicians for Medicaid and uninsured patients. These uncompensated care physician costs are currently included in the UCCR cost finding through Schedule D of the UCCR. The Massachusetts cost protocol provider definition includes acute hospital-employed physician services and contracted physician services.

- **Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable OMB Circular A-87 requirements**

  These costs are related to physicians that are employed by the hospital and who provide services in various settings and clinics..

- **Patient and community education programs, excluding cost of marketing activities.**

  These programs are part of public health and prevention activities relevant to the medical care of the Medicaid-eligible and uninsured populations. Some examples include: chronic disease prevention including smoking cessation and heart health services, community education for healthy eating, and suicide prevention and mental health promotion. These services are provided by hospitals with an orientation on Medicaid-eligible uninsured populations.

- **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.**

  These health care services are stepped down from the CMS Medicare 2552 Cost Report because they are not generally related to Medicare populations. These services should be included as additional allowable costs specifically because they are health care services primarily provided to Medicaid-eligible and uninsured patients, especially at safety net institutions. These unreimbursed costs are reflected in the current UCCR cost finding. CMS approved this as a Schedule E, UCCR element because it was essential to adapt the Medicare 2552 which is for the Medicare population to the Medicaid-eligible and uninsured population.

- **Social, Financial, Interpreter, Coordinated Care and other services for Medicaid eligible and uninsured patients**

  These health care services are stepped down from the CMS Medicare 2552 Cost Report because they are not generally related to Medicare populations. These services should be included as additional allowable costs specifically because they are health care services primarily provided to Medicaid-eligible and uninsured patients, especially at safety net institutions. These unreimbursed costs are reflected in the current UCCR cost finding. CMS approved this as a Schedule E, UCCR element because it was essential to adapt the Medicare 2552 which is for the Medicare population to the Medicaid-eligible and uninsured population.

- **Public Hospital Pensions and Retiree Benefits**

  Public hospital pensions and retiree health benefits are an operating cost for personnel who provide medical and other health care services to Medicaid-eligible and uninsured patients at government hospitals. These are annual expenditures for pension obligations

and the financial requirements for retiree health benefits for the subset of retirees covered under the public pension plan for public and governmental hospitals.

- **340b and other pharmacy costs**

  340b and pharmacy costs are for medically necessary and prescribed pharmaceuticals provided by some qualifying acute hospitals to Medicaid-eligible and uninsured patients. These costs are reflected in the current UCCR cost finding.

- **Outlier Day: Each day beyond 20 acute days, during a single admission, for which a Member remains hospitalized at acute status**

  This cost item includes inpatient hospital costs for medically necessary days beyond 20 acute days for Medicaid-eligible and uninsured patients are currently reimbursed by the Health Safety Net. These medical services are reflected in the current UCCR cost finding.

Table 2. Crosswalk between Provider and Safety Net Care Pool Payments

Payment	Provider	Development Tool Designation
Public Safety Net Hospital Safety Net Care Payment	Boston Medical Center Cambridge Health Alliance	Acute Inpatient and Outpatient Hospitals
Health Safety Net Trust Fund Safety Net Care Payment	All acute hospitals	Acute Inpatient and Outpatient Hospitals
Institutions for Mental Disease	Psychiatric inpatient hospitals Community-based detoxification centers	Institutions for Mental Disease
Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	Chronic Disease and Rehabilitation Inpatient and Outpatient Hospitals
State-Owned Non-Acute Hospitals Operated by the Department of Mental health	Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Lindemann Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester State Hospital	Chronic Disease and Rehabilitation Inpatient and Outpatient Hospitals

ATTACHMENT I
HOSPITALS ELIGIBILE FOR DSTI

Based on the eligibility criterion specified in STC 49(e)(1), the hospitals listed below are the providers who are eligible to participate in DSTI for the term of this Demonstration approval period, and may be eligible to earn incentive payments based on an initial proportional allotment indicated below as outlined in STC 49(e)(7). This is not a guarantee of funding for DSTI providers, but an initial estimate of potential allocation and actual funding will be based upon incentive payments as outlined in an approved DSTI master plan, approved hospital specific DSTI plan and approved DSTI payment and funding protocol pursuant to STC 52.

Participating Hospital	**Initial Proportional Allotment Participating Hospitals Maybe Eligible to Earn through Incentive Payments**	
	Foundational Amount of Funding	Relative Share of Medicaid and Low-Income Public Payer GPSR
Public Acute Hospital:		
Cambridge Health Alliance	$4 million	$130.6 million
Private Acute Hospitals:		
Boston Medical Center	$4 million	$306.7 million
Holyoke Medical Center	$4 million	$20.5 million
Lawrence General Hospital	$4 million	$39.3 million
Mercy Medical Center	$4 million	$41.6 million
Signature Healthcare Brockton Hospital	$4 million	$46.1 million
Steward Carney Hospital	$4 million	$15.2 million

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Steward Carney Hospital	$4 million	$15.2 million

ATTACHMENT J
MASTER DSTI PLAN – APPROVED MAY 18, 2012

I. PREFACE

1. MassHealth Medicaid Section 1115 Demonstration Waiver

On December 20, 2011, the Centers for Medicare & Medicaid Services (CMS) approved the Commonwealth of Massachusetts' request to extend the term of the section 1115 Demonstration waiver, entitled MassHealth (11-W-00030/1) (Demonstration) in accordance with section 1115(a) of the Social Security Act. The new extension period was approved through June 30, 2014.

2. Delivery System Transformation Initiatives (DSTI)

STC 49 of the Demonstration authorizes the Commonwealth to create 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.

Eligible safety net hospitals (also referred to as "hospital(s)" herein) will be required to develop and implement these initiatives and activities in order to receive the incentive payments. Pursuant to STC 49(e)(3), participating hospitals must implement new health care initiatives within their respective health systems, or significantly enhance existing initiatives, in order to qualify for DSTI incentive payments. In addition, these initiatives may complement or enhance other federal initiatives in which a hospital may be participating, but they may 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. Pursuant to STC 49(e)(6), 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, and will not be offset against other Medicaid reimbursements to a hospital system.

3. Master DSTI Plan

In accordance with STCs 49(e), 52(a), 52(c), and 53(c), 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

STC 52(a). The master DSTI plan also incorporates the required elements of the DSTI payment and funding protocol as described in STC 52(c)(4).

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 days of submission by EOHHS. Such revisions shall not require a waiver amendment, provided that they comport with all applicable STC requirements.

4. **Hospital Specific DSTI Plans**

Upon CMS approval of the Commonwealth's master DSTI plan, each eligible safety net hospital must submit an individual DSTI plan 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. State & Federal Review Process of Hospital Specific Plans
VI. Non-Federal Share of DSTI Payments
VII. Reporting & Payments in DY 15, DY 16, and DY 17
VIII. Disbursement of DSTI Funds
IX. Plan Modification, Grace Periods, and Carry-Forward & Reclamation
X. Master DSTI Projects and Metrics
XI. DSTI Evaluation

II. COMMONWEALTH'S PAYMENT & DELIVERY SYSTEM PROGRESS AND GOALS

6. Global Context

In April 2006, Massachusetts signed into law a landmark health care reform bill with the aim of providing access to affordable health insurance to all Massachusetts residents. The legislation, Chapter 58 of the Acts of 2006 (Chapter 58), titled *An Act Providing Access to Affordable, Quality, Accountable Health Care*, 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 consisted of a series of bold interdependent activities and programs, each necessary for the other to be successful and to achieve the overall goal of drastically reducing the rate of uninsurance in Massachusetts. Chapter 58 later served as an inspiration for federal health care reform legislation, the *Patient Protection and Affordable Care Act* of 2010 (ACA). As in Massachusetts, the ACA includes the creation of state health insurance exchanges, subsidies for low- and moderate-income individuals to purchase health insurance, an individual mandate to purchase insurance, shared responsibility requirements for employers, and expansions of public health insurance programs.

Health care reform in Massachusetts, with the support and partnership of CMS, has been an unrivaled success. More than 98% of the population is insured, and only 0.2% of children lacked coverage in 2010.[4] According to a recent report 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 report's key findings are:[5]

- Massachusetts made sustained gains in access to and use of health care between 2006 and 2010. 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.

- 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.[6]

[4] Massachusetts Division of Health Care Finance and Policy. *Key Indicators: Quarterly Enrollment Update June 2011 Edition (Released in February 2012)*. <http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/12/2011-june-key-indicators.pdf>

[5] 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.

[6] 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).

- 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 Blue Cross Blue Shield Foundation report affirms that, despite the challenges posed by the nationwide recession that began in 2009, Massachusetts has sustained the progress made under state health reform. The Commonwealth has remained steadfast in its commitment to universal access in spite of the fact that the worst economic downturn in more than 70 years has resulted in more Massachusetts residents relying on safety net programs.

The Commonwealth's success in insuring nearly all Massachusetts residents has highlighted a new set of challenges. Massachusetts, like states around the country, the federal government, the private sector, and individuals, is burdened by health care cost inflation and in many cases utilizes a fee-for-service payment system that can reward the delivery of services rather than improvements in the health outcomes of the population. Massachusetts health care costs are currently projected to rise by an average of 6% annually during the next decade, while GDP is projected to grow at less than 4%.[7]

Rising health care costs threaten the sustainability of the reforms that have borne such success. The challenge of ensuring that improvements in access to care for low-income populations endure is particularly critical as a shrinking state budget places additional fiscal pressure on the Commonwealth's Medicaid program. More than four-fifths of insurance coverage expansion since 2006 came through the Medicaid program. Moreover, the residually uninsured population is highly concentrated in low-income, urban communities. These realities, compounded by the economic downturn, have put serious financial pressure on safety net providers who face increasing Medicaid caseloads.

To address these challenges, Massachusetts must now turn its focus to reducing the actual costs of medical care and the rate of growth over time, even as we redouble our efforts to improve quality and the patient experience while ensuring the sustainability of safety net providers.

7. Commonwealth's Goals & Outcomes

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

[7] Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health Care Spending Baseline Trends and Projections," February 4, 2009. Massachusetts Health Care Quality and Cost Council, "Roadmap to Cost Containment," page 1, October 2009.

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 will be integrating 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 will mean 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 reforming the way we pay for care, moving from volume based fee-for-service payments to payments based on maintaining access and quality.

For MassHealth, supporting safety net populations and the safety net providers that provide the majority of their care is the natural place to start 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 shared by CMS and EOHHS: 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 will be offered to eligible safety net hospitals that serve a high proportion of low-income Medicaid and uninsured patients to support projects that will 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 will be tied to achieving specific transformation milestones. The vision is to provide critical support that will position the eligible hospitals for payment reform and toward success in alternative payment arrangements that reward cost effective and high quality care.

8. Payment & Delivery System Reform Efforts

Massachusetts has been a model for the nation in expanding access to health care services, and now it is taking the lead in controlling costs and improving quality through payment and delivery system reform initiatives.

In order to advance statewide reform, the Administration and the Legislature are currently pursuing legislation that would improve quality and control costs by reforming health systems and payments. Governor Patrick introduced a bill in February 2011 that would begin moving providers and payers – including state purchasers of health care such as MassHealth, the Group Insurance Commission and the Health Connector – away from fee-for-service methods of payment and toward the use of alternatives to fee-for-service such as global payments, bundled payments, and other alternatives. The successful adoption of the reform currently contemplated will promote the transformation of the Massachusetts delivery system into an innovative care delivery and health care financing model.

The Executive Office of Health and Human Services (EOHHS) already has made significant progress in advancing the goals of payment and delivery system reform under existing initiatives and planning efforts. Ongoing initiatives include:

ACO Development

In June 2011, EOHHS issued a Request for Information to gather input, information and advice on how best to implement payment reform for state health programs, including MassHealth, Commonwealth Care, state employees' health insurance, and other programs. EOHHS received 42 responses, which came from every sector of the health care community: patient advocates, physicians, hospitals, employers, specialists, medical device companies, other providers and other industry advocates. The responses will help shape a MassHealth procurement of ACOs, currently in development, to promote coordinated care and value based purchasing. The ACO initiative is projected to launch in 2013. EOHHS aims to align the ACO initiative with DSTI and other delivery system reform efforts to promote synergies across initiatives, in order to advance the goal of integrated delivery systems built on Patient Centered Medical Home principles.

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 will be a critical building block 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, enhancing health care quality by making patient health information available at all points of care, reducing costs through earlier diagnosis and characterization of disease, and increasing 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.

Patient-Centered Medical Home Initiative (PCMHI)

The Patient-Centered Medical Home Initiative (PCMHI) is a statewide, multi-payer demonstration project that supports 46 primary care practices in becoming patient-centered medical homes. The practices include community health centers, hospital-affiliated primary care offices, and group and solo primary care physician practices. PCMHI establishes a foundation for transforming the primary care landscape in Massachusetts through these pilot sites. This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. Instead, the patient-centered medical home model emphasizes enhanced chronic disease management through team-based care. Patient-centered practices place increased focus on recognizing the patient as an individual, respecting the patient's values, language and culture, and promoting the exchange of information about care options between patients and providers. Pending CMS approval, selected

PCMHI practices will participate in shared savings arrangements with PCMHI payers. With this demonstration as a foundation, the Commonwealth has set the goal for all primary care practices in Massachusetts to become patient-centered medical homes by the year 2015.

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 will aim 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 may request CMS approval to implement a bundled payment for all ambulatory services required for the most effective treatment and management of pediatric asthma for high-risk patients. The Commonwealth's goal in establishing the program is to evaluate the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower cost.

Non-Elderly Duals Integration Demonstration Project

Massachusetts is one of 15 states that received a $1 million planning contract from the CMS Center for Medicare and Medicaid Innovation to support the development of a design proposal for a State Demonstration to Integrate Care for Dual Eligible Individuals. The Commonwealth's proposal, recently submitted to CMS, promotes person-centered models that integrate the full range of acute care, behavioral health services and care, and long term supports and services for approximately 115,000 members between the ages of 21-64 who are eligible for Medicaid and Medicare. These dual eligible adults have disproportionately experienced the shortcomings of fragmented, uncoordinated care and payment streams. The Duals Demonstration will provide a strong foundation for 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 financed jointly with Medicare through global payments.

MassHealth Pay for Performance

The MassHealth Acute Hospital P4P Program, implemented in 2008, seeks to reward hospitals for excelling in or improving quality for MassHealth members as evidenced by positive outcomes and cost-effective care. Quality performance goals and measures are selected based on strategic importance, relevance to Medicaid population health outcomes and status, and consistency with nationally-recognized standards for quality measurement. Current measurement approaches cover maternity/newborn, chronic conditions, surgical infection prevention, pediatric

asthma, community acquired pneumonia, and clinical health disparities. MassHealth is currently exploring the possibility of expanding measurement to cover a wider range of quality domains, such as care transitions, outcomes, and patient experience of care, to support alignment with Medicaid delivery system and payment reform activities. EOHHS will continue to coordinate across initiatives to ensure that P4P measures do not duplicate quality measures tied to hospital payments in existing initiatives in a way that would result in duplication of state or federal funds.

All Payer Claims Database

Massachusetts is developing an All Payers Claims Database (APCD) that will provide timely, valid, and reliable health care claims data that will allow a broad understanding of cost and utilization across institutions and populations. This dataset will be 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 is anticipated to be available for use by interested parties as of July 1, 2012. Potential users will apply for data release through an application and governance process.

DSTI will build upon and complement these existing initiatives by incenting safety net providers to make critical investments in developing integrated care models based on PCMH principles, implementing innovative programs to improve health care quality and outcomes, and preparing to participate in alternative payment arrangements. As the Commonwealth increasingly moves beyond pilots and demonstration programs to statewide delivery system and payment reform, DSTI will help to ensure that safety net providers are sustainable and successful in the new health care context.

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.[8] 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.[9]

However, the communities that DSTI-eligible safety net providers serve are characterized by lower incomes, more severe socioeconomic challenges, and more adverse health status

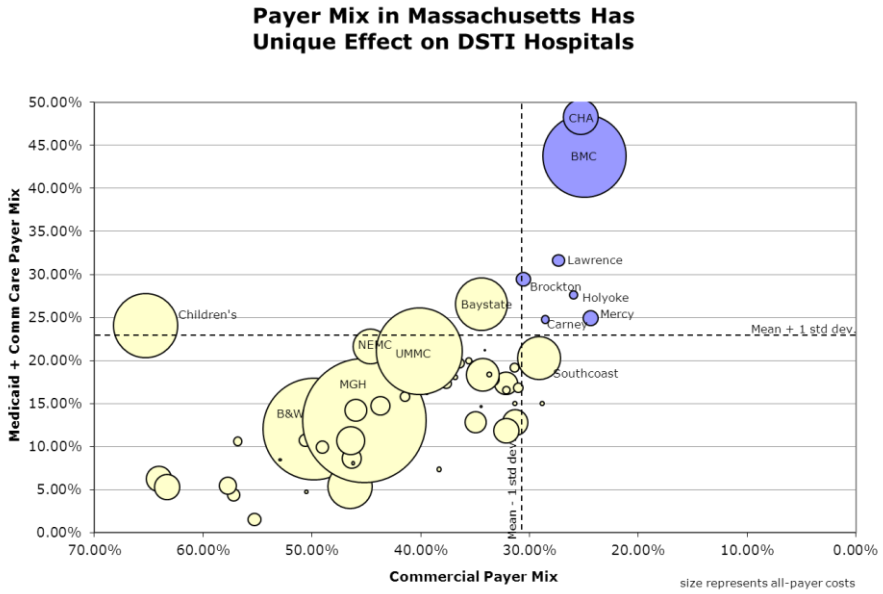
[8] 2010 American Communities Survey.
[9] Kaiser Family Foundation. State Health Facts: Massachusetts State Profile. < http://www.statehealthfacts.org>

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).[10] 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.[11] 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 crucial 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 continue to seek health services where they already have a connection. As a result, these hospitals experienced a 30% increase in Medicaid patient care volume during health care reform from 2006 to 2010.[12] DSTI eligible safety net hospitals have a Medicaid and Commonwealth Care payer mix that is, on average, nearly 2.5 times the statewide acute hospital average (as illustrated in the chart below). In addition, despite the expansion in health coverage under Chapter 58 reforms, safety net hospitals continue to provide concentrated care to the residual uninsured population. Safety net hospitals currently have a weighted-average uninsured payer mix of 8% (with one provider having an uninsured rate of 13%). This disproportionately high Medicaid and low-income public payer mix, combined with historically low rates of commercial payer reimbursement and the effects of the recent economic downturn, has contributed to significant financial pressure on these safety net hospitals.

[10] Massachusetts Community Health Information Profile (MassCHIP), available at <http://www.mass.gov/eohhs/researcher/community-health/masschip/welcome-to-masschip.html>
[11] Ibid.
[12] 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.



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 management; clinical information systems; and data analytics to enhance performance measurement.[13] 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.

DSTI presents a unique opportunity for the eligible safety net hospitals to begin to overcome these challenges and make significant progress toward delivery system transformation. The Commonwealth and eligible safety net hospitals seek to leverage DSTI funds to advance new models of care delivery that emphasize greater clinical integration and care management, as well as to advance payment models that align incentives more effectively at the provider level. Each of the DSTI hospitals, within the context of its unique starting place and community setting, aims to develop a set of core capabilities to transform health care delivery in the context of new payment reform models. With oversight by both EOHHS and CMS, participating hospitals will utilize the opportunity for DSTI incentive payments to make strategic investments in delivery system transformation initiatives with the ultimate goal of achieving the Triple Aim – better care, better health and lower costs.

[13] Accountable Care Organization Learning Network Toolkit. Engelberg Center for Health Care Reform | The Dartmouth Institute and The Brookings Institution, January 2011.

11. **DSTI Eligibility Criteria**

STC 49(e)(1) describes the eligibility criteria for the DSTI program. Providers eligible for incentive payments are defined 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 FY 2009 cost report data. Based on the eligibility criterion specified in STC 49(e)(1), the hospitals listed below are the providers who are eligible to participate in DSTI for the term of this Demonstration approval period, and shall be eligible to earn incentive payments based on an initial proportional allotment indicated in STC 49(e)(7) 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.

IV. KEY ELEMENTS OF PROPOSED HOSPITAL SPECIFIC PLANS

12. **Hospital Specific DSTI Plans**

Each eligible safety net hospital must submit an individual DSTI plan that identifies the projects, population-focused objectives, and specific metrics adopted from Section X ("Master DSTI Projects and Metrics") and meets all requirements pursuant to STC 49(e)(4), STC 49(e)(3), STC 52(a)(2), STC 52(b), and all requirements set forth in Section IV ("Key Elements of Proposed Hospital Specific Plans").

13. **Minimum Number of Projects**

Hospitals shall select a minimum of five projects across Categories 1, 2 and 3 from Section X ("Master DSTI Projects and Metrics"). The distribution of each hospital's projects across Categories 1, 2 and 3 shall 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 submit more than five projects in total for Categories 1, 2 and 3.

In Category 4, hospitals shall report on a specified number of population-focused health improvement metrics in the core set of common measures (11 in DY 16 and 12 in DY 17) as described in Section X ("Master DSTI Projects and Metrics"), pursuant to STC 52(a)(10). Hospitals also must report a minimum of 6 hospital-specific metrics selected from among the measures described in Section X ("Master DSTI Projects and Metrics"). Hospitals may also report additional hospital-specific measures up to a total maximum of 15 as described in Section X ("Master DSTI Projects and Metrics"). Pursuant to STC 49(e)(4), Category 4 metrics may vary across participating providers, but should be consistent within projects described in the DSTI master plan to facilitate evaluation. Due to the time required for

hospitals to develop new data reporting systems, eligible safety net hospitals are required to report Category 4 measures in DY 16 and DY 17 only.

14. **Organization of Hospital Specific DSTI Plans**

Hospital-specific DSTI Plans shall include the following sections:

a) Executive Summary

The Executive Summary shall 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 shall also include a description of key challenges facing the hospital and how the three-year DSTI plan supports the hospital's five-year vision. The Executive Summary should address:

- How the individual projects support the five-year vision;
- How the individual projects reinforce/support each other;
- How Category 4 measures are relevant to the hospital's 5-year vision and population/outcomes health improvement.

b) Background Section

The background section shall 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 five-year vision of delivery system transformation. The background section also shall 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)(b), each hospital shall 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 49(e)(3)), 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;

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 shall submit milestones and metrics adopted in accordance with Section X ("Master DSTI Projects and Metrics") and meet the requirements pursuant to STC 49(e)(5) entitled "DSTI Metrics and Evaluation." In a table format, hospitals shall indicate by Demonstration year, when project metrics will be achieved and indicate the data source that will be used to document and verify achievement.

d) Section on Category 4

This focus area involves population-focused improvements associated with Categories 1, 2 and 3 projects. Each eligible safety net hospital shall report on a core set of common metrics in addition to hospital-specific metrics, pursuant to Section X ("Master DSTI Projects and Metrics"). Pursuant to STC 49(e)(4), metrics include those that are related to the impact of the transformation projects undertaken by hospitals, such as health care delivery system and access reform measures on the quality of care delivered by participating providers. Metrics also include those that are related to the impact of the payment redesign and infrastructure investments to improve areas such as systems of care, coordination of care in community settings, and cost efficiency. Metrics may vary across participating providers, and will be consistent within project options developed in Section X ("Master DSTI Projects and Metrics") to facilitate evaluation. Due to the time

required for hospitals to develop new data reporting systems, eligible safety net hospitals are required to report Category 4 measures in DY 16 and DY 17 only.

e) Distribution of DSTI Funds

In this section, the hospital shall 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 shall be in accordance with the stipulations of STC 49(e)(7), STC 52(c), Attachment I and Section VIII ("Disbursement of DSTI Funds").

V. STATE & FEDERAL REVIEW PROCESS OF HOSPITAL SPECIFIC PLANS

15. **Review Process**

The Executive Office of Health and Human Services (EOHHS) will review all hospital-specific DSTI plan proposals prior to submission to CMS for final approval according to the following timeline, which is based on the Commonwealth's Master DSTI Plan submission to CMS on March 15, 2012. The EOHHS and CMS review process for hospital-specific DSTI plan proposals shall include the following schedule:

a) EOHHS Review of Hospital Specific DSTI Plan

1) Submission of Hospital Specific Plans to EOHHS

By March 16, 2012, each eligible safety net hospital (identified in section III, "Community Needs & DSTI Eligibility Criteria") will submit a draft hospital-specific DSTI plan proposal to EOHHS for review.

2) EOHHS Review of Hospital Specific Plans

EOHHS shall review and assess each plan according to the following criteria:

i. The plan is in the format and contains all required elements described herein and is consistent with the special terms and conditions, including STC 49(e)(3), STC 49(e)(4), STC 49(e)(5), STC 52(b) and STC 52(c).

ii. The plan conforms to the requirements for Categories 1, 2, and 3, and 4, as described in section IV ("Key Elements of Proposed Hospital Specific Plans").

iii. Category 1, 2, and 3 projects clearly identify goals, metrics, and expected results. Category 4 clearly identifies the population-focused health improvement measures to be reported.

iv. The amount and distribution of funding is in accordance with the stipulations of STC 49(e)(7), STC 52(c), Attachment I, and Section VIII ("Disbursement of DSTI Funds").

v. The plan and all of the projects proposed within are consistent with the overall goals of the DSTI program.

By April 6, 2012, EOHHS will complete its initial review of each timely submitted hospital-specific DSTI plan proposal and will respond to the hospital in writing with any questions or concerns identified.

The hospital must respond in writing to any notification by EOHHS of questions or concerns. The hospital's response must be received by EOHHS within 3 business days of the aforementioned notification. The hospital's initial response may consist of a request for additional time to address EOHHS' comments; provided that the hospital's revised plan must address all of EOHHS' comments and must be received by EOHHS by April 24, 2012. Each hospital must further revise its plan as needed to conform to the final approved master DSTI plan. Pending CMS approval of the master DSTI plan, each hospital must submit a revised plan that conforms to the final approved master plan by May 21, 2012.

b) EOHHS Approval of Hospital Specific Plans

By May 22, 2012, pending CMS approval of the master DSTI plan, EOHHS will take action on each timely submitted revised hospital-specific DSTI plan, will approve each such plan that it deems satisfactory according to the criteria outlined in above, and submit approved plans to CMS for final review and approval.

c) THE CMS Review of Hospital Specific Plans

1) The CMS will review each hospital's individual DSTI plan upon receipt of the plan as approved by EOHHS. CMS' review will assess whether each hospital's DSTI plan as approved by EOHHS meets the following criteria:

i. The plan is in the format and contains all required elements described herein and is consistent with the special terms and conditions, including STC 49(e)(3), STC 49(e)(4), STC 49(e)(5), STC 52(b) and STC 52(c).

ii. The plan conforms to the requirements for Categories 1, 2, and 3, and 4, as described in section IV ("Key Elements of Proposed Hospital Specific Plans").

iii. Category 1, 2, and 3 projects clearly identify goals, metrics, and expected results. Category 4 clearly identifies the population-focused health improvement measures to be reported.

iv. The amount and distribution of funding is in accordance with the stipulations of STC 49(e)(7), STC 52(c), Attachment I and Section VIII ("Disbursement of DSTI Funds").

v. The plan and all of the projects proposed within are consistent with the overall goals of the DSTI program.

2) During the 45-day review process for hospital-specific plans, CMS will complete an initial review of each eligible safety net hospital's plan and will respond to the hospital in writing, with a copy to EOHHS, with any questions or concerns identified. If CMS finds that a component of a hospital's plan is inconsistent with the specific requirements or the overall goals of the DSTI, CMS will request additional information from the eligible safety net hospital and may request a revision to the hospital's project.

The hospital must respond in writing to any notification by CMS of questions or concerns. The hospital's response must be received by CMS within 3 business days of the aforementioned notification. The hospital's initial response may consist of a request for additional time to address CMS' questions, concerns, or request for revision. If CMS has requested a revised project, the hospital must revise the project to address CMS' concerns and submit the revised project to CMS.

d) THE CMS Approval of Hospital Specific Plans

Pursuant to STC 49(e)(3), plans reviewed and approved by EOHHS will result in approval by CMS within 45 days of receipt from EOHHS, provided that the plan(s) meet all DSTI requirements as outlined above and in STC 49(e)(3). If CMS finds that a hospital's plan meets all DSTI requirements, CMS may approve it at any time within the 45-day period after receipt of the plan from EOHHS.

1) Within 45 days of receipt of a hospital-specific plan from EOHHS, CMS will complete its review of each eligible safety net hospital's plan and will either:

i. Approve the plan; or

ii. Notify EOHHS and the hospital if approval will not be granted for a component of the hospital's plan. Notice will be in writing and will include any questions, concerns, or problems identified in the application.

2) If CMS does not approve a hospital's plan, the hospital must submit a revised plan that addresses CMS' concerns, as described in the notification that the plan will not be approved, within 15 days of notification. CMS will respond within 15 days to the revision submitted by the hospital. If the revision meets the requirements for approval of the hospital's plan, then CMS will provide such approval and permit the first DY 15 payment of 50% of the hospital's annual proportional DSTI allotment in accordance with the expedited DY 15 process under section VII ("Reporting and Payments in DY 15, DY 16, and DY 17"). If the revision does not meet the requirements for final approval, the hospital must continue to revise the project(s) or component(s) in question until CMS determines that the project meets all DSTI requirements and provides approval of the hospital's plan.

e) Revisions to the Master Plan

If the CMS review process for hospital-specific DSTI plans results in the modification of any component of any hospital's plan, including but not limited to projects, measures, metrics, or data sources, that was not originally included in the approved master DSTI plan, the Commonwealth may revise the master DSTI plan accordingly. CMS will review and approve these proposed revisions within 30 days of submission by EOHHS, provided that the master DSTI plan revisions are in accordance with the final approved hospital-specific plan(s) prompting the revision(s) and all applicable STC requirements. Such revisions to the master DSTI plan do not require a waiver amendment.

VI. NON-FEDERAL SHARE OF DSTI PAYMENTS

16. **Identification of Allowable Funding Sources**

a) Allowable Funding Sources

1) Allowable funding sources for the non-federal share of DSTI payments shall include all sources authorized under Title XIX and federal regulations promulgated thereunder.

2) Except as provided in paragraph 16.a.3 below, the source of non-federal share of DY 15, 16 and 17 DSTI payments will be state appropriations.

3) The source of non-federal share of DYs 15, 16, and 17 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 15, DY 16 or DY 17 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) THE CMS Approval of Funding Source

The source of non-federal share for DSTI payments is subject to CMS approval. EOHHS shall 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 shall render a decision on the source of non-federal share within 30 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 shall notify CMS and seek CMS' approval of such change prior to claiming FFP for any payment utilizing such funding source. No waiver amendment is required.

VII. REPORTING AND PAYMENT IN DY 15, DY 16, AND DY 17

17. **Expedited Reporting and Payment in DY 15**

a) Hospital Reporting for Payment in DY 15

1) Hospital-specific DSTI plan approval will serve as the basis for transaction of 50% of each hospital's total DY 15 DSTI incentive payment amount. EOHHS will schedule the initial payment transaction for each hospital within 30 days 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) By July 31, 2012, each hospital shall submit a report to the Commonwealth demonstrating progress on the achievement of its DY 15 metrics through June 30, 2012. Pursuant to STC 53(c)(i), the report shall be submitted using the standardized reporting form approved by EOHHS and CMS. The report shall include the incentive payment amount being requested for the progress achieved in accordance with payment mechanics (see section VIII "Disbursement of DSTI Funds"). The report shall furthermore include data on the progress made for all DY15 metrics and shall provide a narrative description of the progress made. The hospital shall 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.[14] The hospital system shall have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

This report will serve as the basis for authorizing payment of an amount up to the balance of each hospital-specific DY 15 DSTI incentive payment amount as approved by CMS in the hospital-specific DSTI plan. The actual payment amounts will be determined by EOHHS based on the achievement of the DY 15 metrics in accordance with the criteria established in Section VIII ("Disbursement of DSTI Funds"). EOHHS will schedule the payment transaction for each hospital for the approved amount of incentive funding based on each hospital's achievement of DSTI metrics 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.

b) Hospital Annual Year-end Report

Pursuant to STC 53(c)(1)(ii), each hospital shall submit an annual report by July 31, 2012. The annual report shall be prepared and submitted using the standardized reporting form approved by EOHHS and CMS. The annual report shall include data on the progress made for all metrics and shall provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The hospital system shall have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

c) Year-End Payment Reconciliation

Based on its review and verification of each hospital's annual year-end report, 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

[14] 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.

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.

If a governmental hospital provided the non-federal share of an overpayment determined by EOHHS, then EOHHS shall refund to the hospital the amount of the intergovernmental funds transfer attributable to the overpayment, provided that the hospital first refunds to EOHHS the full amount of the overpayment. If EOHHS determines that a governmental hospital that elects to provide the non-federal share of DSTI payments was underpaid, then EOHHS will schedule the appropriate funding and payment transactions, or will adjust the payment amounts to the next DSTI funding and payment transactions for the governmental hospital, as determined by EOHHS and consistent with all terms and conditions regarding payment under the demonstration.

d) Commonwealth Reporting to CMS in DY 15

1) Quarterly and Annual Reporting
Following approval of the master DSTI plan and hospital specific plans, pursuant to STC 53(c)(2), STC 58 and STC 59, 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; and
iv. Evaluation activities and interim findings of the evaluation design pursuant to STC 84.

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 shall have available for review by CMS, upon request, all supporting data and back-up documentation.

18. **Reporting and Payment in DY 16 and DY 17**

a) Hospital Reporting for Payment

Twice per year, each hospital seeking payment under the DSTI shall submit reports to the Commonwealth demonstrating progress on DSTI projects, measured by category specific metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by EOHHS and CMS. The reports shall include the incentive payment amount being requested for the progress achieved on DSTI metrics in accordance with payment mechanics (see section VIII "Disbursement of DSTI Funds"). The report shall include data on the progress made for all Demonstration year metrics and shall provide a narrative description of the progress made; the mid-year report shall furthermore provide a narrative explaining how the hospital will achieve the remaining metrics for each project before the end of the year. The hospital shall 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.[15] The hospital system shall 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.

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 VIII ("Disbursement of DSTI Funds"). EOHHS will schedule the payment

[15] 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.

transaction for each 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.

b) Mid-Year Assessment: 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.e below.

c) Hospital System Annual Year-End Report

Pursuant to STC 53(c)(1)(ii), each hospital shall submit an annual report by July 31 following the end of the Demonstration year. The annual report shall be prepared and submitted using the standardized reporting form approved by EOHHS and CMS. The report will include the information provided in the interim reports previously submitted for the Demonstration year, including data on the progress made for all metrics. Additionally, the eligible safety net hospital will provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The hospital system shall have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

d) Year-end Payment Reconciliation

Based on its review and verification of each hospital's annual year-end report, 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.

If a governmental hospital provided the non-federal share of an overpayment determined by EOHHS, then EOHHS shall refund to the hospital the amount of the intergovernmental funds transfer attributable to the overpayment, provided that the hospital first refunds to EOHHS the full amount of the overpayment. If EOHHS determines that a governmental hospital that elects to provide the non-federal share of DSTI payments was underpaid, then EOHHS will schedule the appropriate funding and payment transactions, or will adjust the payment amounts to the next DSTI funding and payment transactions for the governmental hospital, as determined by EOHHS and consistent with all terms and conditions regarding payment under the demonstration.

e) Commonwealth Reporting to CMS in DY 16 and DY 17

1) Quarterly and Annual Reporting

Pursuant to STC 53(c)(2), STC 58 and STC 59, 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; and
iv. Evaluation activities and interim findings of the evaluation design pursuant to STC 84.

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 shall have available for review by CMS, upon request, all supporting data and back-up documentation.

VIII. 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 VII ("Reporting and Payment in DY 15, DY 16, and DY 17") 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. DSTI incentive payments to an individual hospital may equal but not exceed the initial proportional allotment outlined in Attachment I.

b) DY15 DSTI Payments

In DY15, each hospital will receive 50% of its annual proportional DSTI allotment based on CMS approval of its hospital-specific plan, pursuant to STC 49(e)(6) and Attachments E and I. The remaining 50% of the hospital DSTI allotment will be based on successfully achieving metrics associated with approved projects within DSTI Categories 1, 2 and 3 as described in Section X ("Master DSTI Projects and Metrics") and in approved hospital-specific plans. No funding will be allotted to Category 4 in DY15.

c) DY 16 and DY17 DSTI Payments

In DY16 and DY17, 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 4 as described in Section X ("Master DSTI Projects and Metrics") and in approved hospital-specific plans.

20. **DSTI Funding Allocation Formula**

a) Funding Allocation Formula for Categories 1-3

1) In DY 15, 50% of total DSTI funds ($104.67 million) are available as incentive payments for successful achievement of metrics for projects in Categories 1-3. In DY16 and DY17, 75% of total DSTI funds ($157.00 million per year) are available as incentive payments for successful achievement of metrics for projects in Categories 1-3.

2) Projects within Categories 1-3 have an annual base value that is uniform across all projects, except for Project 3.9: 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 ($104.67 million in DY 15; $157 million in DY 16 and in DY 17) by a standard number of projects (6.25). The table below specifies the annual base values for projects in Categories 1-3.

Annual Project Base Values for Categories 1-3		
DY/SFY	Base Value for Projects 1.1-3.8	Base Value for Project 3.9
DY15/SFY12	$16,746,667	$4,186,667
DY16/SFY13	$25,120,000	$6,280,000
DY17/SFY14	$25,120,000	$6,280,000

3) 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 3.9: 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	Annual Base Value for Metrics in Projects 1.1-3.8	Annual Base Value for Metrics in Project 3.9
DY15/SFY12	$3,349,333	$837,333
DY16/SFY13	$5,024,000	$1,256,000
DY17/SFY14	$5,024,000	$1,256,000

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 49(e)(7) 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 Brocton 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 49(e)(7). 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 Category 4

1) No funding for Category 4 is allotted for DY 15. Funding for Category 4 in DY 16 and DY 17 is 25% of the total annual DSTI funding ($52.33 million per year). Payment for Category 4 metrics will be based on reporting of the common and hospital-specific measures in each hospital's approved individual DSTI plan.

2) Category 4 metrics have an annual base value that is uniform across all Category 4 measures. The metric base value is calculated by dividing the total annual available amount of DSTI funding in DY 16 and DY 17 for Category 4 ($52.33 million) by the total number of common measures and hospital-specific measures for Category 4. In DY 16, all hospitals will report on a minimum of 17 Category 4 measures (11 common measures and a minimum of 6 hospital-specific measures). In DY17, all hospitals will report on a minimum of 18 Category 4 measures (12 common measures and a minimum of 6 hospital-specific measures). Hospitals may elect in approved hospital plans to report on up to a total of 15 Category 4 hospital-specific measures. The table below specifies the annual base value for metrics in Category 4 based on the minimum number of measures per hospital in each Demonstration year.

Annual Metric Base Values for Category 4	
DY/SFY	Base Value for Category 4 Metrics
DY15/SFY12	N/A
DY16/SFY13	$3,078,431
DY17/SFY14	$2,907,407

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 49(e)(7) and Attachment I. Each hospital must multiply the metric base value by its hospital-specific proportional allotment factor:

Hospital-Specific Proportional DSTI Allotment Factor	
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 Brocton Hospital	0.0798
Steward Carney Hospital	0.0306

ii. To adjust for the number of hospital-specific Category 4 metrics in the hospital's final approved hospital plan, if the hospital is reporting more than the minimum number of Category 4 measures. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratios: for DY 16 (17/# metrics in Category 4 for the hospital), and for DY 17 (18/# metrics in Category 4 for the hospital).

IX. 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.

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 Category 4. 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:

1) 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;

2) Information that was believed to be available to achieve a metric or measure is unavailable or unusable, necessitating a modification to the hospital plan to revise or replace the metric/measure;
3) A hospital identifies superior information to demonstrate achievement of a metric and requests a modification to incorporate that data source;
4) 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;
5) 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;
6) A hospital encounters an unforeseen operational or budgetary change in circumstances that impacts project components, metrics, and/or timelines;
7) A grace period request that meets the requirements of paragraph 22 below; and
8) 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 at any time during the Demonstration renewal period. EOHHS shall take action on the plan modification request and submit recommended requests to CMS for approval within 15 days of receiving a modification request. CMS shall take action on the plan modification request within 30 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 22 above. However, no grace period is available for DY 17 beyond June 30, 2014. 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:

1) Additional time is needed to collect and prepare data necessary to report on a metric;

2) Unexpected delays by third parties outside of hospital's control (e.g., vendors) impact the timing of a metric achievement date;

3) 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);

4) An approved plan modification delays the timing for completing an approved metric;

5) 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 shall 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 shall take action on the request within 30 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 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 24.

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 XII ("Reporting and Payments in DY 15, DY 16, and DY 17").

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 22 above, the allowable time period for a grace period is 120 days from June 30 for DY 15 and DY 16. No grace period is available for DY 17 beyond June 30, 2014.

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 22 above, the allowable time period for a grace period is 60 days from the June 30 for DY 15 and DY 16. No grace period is available for DY 17 beyond June 30, 2014.

3) Category 4

With respect to incentive payments associated with a measure in Category 4, the allowable time period for a grace period is 60 days from June 30 for DY 16. No grace period is available for DY 17 beyond June 30, 2014.

24. **Carry Forward and Reclamation**

Hospitals may carry forward unclaimed incentive payments in DY 15 and DY 16 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 17.

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;

2) Each metric in Category 4 is considered to have a corresponding metric, which is the exact same metric being reported in the subsequent 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 22 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.

c) Category 4 Measures

If an eligible safety net hospital does not report a measure in Category 4 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 reporting measure for 12 months and be available for full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed reporting measure in addition to the corresponding measure within the year 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.

X. 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 process measures and improvement measures and include at least one process measure and one improvement measure for each project over the Demonstration period that support the goals of the project, and related metric(s). The mandatory Project 3.9, "Participate in a Learning Collaborate," will only have required process measures, as its purpose is to establish a forum for eligible DSTI safety net providers to learn from other providers that share similar goals and to support the development of a shared culture of continuous improvement and innovation, which will facilitate and enhance the individual hospital's efforts 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.
   1.
b) Potential Project Elements: This component lists example approaches/elements a hospital plan may adopt to implement the project goal.
   2.
c) Key Measures**:** This component includes the measures from which the eligible safety net hospital may choose:

   1) Process Measures: These measures are key process steps leading towards a project's full implementation and results;

   2) Improvement Measures: These measures represent the process results or other major milestones of the project.

d) Metric: For a measure selected, the hospital plan shall incorporate a related metric that may be tailored to the hospital plan. For example, a hospital may tailor a metric to target a specific population; or a hospital may include metrics based on an absolute number or metrics based on a percentage.

e) Data Source: The data source identifies appropriate sources of information that a hospital may use to support and verify the measure/metric. Hospital plans also may

identify alternative sources appropriate to their individual hospital system and that provide better or comparable information.

27. **Category 4 Measures**

This section includes a menu of Category 4 measures related to population-focused improvements. The purpose of Category 4 is to evaluate the impact of the investments and system changes described in Categories 1, 2 and 3 through population-focused measures. Category 4 metrics shall recognize that the population-focused objectives do not guarantee outcomes but result in learning, adaptation, and progress. As such, eligible safety net hospitals will measure and report on selected measures but will not have milestones associated with the achievement of specific improvements. Hospitals shall commence reporting Category 4 measures starting in Demonstration Year 16 (SFY 2013).

a) Common measures: All participating safety net hospitals will develop plans to report on a core set of Category 4 measures that are included in Section X, paragraph 31 below. Hospitals shall report on 11 Common Measures in Demonstration Year 16 (SFY 2013) and report on one additional Common Measure in Demonstration Year 17 (SFY 2014), for a total of 12 Common Measures in Demonstration Year 17.

b) Hospital-specific measures: For each project a hospital selects in its individual DSTI plan, the hospital shall elect at least one Category 4 hospital-specific measures up to a total of 15 Category 4 hospital-specific measures on which the hospital will include a plan to report, selected from the list included in Section X, paragraph 31 below. Project 3.9: Participate in a Learning Collaborative will not have associated Category 4 hospital-specific measures.

28. **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."[16] 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.

[16]Shih A, Davis K, et al. "Organizing the U.S. Health Care Delivery System for High Performance." *The Commonwealth Fund*. Aug. 2008.

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.

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.[17]

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

[17] "Recommendations of the Massachusetts Special Commission on the Health Care Payment System." *Massachusetts Special Commission on the Health Care Payment System.* July 16, 2009.

systems that fail to invest adequately in primary care.[18] 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.[19]

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.[20] 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.

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.

[18]Beal 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.
[19] Ibid.
[20] APA Practice Organization. "Research roundup: Integrating physical and behavioral health interventions into psychological service delivery." ,*Practice Update.* Apr. 2011.

ATTACHMENT J
MASTER DSTI PLAN – APPROVED MAY 18, 2012

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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 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"[21], and "the medical home model supports fundamental changes in primary care service delivery and payment reforms, with the goal of improving health care quality."[22]

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.[23] [24] 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 ED 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 projects including PCMH readiness preparations, the establishment or expansion of medical homes which may include gap analyses and eventual application for PCMH recognition to a nationally recognized organization such as NCQA, or clinical collaboration by a hospital system toward referral and care coordination systems with an affiliated PCMH, as well as educating various constituent groups within hospitals and primary care practices about the essential elements of the NCQA medical home standards. 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.

[21] "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.

[22] "Overview of PCMHI." *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/

[23] Cosway R et al., "Analysis of Community Care of North Carolina Cost Savings." Milliman, Inc. 2011.

24 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
DSTI hospitals undertaking this project may select from among the following project elements:

A. Develop and implement action plans to eliminate gaps in the development of various aspects of PCMH standards.
B. Utilize a gap analysis to assess and/or measure hospital-affiliated and/or hospital-employed PCPs' NCQA PCMH readiness.
C. Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status (e.g., Level 1, 2, or 3) with hospital-affiliated and/or employed-PCPs.
D. Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
E. Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients.
F. Improve data exchange between hospitals and affiliated medical home sites.
G. Develop best practices plan to eliminate gaps in the readiness assessment.
H. Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license.
I. Establish or expand patient-centered medical homes.
J. Apply for Patient-Centered Medical Home recognition by a nationally recognized organization such as NCQA.
K. Empanel patients who would most benefit from medical homes (as specified in hospital-specific plans)
L. Actively manage medical home patient panels.

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)**
3. Identify physician champion at hospital and affiliated practices to educate and lead PCMH initiative.	• Document of physician champions	• 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)**
4. Educate stakeholders including patients, hospital and affiliated practices' leadership, primary care offices, and staff members on the elements of PCMH rationale and vision.	• Document attendance of attending education program on the elements PCMH rationale and vision or • Education materials developed and distributed on benefits of PCMH	• Internal hospital records/documentation of attendance and educational content • Internal hospital records/documentation of distribution of educational materials
5. Establish a PCMH working group and design a tool to assess readiness gaps.	• Document creation of work group • Document development of tool	• Internal hospital records/documentation & meeting minutes • NCQA requirements
6. Conduct a gap analysis against PCMH criteria from a nationally recognized agency (e.g., NCQA).	• Documentation of a completed, gap analysis required. • In addition to completed gap analysis, other metrics may include: ➢ Documentation of completed action plan for each primary care site. ➢ Documentation of action efforts towards PCMH accreditation ➢ Identification of internal/external resources to be allocated to each site to begin implementation of plan. ➢ Documentation of work plan to complete gap assessment against	➢ 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)**
	NCQA medical home recognition criteria	
7. Prioritize PCMH readiness gaps identified in gap analysis.	• Develop action plan to address gap	• Documentation of completed action plan
8. Implement findings of gap analysis and components of action plan.	• Documentation that findings have been implemented	• Internal hospital records/documentation
9. Establish criteria for medical home assignment and empanelment, including for the targeted patient population	• Establish criteria for medical home assignment	• Document submission of empanelment criteria
10. Develop reports for panel size per provider/care team.	• Report developed for panel size per provider/care team	• Document submission of panel productivity
11. Identify sites to transform into PCMHs.	• Identify at least X number of additional primary care sites for PCMH transformation	• Documentation of the selection of X number of primary care sites
12. Develop approach and toolkit to assist primary care practices with patient engagement in Practice Improvement.	• Documentation of patient engagement approach and toolkit to assist practices to identify and engage patients effective in practice improvement activities	• Copy of framework and toolkit from hospital 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)**
13. Establish a joint team of Hospital and PCMH Practice representatives to analyze gaps and determine priorities for the integration of care management and coordination for target patient population [e.g., diabetes (DM), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD)].	• Documentation of regular meetings and communications of the Joint Hospital/PCMH Team	• Joint team minutes
14. Identify areas of improvement in Hospital/PCMH practice linkages related to NCQA requirements for PCMHs.	• Report on at least X[25] factors for improvement related to the identification of individual patients and care management plans that will be jointly addressed by the Hospital and PCMH Practice	• Gap analysis based on 2011 NCQA PCMH Documentation tracking tool
15. Identify existing clinical and demographic data on target patient population(s) targeted for PCMH Practice.	• Report of clinical data elements that currently exist at each institution for the target patient population	• Electronic medical record databases for each institution and joint team meeting minutes
16. Establish a hospital/ PCMH practice agreement outlining data elements to be tracked for target patient population.	• Report of clinical data elements that currently exist at each institution and data elements that need to be developed for the targeted conditions as agreed upon by parties from both institutions	• Electronic medical record database and joint team meeting minutes

[25] Throughout this document, where "X" appears in relation to project measures and metrics, each hospital electing the measure or metric will specify the appropriate number or percentage within its hospital specific plan. As each hospital has a unique starting place for DSTI projects, the master DSTI plan provides flexibility for each hospital to determine an appropriate level of improvement relative to its own baseline.

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)**
17. Develop a Joint Hospital and PCMH Practice comprehensive plan for care management and coordination including data items to be tracked, clinical roles and agreements, and care management processes among relevant providers in the area.	Select all metrics**:** • Report identifying the roles and community organizations needed to integrate care related to the factors. • Documented agreements between health and health-related entities in the community and the Hospital and PCMH Practice • Map Care Management Processes for Hospital/PCMH Practice patients with targeted chronic conditions • Develop baseline on the percentage of shared patients who have had documented care management/ coordination interventions from hospitals and PCMH practices relating to the selected factors agreed to in the first year (e.g., sharing of treatment plans and other medical interventions, disease specific education administered, medication reconciliation, and psychosocial, economic, environmental, and cultural factors that create barriers to care).	Summaries of consultation between the joint team and professionals from other community agencies. • Reports on shared patients with referrals made to a certified educator for a specific chronic disease • Agreements with health-related entities • Joint Team report • Hospital and PCMH Practice electronic databases

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)**
18. Perform evaluation of implementation plan for care management and coordination.	• Development of evaluation report	• Minutes of Hospital/PCMH Practice executive meetings to review progress on DSTI initiatives
19. Establish baseline data for preventive health measures in participating primary care practices.	• Baseline rate for influenza vaccination	• Internal hospital records/documentation
20. Establish baseline data of hospital and PCMH shared hospitalized patients with a chronic disease who receive a referral to an educator for their chronic condition.	• Baseline measure of hospital and PCMH shared hospitalized patients with a chronic disease who receive a referral to an educator for their chronic condition	• Internal hospital records/documentation
21. Establish a Quality Committee for Primary Care Practice.	• Documentation of QI committee minutes that reviews Quality Dashboard performance	• Hospital Committee minutes

Key Improvement 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**
1. Implement action plan(s) to eliminate gaps in PCMH readiness identified by a nationally recognized entity (e.g., NCQA).	• X percent of plan implemented to address a PCMH readiness standard defined by a nationally recognized entity (e.g., NCQA)	• Internal hospital records/documentation

Key Improvement 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. Apply for PCMH recognition for selected number of primary care sites (e.g., NCQA accreditation).	• Apply for medical home recognition from NCQA for X number of primary care sites	• Documentation of application to nationally recognized agency
3. Address action plan items for seeking Higher Level NCQA PCMH Certification.	• Initiate and improve referral tracking • Establish and document patient self-care and patient education in EMR	• Internal hospital records/documentation
4. Achieve medical home recognition for selected number of primary care sites from a nationally accredited agency (e.g., NCQA).	• Achieve medical home recognition for X number of primary care sites from NCQA	• Documentation of NCQA accreditation
5. Develop patient empanelment to medical home care teams and/or care teams managing panels of patients for targeted number of patients.	• Submission of team structure and team panel size for X number of patients	• Hospital documentation of submission of care team structure for X number of patients
6. Engage patients in practice improvement at increasing number of primary care sites.	• X number of primary care sites have patients engaged in practice improvement activities. X number increase in number of primary care sites with patients engaged in practice improvement activities	• Documentation of defined number sites have patients engaged through minutes of practice improvement activities

Key Improvement 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. Implement a joint plan for efficient care management and coordination and tracking care.	• Reports of key measures of care management and coordination of patients with targeted chronic conditions (e.g., DM, CHF, and COPD). Key measures will include the annual percentage of patients with these conditions that have documented interventions relating to care management and coordination across multiple institutions	• Hospital and PCMH Practice Reporting Tools
8. Increase number or percent of target patient population with a chronic condition who receive a referral to a certified educator for their chronic condition following hospital discharge to home.	• Percentage increase in target patient population with a chronic condition who receive a referral to a certified educator for their chronic condition following hospital discharge to home	• Internal hospital records/documentation
9. Identify system-wide opportunities for PCMH readiness steps and gap closure and increase number of gaps closed over the demonstration years.	• Report on gap closure for key system-wide PCMH readiness steps • Documentation of number of gaps closed • Document X increase in number of system-wide PCMH readiness gaps closed	• Hospital documentation of progress on key PCMH readiness system-wide gap closure elements
10. Work to improve baseline performance and data capture of 1 preventive health measure in selected primary care sites.	• Influenza vaccination rate for population	• Internal hospital records/documentation

Key Improvement 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**
11. Expand performance improvement program to 1 cancer screening measure; ongoing performance improvement in prior year selected measure.	• Improve by X % Influenza Vaccination in participating Primary Care Practices from baseline measure • Measure baseline rate of Cervical Cancer Screening in participating primary care practices	• 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). 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.[26] 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.

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 for managing patients with mental health and substance abuse concerns.[27] 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, the presence of tracking systems and registries to support effective monitoring of patients, the "Stepped Care" approach for appropriate level of treatment, care management for the highest risk patients with mental health and substance abuse disorders, and relapse prevention, among others.[28]

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[26] Druss BG, Reisinger Walker E., "Mental Disorders and Medical Co-Morbidity." *Robert Wood Johnson Foundation, The Synthesis Project:* Issue 21 (2011).

[27] 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 Suiciology 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.

[28] 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*

Project Goal
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.

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

A. Better identify patients needing behavioral health care.

B. Conduct an analysis of the system's behavioral health population.

C. Improve coordination and referral patterns between primary care and behavioral health.

D. Train primary care providers in behavioral health care.

E. 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.

F. 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).

G. Implement physical-behavioral health integration pilots.

H. Implement integrated care models and assess outcomes of the model.

I. Link patients with serious mental illnesses to a medical home or another care management program.

J. Measure patient satisfaction levels of Mental Health/Substance Abuse (MH/SA) Emergency Department patients.

Improvement and Minnesota Family Health Services. Presentation to the Institute for HealthCare Improvement Annual Forum, Dec. 2010.

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. Conduct an analysis of the behavioral health population at the hospital.	• 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	• Internal hospital records/documentation
2. Develop an integrated, collaborative care model for behavioral health patients at primary care sites with co-located behavioral health services using the Stepped model and the Diamond/Impact model as a framework.	• Submission of document describing the integrated care model for behavioral health patients at primary care sites with co-located behavioral health services	• Internal hospital records/documentation
3. Develop recommendations 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.	• Submission of recommended measures to track behavioral health integration in primary care	• Internal hospital records/documentation, such as minutes for ambulatory department or mental health department

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)**
4. Establish baseline for adult diabetes depression screening in primary care-behavioral health integration pilot site(s).	• Establish baseline rates for percent of patients 18-75 years of age with diabetes (type 1 or type 2) who were screened for depression using PHQ-2 or other approved screening instruments during the measurement period at implemented pilot site(s) (NQF 0575)	• Internal hospital records/documentation
5. Receive approval from Department of Public Health to operate remodeled hospital emergency department behavioral health "Psych Pods."	• Approval from DPH	• DPH letter
6. Develop guidelines for management of the behavioral health patients in the hospital ED.	• Signed approval of guidelines by hospital officials	• Documentation of guidelines approval
7. Engage vendor to identify actionable process improvements in treating MH/SA patients in the hospital ED and to collect qualitative data on delivery of care for behavioral health patients.	• Signed letter of agreement with vendor • Vendor report on clinical and administrative interviews	• Copy of letter of agreement • Vendor report
8. Analyze vendor's Final Report detailing actionable recommendations to measurably improve hospital ED process with MH/SA patients.	• Final report	• Final 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)**
9. Develop joint plan to optimize performance processes to integrate behavioral health and physical health between acute care hospital and behavioral health hospital.	• Joint plan	• Documentation of plan
10. Develop guidelines for management of Clinical Assessment Center "secured assessment area" at the hospital.	• Approval of CAC Secured Assessment Area guidelines	• Documentation of guidelines approval
11. Develop plan to expand hospital's Clinical Assessment Center hours to 24/7 by a certain date.	• Plan to expand hospital hours to 24/7	• Documentation of plan
12. Develop plan to deploy a "psychiatric provider of the day" to the hospital ED.	• Plan to deploy psychiatric provider to hospital ED	• Documentation of plan
13. Designate a "psychiatric provider of the day" to be deployed at the hospital ED.	• Provider work schedule	• Documentation of provider work schedule
14. ED-based Screening, Brief Intervention and Referral to Treatment "SBIRT" social workers re-assigned to MSW case manager clinical supervision.	• New SBIRT Position Description	• Documentation of new SBIRT position description
15. Develop MH/SA Patient Registry for patients who visit the hospital ED.	• MH/SA Patient Registry	• Documentation of MH/SA patient registry
16. Determine baseline satisfaction levels for at least X number or percent of MH/SA ED patients and all appropriate ED clinical staff.	• Completed surveys	• Documentation of completed surveys

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)**
17. Document baseline ED performance on cost and quality measures related to MH/SA patients.	• Vendor report on hospital ED performance	• Documentation of vendor's report
18. Establish baseline for the percentage of Emergency Department "High-End" Utilizers assessed for MH/SA issues.	• Percentage of Emergency Department "High-End" Utilizers assessed for MH/SA issues	• Documentation of ED "High-End" Utilizers assessed for MH/SA issues
19. Identify specific data elements for MH/SA Patient Registry.	• Data elements for MH/SA Patient Registry	• Documentation of data elements for MH/SA patient registry

Key Improvement 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**
1. Implement collaborative, integrated care model at X number of primary care sites with co-located behavioral health services. Hospital may implement model at increasing number of sites over the demonstration period.	Implement collaborative, integrated care model at X number of primary care sites co-located with behavioral health services as demonstrated by: • Submission of documents demonstrating number of primary care and behavioral health team members trained at primary care site(s) • Submission of meeting dates documenting collaborative meetings to review patient cases between primary care and mental health staff at the primary care site(s) • Scheduling documentation	• Internal hospital records/documentation

Key Improvement 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**
	demonstrating co-location of behavioral health staff at primary care site(s) • Establishing baseline rates for related screening for a behavioral health condition at pilot site(s) such as the use of the following example measure for depression screening: ➢ Percentage of patients 18 years of age or older receiving depression screening through the use of PHQ-2 or other approved screening instruments during the measurement period (NQF 0712)	
2. Assess outcomes of collaborative care model at primary care site with co-located behavioral health services.	• # of consultations or visits for BH conditions completed at primary care site by co-located behavioral health clinicians	• Internal hospital records/documentation
3. Increase the number of collaborative care model elements implemented at primary care-behavioral health integration pilot site(s).	• Increasing # of collaborative care model elements implemented at primary care-behavioral health integration pilot site(s)	• Internal hospital records/documentation, including documentation and data that collaborative care model elements have been implemented, including data on depression screening

Key Improvement 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**
4. Improve adult diabetes depression screening rates at pilot site(s).	• Document X percentage improvement over established baseline rate for percent of patients 18-75 years of age with diabetes (type 1 or type 2) who were screened for depression using PHQ-2 or other approved screening instruments during the measurement period at implemented pilot site(s) (NQF 0575)	• Internal hospital records/documentation
5. Deploy MH/SA case manager with Master's-level social work training to the hospital ED.	• Placement of Masters level clinician in hospital ED	• Position description
6. Implement patient satisfaction survey to X additional MH/SA ED patients above baseline.	• Completed patient satisfaction survey	• Vendor surveys of hospital ED patients
7. Percentage of Emergency Department "High-End" Utilizers assessed for MH/SA issues.	• X percent increase in percentage of Emergency Department "High-End" Utilizers assessed for MH/SA issues	• Documentation of ED "High-End" Utilizers assessed for MH/SA issues
8. Expand hospital's Clinical Assessment Center (CAC) schedule of operations to 24 hours per day, 7 days per week.	• CAC schedule of operations are 24/7	• CAC schedule of operations

Project 1.3 Further Develop Integrated Care Network for Primary and Specialty Care

Project Goal

This project is oriented to enhancing access and reducing barriers and shortages in primary and specialty care so that the local community has adequate capacity for successful development of a more fully integrated delivery system, and patients have local provider options in place of more costly health care alternatives for physician access (such as emergency rooms or out-migration for care at more costly settings). The existing capacity of primary care physicians in the Commonwealth is insufficient. The 2011Workforce Study by the Massachusetts Medical Society indicated that less than 50% of primary care physicians were accepting new patients.[29] Through greater access and availability of physicians and caregivers within the local community, the local network of caregivers affiliated with the system will be enhanced and advance delivery system development and further integration. Inadequate access to specialty care and primary care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Develop a PCP network focused on patient centered medical home (PCMH) delivery models, as a key element of an integrated delivery system.

B. Establish clerkship affiliation agreements and corresponding curricula with medical schools for students interested in primary care and internal medicine.

C. Conduct a gap analysis of the integration of care management and coordination among hospitals and affiliated physician practices.

D. Conduct gap analyses and/or identify primary and specialty services that are lacking in the community in order to meet demand and more fully integrate care at the local level.

E. Conduct interviews of key referral staff and care coordinators of local practices to define the care needs of the community.

F. Develop a multi-year plan and programs to alleviate identified provider shortages and close gaps in the continuum of care.

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. Establish committee to support primary care access projects.	• Committee membership list and charge	• Documentation of committee membership list and charge

[29] "Physician Workforce Study." *Massachusetts Medical Society.* (Sep. 2011) p. 73.

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. Assess primary and specialty provider care coverage across the continuum. This will assure patient access to PCPs in a timely manner.	• Identify the need for primary and specialty care services using national benchmarks for primary care panels and community size • Conduct interviews of key referral staff and care coordinators with X percent of local primary care practices who rely primarily on the hospital for their patient care needs in order to confirm specialty care access gaps • Development of access protocols • Development of staffing plan for non-PCP providers to facilitate access • Development of a report to assess current ability to measure access and an assessment of reporting methodologies • Complete study on regional PCP supply, demographics, and succession planning	• Copy of gap analysis • Report of the access issues faced by underserved population
3. Develop a plan(s) to address identified provider shortages and to close gaps in the continuum of care.	Metrics may include: • Based on gap analysis, prepare a multi-year plan to address identified provider shortages and to close gaps in primary and specialty care • Develop a recruitment/ retention plan for primary	• Plan document • Recruitment plan for residency graduates • IDX Practice Management • Space Assessment

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 providers
	• Establish clinical programs with affiliate partners or independently to address 2 specialty care gaps identified and confirmed in the baseline report
	• Develop a plan to expand physical space for primary care and / or specialty care services
	• Develop a plan(s) with the following core elements:
	  • Market based needs assessment
	  • Provider recruitment plan to include projected location, ramp up, and support needs
	  • Development of separate midlevel plan to include team based medical care
	  • Space needs and acquisition plan
	  • Development of access protocols
	  • Identify staffing needs of non-PCP providers to facilitate access
	  • Develop a report of current ability to measure	

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)**
	access and assessment of new reporting methodologies • Work with the independent local health center and joint residency program leadership to develop a plan to recruit graduates to remain in the area (the plan may include practice placement, real estate consultation, and loan forgiveness)	
4. Assess efficacy of the new clinical programs established in Year 2 (time to first available appointment).	• Assessment of new clinical programs established in Year 2 (time to first available appointment)	• Reports on time to first available appointment Reports on time to first available appointment
5. Identify ongoing barriers to specialty care access for the hospital's populations.	• Prepare report on access to specialty care compared to baseline report to determine improvements and continue to inform the 3-year plan	• Specialty care access report
6. Begin expansion of physical space for primary care and specialty care services.	• Building permit	• Documentation of building permit

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. Establish a 4th Year Clerkship for medical students interested in primary care and internal medicine (measures may include establishing affiliation agreements, creating a curriculum, and gaining approval from the medical school).	• Executed affiliation agreement with the medical school • Completion of curriculum approval by the medical school	• Documentation of affiliation agreement • Completion of curriculum • Documentation of medical school approval of the 4th Year Clerkship site
8. Report on the number of 4th-Year Clerkship Students that select hospital as their Clerkship Site.	• 4th-Year Clerkship List of medical school students who select hospital as Clerkship Site	• Documentation of 4th-Year Clerkship List of medical school students who select hospital as Clerkship Site
9. Develop a plan to incorporate outpatient placements to be included as part of the 4th Year Clerkship program.	• Completion of outpatient placement plan	• Documentation of plan
10. Implement same day access plan across X number of PCP practices.	Metrics may include: • Establish baseline number of same day appointments available on average across the system • Establish baseline number of patients seen by non-PCP providers per month • Establish baseline number of express care volume in hospital Emergency Department for PCP practice patients • Develop ability to track 3rd next available appointments	• Internal hospital records/documentation • Practice management system, internal space 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)**
11. Establish baseline for the number of referrals to PCPs for Emergency Department patients that were unable to identify a PCP at time of ED Admission.	• The number of referrals to PCPs for Emergency Department patients that were unable to identify a PCP at time of ED Admission	• Documentation of PCP referrals
12. Establish baseline to measure time to 3rd next available appointment for specialty and/or primary care.	• Survey of specialty and/or primary care practices to measure baseline time to 3rd next available appointment	• Internal hospital records/documentation

Key Improvement 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**
1. Develop a program to alleviate identified provider shortages and to close gaps in the continuum of care.	• Establish a clinical program (s) with affiliate partners, or independently, to address X number of specialty care gaps identified and confirmed in the baseline report	• Hospital contracts with clinical affiliates or agreements with specialists
2. Implement Year 1 objectives of the multi-year plan.	• Meet recruitment target of X in primary care and specialty care • Establish X additional clinical programs to address gap in specialty care	• Report on Year 1 Plan actions • Documentation of establishment of clinical program
3. Launch 4th Year Clerkship for medical students at the hospital.	• X number of medical students select the hospital as clerkship site	• List of students participating in clerkship program

4. Complete expansion of physical space for primary care and specialty care services.	• Certificate of occupancy	• Documentation of certificate of occupancy
5. Implement PCP recruitment and retention strategy.	• Progress report detailing PCP recruitment and retention strategy	• Documentation of recruitment and retention
6. Increase number of clinical programs to address specialty care gaps.	• X number of additional clinical programs to address specialty care gaps is/are established	• Hospital contracts with clinical affiliates or agreements with specialists
7. Extend "same day" access plan to increase access to PCP and non PCP providers in X number of sites.	• X number of sites implement "same day" access plan • Hours of operations of same day access project • Number of same day visits available across system • Express care volume in hospital Emergency Department for PCP practice patients	• Growth Strategy Plan • Practice management system, internal space data
8. Increase number of PCPs and/or mid-level providers above previous year.	• Total number of PCPs and/or mid-level providers increased over number present from previous year independent of any PCP/mid-level provider who leaves employment of hospital	• IDX Practice Management • Provider Recruitment plan

9. Acquire space for providers based on PCP Access Plan.	• Implement space plan based on PCP space requirements and total number of growth of primary care across the medical group • Documentation of plan with following core elements: 1. Market-based needs assessment 2. Provider recruitment plan to include projected location and support needs 3. Development of separate midlevel plan to include team based medical care 4. Space needs and acquisition plan	• IDX Practice Management • Provider Recruitment plan
10. Assess provider panels as compared to established benchmarks (details will be incorporated into hospital-specific plans).	• Demonstrate ability to report on individual PCP panels relative to established benchmarks to assure providers have appropriate capacity	• IDX Practice Management • Provider Recruitment plan
11. Increase mid-level PCP partnering contract with additional PCP providers as per plan.	• Demonstrate increase in mid-level primary care appointments as compared to prior year by X percent	• IDX Practice Management • Provider Recruitment plan
12. Increase the number of referrals to PCPs for Emergency Department patients that were unable to identify a PCP at time of ED Admission.	• X% increase in the number of referrals to PCPs for Emergency Department patients that were unable to identify a PCP at time of ED Admission	• Documentation of PCP referrals

13. Improve specialty care time to 3rd next available appointment for target patient population.	• X % improvement in measure of time to 3rd next available appointment for specialty care for target patient population	• Internal hospital records/documentation • Report on Year 1 Plan action items

Project 1.4 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) 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.

Aggregating and warehousing this data is critical as a foundation for an integrated delivery system. 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

DSTI hospitals undertaking this project may select from among the following project elements:

A. Conduct environmental scan and identification of requirements and technical needs to 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.

B. Establish governance structure for management of data exchange tool(s), which shall include physician champions and key stakeholders representing care settings that will have access to—and provide information for—the data exchange tool(s).

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

C. Identify best practices surrounding privacy, security, data ownership and stewardship and develop a comprehensive policy and protocol document that address security and governance issues.

D. Design and determine how clinical shared data will be submitted, processed, and stored.

E. Educate community providers, develop educational materials for participants, and adopt and use a patient consent form.

F. Select and define a set of data elements, metrics, and other health information that will facilitate integrated patient care for one or more or more preventive, primary, routine and chronic care needs.

G. Develop a plan to collect and aggregate the data, which may include initial paper collection, but which will lead to a data exchange warehouse.

H. Build a data exchange warehouse and reporting functionality.

I. Develop and implement a training program for identified providers on use of the data exchange.

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. Establish governance structure for a health information exchange with community physician champions.	• Governance Committee created with community physician involvement	• Information Systems Steering Committee
2. Identify potential stakeholders and participants for a health information exchange within the hospital-affiliated practices.	• List of hospital-affiliated providers committed to participating in the health information exchange	• Governance Committee
3. Provide education of health information exchange data-sharing models, privacy, and security concerns and regulations.	• Continuing medical education program for community providers	• Compliance, Legal, Director of Information Technology

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)**
4. Research privacy, security, and data ownership and stewardship best practices.	• Policy documentation for privacy, security, and data ownership	• Compliance, Legal, Director of Information Technology
5. Determine how clinical shared data will be submitted, processed, stored and used within the health information exchange system.	• Description of the clinical data architecture with technical diagram	• Governance Committee
6. Develop policy and protocol documentation on how data exchange issues such as interface and connectivity problems will be resolved.	• Completion of policy and protocols documentation for the resolution of data exchange	• Information systems
7. Develop educational materials relating to patient data sharing in the area of privacy, security, and data retention.	• Production of training materials to be provided to participating providers	• Compliance, Governance Committee, Legal, Information Systems
8. Perform workflow review of appropriate methodology for obtaining patient consent for inclusion in the health information exchange.	• Documentation of workflow for patient consents to implement an appropriate patient consent form to all users of the electronic health exchange	• Compliance, Legal, Governance Committee, internal EHR systems and records, hospital provider EHR 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)**
9. Select a set of preventative measures, including screening tests and immunization in adult medicine that will be aggregated in a pilot test. Preventative measures shall include, but not be limited to: • Blood Pressure Screening in Adults • Breast Cancer Screening • Cervical Cancer Screening • Cholesterol Abnormality screening in men 35 and older • Cholesterol Abnormality screening in women 45 and older • Colorectal Cancer Screening.	• Documentation of the selected measures, based on the United States Preventative Services Task Force recommendations for adults	• Measure examples
10. Provide baseline data with compliance for the 6 identified USPSTF adult preventative tests.	• Provide currently measurable baseline compliance for breast, cervical and colorectal cancer, cholesterol screening in men and women, and blood pressure screening for all PCPs	• Internal electronic health record (EHR) system and records; hospital-affiliated providers EHR 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)**
11. Design and pilot test a paper-based form that aggregates preventative testing results in one adult primary care practice.	• Narrative summary of the pilot process authored by the provider who participated in the pilot	• Summary narrative of pilot program
12. Develop a data aggregation tool that will be used to present adult preventative test results data.	• Documentation of the data aggregation tool	• Written data warehouse house plan • Written data warehouse schema
13. Create a plan to build a data warehouse that would replace the paper form and build the data warehouse in a test environment.	• Written plan describing structure and functionality of the data warehouse in the test system • Written document outlining exported tables of preventative care data and the data base scheme for the warehouse	• Written data warehouse house plan • Written data warehouse schema

Key Improvement 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**
1. Integrate X number or percent of hospital-affiliated system providers into the electronic information exchange.	• X percent increase in the number of providers who opted into the health information exchange	• Internal electronic health record (EHR) system and records; hospital-affiliated providers EHR records
2. Pilot test the electronic aggregation tool for reporting preventative test results in X adult primary	• X percent reduction in missing preventative testing for one or more measure by PCP at piloted practice site	• Internal electronic health record (EHR) system and records; hospital-affiliated providers EHR records

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
care provider sites.	• X percent increase in number of patients who completed a particular preventative measure by PCP at piloted practice site • Develop report of percent of providers who access the HIE • Develop report of percent of unique patient encounters where provider obtained data from the HIE • Sample report on the number/percentage of patients in a specific provider practice who have preventative testing completed for one test	• Sample reports generated by data warehouse

Project 1.5 Practice Support Center

Project Goal

This project's goal is to design and implement a dedicated practice support call center to improve the patient experience in the primary care setting, 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 endurable, scalable, and flexible support system to better support patients and providers in a high-quality, cost-efficient, integrative model. The Practice Support Center will provide support through the development of scheduling protocols and work flows, utilizing Patient Care Assistants that will streamline administrative practice workflow, thereby allowing clinicians to operate at the top of their license. Performance standards and monitoring will be incorporated, and the Practice Support Center leadership will work collaboratively with the Practice Operations Management.

The Practice Support 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 also be supported by preparing patients for their visits during visit reminder calls, performing outreach functions for patients with important care gaps, and improving population management with outreach for chronic care. As such, the Practice Support Center will serve a key outreach function of the hospital primary care practice(s)' PCMH.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Develop a Patient/Practice Call Center that enhances patient access while providing necessary support for clinical staff.

B. Provide real time patient demand matching with scheduling capacity.

C. Identify issues and barriers associated with scheduling and developing a plan to improve patient continuity.

D. Identify issues and barriers associated with patient failure to show for scheduled appointments and develop plan for decreased no-show rates.

E. Identify pertinent clinical information and develop plan to include it for the physician for the scheduled appointment.

F. Measure and improve patient service performance.

G. Recruit clinically trained staff with multiplicity of skill sets to better direct patient needs.

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 staffing plan and recruitment of appropriate number of Patient Care Assistants.	• Copy of job descriptions • Copy of staffing schedule based on call analysis and demand	• Internal hospital records/documentation
2. Designate and design space plan for Practice Support Center.	• Copy of space plan that includes IT, telecom, furniture, etc.	• Hospital and department project plans
3. Develop training curriculum program for Patient Care Assistant staff.	• Training plan and curriculum document	• Department training plan and orientation
4. Complete staffing and open Practice Support Center for incoming calls.	• Practice Support Center open to accept inbound scheduling calls	• Internal hospital records/documentation
5. Establish baseline level of calls to track increases in call volumes.	• Average number of fielded calls	• Internal hospital records/documentation
6. Develop and collect baseline data set of key measures (e.g., call volume, service level, abandonment rate, patient satisfaction, appointment access.	• Document one action plan for an outreach effort for a care gap	• Internal hospital records/documentation
7. Develop understanding of baseline measures for reasons patients are calling.	• Report on most common reasons for call and distribution of calls in each grouping	• Internal hospital records/documentation
8. Develop understanding of patient access.	• Report on no-show rate and patients seen per session (measure of practice efficiency)	• Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
Milestone	**Metric(s)**	**Data Sources**
1. Expand call center capacity by X percent over baseline.	• Average number of fielded calls compared to baseline	• Internal hospital records/documentation
2. Track key measures for which baselines are developed (e.g., call volume, service level, abandonment rate, patient satisfaction, appointment access.	• Track change in baseline for measure (e.g., call volume, service level, abandonment rate, patient satisfaction, appointment access))	• Internal hospital records/documentation
3. Develop reporting tool to identify number of patients seen in primary care within time after inpatient discharge.	• Copy of baseline data	• Internal hospital records/documentation
4. Complete action plan for meaningful improvement of percent of patients seen in primary care within X time after inpatient discharge.	• Copy of report indicating % of patients seen in primary care within X times after discharge	• Internal hospital records/documentation
5. Develop meaningful implementation of outbound call effort related to one chronic care condition or preventative care gap.	• Percent of patients reached by phone with unfulfilled preventative care gap	• Internal hospital records/documentation
6. Improve patient access.	• Decrease no-show rate by X% from baseline data	• Internal hospital records/documentation
7. Improve patient experience in getting through to the practice by phone.	• Improve patient satisfaction in "ease of getting through to the practice by phone" by x %.	• Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
Milestone	**Metric(s)**	**Data Sources**
8. Implement quality assurance and monitoring program with target measures.	Target measures: • X percent of calls answered within X seconds; and • less than X percent of calls abandoned	• Internal hospital records/documentation
9. Expand outbound call program to provide reminder calls with target measure.	• Staff will contact X percent of scheduled patients to confirm appointment and review clinical information	• Internal hospital records/documentation
10. Select appropriate Press Ganey Survey question(s) to trend and target for patient experience improvement.	• Identification of patient survey questions selected • Report results of survey questions	• Internal hospital records/documentation

Project 1.6 Implement Patient Navigation Services

Project Goal

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 navigators will help and support these patients, especially in need of coordinated care, navigate through the continuum of health care services. Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators 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, needed to engage patients in a culturally and linguistically appropriate manner that will be essential to guiding patients through fully integrated health care delivery systems.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Establish or expand health care navigation services.

B. Train health care navigators in cultural competency.

C. Deploy innovative health care personnel, such as patient navigators, case workers, and community health workers.

D. 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).

E. Connect patients to primary and preventive care.

F. Increase access to care management and/or chronic care management, including education in chronic disease self-management.

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. Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care.	• Number of patients enrolled in the patient navigation program • Number of Patient Navigators hired	• Documentation of Patient Navigation program

Key Process Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
2. Provide care management/navigation services to targeted patient group (e.g., high utilizers of ED services).	• Number of targeted patients enrolled in program/receiving Patient Navigation services • Number of uninsured and under-insured patients receiving Patient Navigation services • Percent of patients entering ED assisted	• Patient Navigation activity reports
3. Increase patient engagement, such as through patient education, self management support, improved patient-provider education techniques, and/or coordination with community resources.	• Number of classes and/or initiations offered • Number/ percent of patients enrolled in the program • Number/ percent of patients attending courses	• Class lists or other hospital reports

Key Process Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
4. Provide navigation services to patients using the ED for episodic care.	Potential metrics (select at least one): • Number/percent of patients without a primary care provider who received education about a primary care provider in the ED • Number/percent of patients without a primary care provider who were referred to a primary care provider in the ED • Number/percent of patients without a primary care provider who are given a scheduled primary care provider appointment • Number/percent of patients with a primary care provider who are given a scheduled primary care provider appointment	• Internal hospital records/documentation
5. Conduct analysis of patient knowledge / service assistance gaps.	Gap analysis status: • Project plan • Vendor hired • Completion	• Documentation of process
6. Identify needed skill set needed for patient navigators.	• Completed job description with identified skills	• Documentation of job description
7. Hire community health workers / patient navigators.	• Interviews • Number of navigators on site	• 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.*		
8. Train community health workers / patient navigators in core knowledge, skills, self-efficacy, and cultural competency.	• X% of hires trained • Pre and post-test results ➢ % Improvement ➢ X% at threshold score	• Attendance records • Pre and post-test results
9. Provide continuing education and evaluation of community health workers / patient navigators in core knowledge, skills, self-efficacy, and cultural competency.	• % of navigators attending continuing education • Pre and post-test results ➢ % Improvement ➢ X% at threshold score	• Attendance records • Pre and post-test results
10. Develop process for making patient referrals.	• Completion of ED patient referral policy • Patient navigator training on ED referral policy	• Internal hospital records/documentation
11. Create patient satisfaction survey.	• Completion of patient satisfaction survey for patients receiving navigation services	• Patient satisfaction survey
12. Identify ED top users.	• Identification of X number of top ED utilizers	• Internal hospital records/documentation
13. Develop plan to address identified gaps and barriers.	• Future State Process Map	• Documentation
14. Establish baseline / monitor number of patients targeted for services.	• Number of targeted patients	• Hospital records

Key Improvement 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**
1. Schedule primary care appointments from an ED, Urgent Care, or hospital department.	• Number/percent of patients discharged • Number/percent of patients receiving navigation services	• Internal hospital records/documentation
2. Measure ED visits and/or avoidable hospitalizations.	• Percent of patients enrolled in the navigator program who have had an ED visit or an inpatient admission • Percent of ED visits classified as avoidable/unnecessary	• Internal hospital records/documentation
3. Improve appropriate ED utilization.	• X% reduction in frequent user ED visits • X% reduction in unnecessary ED visits	• Internal hospital records/documentation
4. Improve primary care utilization.	• X% increase in primary care utilization from those discharged from ED • X% increase in primary care utilization from those receiving navigation services	• Internal hospital records/documentation
5. Improve ED patient satisfaction.	• Above threshold • X% improvement	• Press Ganey
6. Improve patient navigator.	• X% of improved knowledge and/or self-efficacy	• Test scores

Project 1.7 Develop Integrated Acute and Post-Acute Network Across the Continuum of Care

Project Goal

This project will integrate patient care between acute 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 is enhanced and providers are transformed to an integrated system capable of managing care along the entire care continuum. Hospitals selecting this project will develop integrative partnerships with post-acute care providers 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 functioning as an accountable care entity able to accept alternatives to fee-for-service reimbursement for entire episodes of care.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Identify significant post-acute providers for patient population.

B. Develop integrative partnerships with post-acute care provider.

C. Deploy personnel to provide enhanced oversight of acute to post-acute care transitions.

D. Develop / implement electronic medical record technology to connect acute and post-acute records.

E. Develop/ implement integrative protocols for regular communications between acute and post-acute setting.

F. Identify gaps in post-acute care.

G. Assist post-acute partners in targeted improvement efforts.

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. Identify post-acute care needs of patient population.	• Recommendations	• Internal hospital records/documentation
2. Identify potential post-acute partners.	• Analysis / recommendations	• 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.*		
3. Execute partnership agreements with post-acute providers.	• Number of partners • Number of patients to be covered	• Agreement
4. Hire personnel to serve as acute to post-acute care experts.	• Number of interviews • Number of personnel on site	• Internal hospital records/documentation
5. Implementation of EMR.	• Number of sites wired	• Internal hospital records/documentation
6. Staff training on EMR.	• X% of hires trained • X% attendance in training sessions • Pre and post-test results ➢ X% improvement ➢ X% at threshold score	• Attendance records • Pre and post-test results
7. Evaluate post-acute partners / gap analysis.	• Evaluation report	• Internal report and recommendations

Key Improvement 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**
1. Coordinate primary, acute, behavioral health, and long-term services of patients in long-term post-acute care.	• Number of patients receiving coordinated care from post-acute setting	• Internal hospital records/documentation
2. Reduce 30 day all cause readmissions.	• X % reduced hospital readmissions • X% reduced readmissions from specified post-acute setting	• Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
3. Use integrative EMR in post-acute setting.	• X% utilization by post-acute staff • Number of post-acute settings using integrative EMR	• Internal hospital records/documentation
8. Identify barriers to use of EMR in post-acute setting.	• Report of identified barriers	• Internal report and recommendations

29. **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.[30] 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.[31]

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.[32]

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.[33] Factors inside health care organizations needed to improve care include strong leadership for safety, an organizational

[30] 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.
[31] 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.
[32] 5 Million Lives Campaign. "Getting Started Kit: Improved Care For Patients with Heart Failure How- To-Guide." *Institute for Healthcare Improvement*. 2008.
[33]Kohn L, Corrigan J, and Donaldson M, Editors. "To Err Is Human: Building a Safer Health System." *Institute of Medicine*. 2000.

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 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.[34]

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.[35]

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

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.

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[36]).

C. Assess common barriers for chronic disease patients to access necessary care and manage their chronic disease effectively using survey or focus group tools (e.g., the Institute of Chronic Illness Care's Patient Assessment of Care for Chronic Conditions—PACIC[37]).

D. Design and implement system for identifying chronic disease patients with difficulty managing their chronic disease.

E. Implement care management intervention(s) targeting one or more chronic disease patient

[34]Rabe KF, Hurd S, et al. "Global Strategy for the Diagnosis, Management and Prevention of COPD." *Global Initiative for Chronic Obstructive Lung Disease* Revised 2011.

[35] 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.

[36] 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.

[37] PACIC measures specific actions or qualities of care, congruent with the chronic care model, that patients report they have experienced in the delivery system.

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

populations. Examples of interventions include, but are not limited to, implementation of:

- Patient and family education initiatives, using evidence-based strategies such as:
  - Teach-back—to reinforce and assess if patient or learner is understanding
  - Patient self-management coaching.
  - Medication management
  - Nurse and/or therapist-based education in primary care sites or patients' homes
  - Standardized teaching materials available across the care continuum.
- Chronic disease management education programs for primary care, emergency department, homecare, skilled nursing facility, and/or health center staff.
- Chronic disease care management protocols (e.g. standing orders, risk-assessments prior to discharge, medication management, etc.).
- Pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers.[38]
- Systems to schedule and track rapid follow-up appointments with primary care physicians, specialists, and/or homecare providers following an inpatient or emergency department discharge.

F. Evaluate the intervention(s)' impact on care management process improvements, patient clinical indicators, and quality.

G. Identify "lessons learned," 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.

[38] Smith M, Bates DW, Bodenheimer T, Cleary P. "Why pharmacists belong in the medical home." *Health Affairs*, 2010; 29(5):906–913.
[38],Crosby J, Grundy P, Rogers E. "Integrating Comprehensive Medication Management to Optimize Patient Outcomes." *Patient-Centered Primary Care Collaborative Medication Management Task Force.* 2010.
[38] Giberson S, et al. "Improving Patient and Health System Outcomes through Advanced Pharmacy Practice, A Report to the U.S. Surgeon General. Office of the Chief Pharmacist." *U.S. Public Health Service* Dec. 2011.

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. 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.	• Documentation of defined patient population	• Internal hospital records/documentation
2. Develop patient registry or manual logs to track target patient population with chronic disease/condition.	• Working registry as evidenced by monthly reporting of target patient population admissions and readmissions	• Hospital EHR and data warehouse
3. Develop care protocols, policies and/or procedures to be followed for the target patient population with a chronic disease/condition.	As evidenced by one or more of the following: • Documentation in the Hospital Meeting minutes of the creation and approval of said protocols, or • Copy of approved protocols, policies and/or procedures	• Internal hospital records/documentation
4. Share chronic disease care protocols for target patient group with community partners to improve care and communication across the continuum of care.	• Identify community partners who will be vital to the chronic disease program • Utilizing the patient registry, reports will be developed to report on outcomes as they relate to patients referred to local partners for follow-up	• Internal hospital records/documentation
5. Implement program to schedule follow-up appointments with primary care physicians and/or specialists scheduled prior to discharge.	• Reports from registry will be created to monitor discharge and the scheduling of follow-up care with the appropriate clinicians	• 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)**
6. Provide a risk assessment to target patient population with chronic disease/condition.	• Risk assessment documented in patient record and registry to provide appropriate post-discharge services	• Hospital Project Coordinator, Case Management, Information Systems
7. Make follow-up appointments for minimum number/ percentage of target patient group with a chronic disease/condition prior to discharge.	• As documented by hospital report showing appointments made prior to discharge	• Electronic discharge instructions, patient registry
8. Target patient population with chronic disease/condition will be monitored to ensure adherence to the recommended medication regimen, unless contraindicated.	• As measured by the # of patients adhering to the recommended medication regimen compared to the total number of patients following a medication regimen – using the patient registry	• Internal hospital records/documentation
9. Analyze hospital data to establish a baseline on "all cause" readmissions for target patient group with a chronic disease/condition.	• Monthly tracking of all cause readmissions with subset of primary or diagnostic code of identified chronic diseases	• 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)**
10. Develop and implement patient training programs, education, and teaching tools for the target patient group to help them self-manage their chronic disease/condition (e.g., "teach-back" method, training on use of medical equipment, etc.).	Metrics may include: • Assess, select, and/or develop patient education tools based on nationally recognized tools previously developed • Development of tool for documenting the existence of patient's self-management goals in patient record for patients with chronic disease(s) at defined pilot sites(s) • Establishment of training programs developed and conducted by clinicians	• Internal hospital records/documentation
11. Identify number of patients with self-management goals.	• Document baseline measure of number of patients with self-management goals in patient record for patients with chronic disease(s) at defined pilot site(s) • Develop tool for documenting patient self-management goals in patient record	• Internal hospital records/documentation
12. Develop and deploy educational materials and/or training programs for clinical staff related to specific chronic disease/condition.	• Documentation of education materials and training programs • # of staff trained	• 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)**
13. Implement a pilot to improve care management of target patient group with a chronic disease/condition at primary care sites.	• Copy of specific disease management protocol • Schedule of patient teaching/education sessions led by clinician or pharmacist	• Internal hospital records/documentation
14. Design and implement system, including the establishment of an internal working group, to identify Emergency Department patients who have difficulty managing a chronic disease/condition.	• Documented parameters/criteria for identifying patients with barriers to managing a chronic condition • Working group membership list and meeting schedule	• Internal hospital records/documentation
15. Identify common complications and develop tracking tool of the same that could directly relate to increased Emergency Department visits or an uncontrolled chronic disease (e.g., diabetes).	• Chronic disease tracking tool	• Internal hospital records/documentation
16. Identify additional needs of patients with chronic conditions to develop further strategies for care management including strategic partnerships with vendors, community agencies, and others to expand quality of care across the continuum.	• Documentation of identified additional needs • Documentation of identified partners	• 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)**
17. Establish a medical record tracking system for target patient group.	• Hospital electronic record flagging system • Documentation of list of hospital providers involved in care of patients with certain chronic conditions	• Hospital electronic health record
18. Design a process to facilitate treatment and rapid referral of patients who present at the Emergency Department with non-urgent chronic disease management needs that includes coordination with hospital outpatient clinic.	• Documentation of referral protocol	• Internal hospital records/documentation
19. Regularly assess, update, and improve care management approaches/programs for patients with a chronic disease/condition.	• Documentation of assessments and updated protocols/programs	• Internal hospital records/documentation
20. Create process measures to track patient compliance (e.g. preventable inpatient admissions, patients participating in chronic disease management program, follow-up appointment scheduling, no-shows).	• Documentation of medical record tracking system to follow outcomes of patient referrals • Baseline measurement of percentage of patients discharged with a chronic disease diagnosis who complete a scheduled follow up within X days of discharge.	• Internal hospital records/documentation • Internal electronic health record (EHR) system and records; hospital-affiliated providers EHR 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)**
21. Establish baseline percentage of patients who were discharged with a targeted chronic disease diagnosis (e.g. heart failure, COPD, etc.) who answered that they agree or strongly agree to the question, "Did staff take my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I leave the hospital?"	• Baseline percentage of patients who were discharged with a targeted chronic disease diagnosis (e.g. heart failure, COPD, etc.) who answered that they agree or strongly agree to the question, "Did staff take my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I leave the hospital?"	• Patient follow-up phone call responses

Key Improvement 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. 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).	• Follow up calls will be documented in the outpatient EHR as evidenced by documentation of a sample of 10 charts or chronic disease log	• Hospital Access Coordinator, Information Systems • Where possible, follow-up call documentation will reside within the patient registry; otherwise logs documenting follow-up phone calls will be created and made available for auditing
2. 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.	• As measured using reports created from the patient registry /manual log	• Hospital Task Force, Information Systems for all patients

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
3. Number/percent of target patient group with a chronic disease/condition that has a risk assessment.	• Risk assessments documented in patient record and patient registry	• Hospital Access Coordinator, Case Management, Information Systems
4. Number/percent of target patient group with a chronic disease/condition that have follow-up appointments made prior to discharge.	• As evidenced by hospital reports	• Electronic discharge instructions; patient registry
5. Number/percent of target patient group who complete a scheduled follow up within 7 days of discharge.	• X percent increase over baseline measurement	• Internal electronic health record (EHR) system and records; hospital-affiliated providers EHR records
6. Increase in number/percent of patients with self-management goals for patients with chronic disease(s) at defined pilot site(s) compared to baseline.	• X number or percent increase in number of patients with self-management goals in patient record • Measurement and reporting of number of patients with self-management goals in patient record for patients with chronic disease(s) at defined pilot site(s) compared to baseline	• Internal hospital records/documentation
7. Increase in number of primary care sites to implement a chronic disease training program for clinicians.	• Copy of training program • Records that training has occurred	• Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
8. Increase in number of primary care sites piloting a care management model/approach for target patient group with a chronic disease/condition.	• Copy of specific disease management protocol • Schedule of patient teaching/education sessions led by clinician or pharmacist	• Internal hospital records/documentation
9. Number /percent of selected clinicians (e.g., RNs, pharmacists, RTs, etc.) educated on chronic disease program.	• X number or percent of selected clinical staff educated on chronic disease program	• Attendance records on education
10. 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, medication management or other intervention.	• Number or percent of patients contacted for intervention	• Internal hospital records/documentation
11. Track number of chronic disease inpatient admissions for specified chronic disease, such as HF, COPD, diabetes, depression, etc.	• X percent decrease in the number of chronic disease inpatient admissions over measurement period	• Internal hospital records/documentation
12. Track percent of patients who participate in select chronic disease program.	• X percent increase in the number of patients participating in select chronic disease program	• Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
13. Using chronic disease tracking tool developed in Year 1, assess prevalence of diabetes complications in patients presenting for evaluation at their first follow-up appointment.	• Analysis of data captured by chronic disease tracking tool	• Internal hospital record/documentation
14. Expanding on identified complications and/or comorbidities to measure the percentage of follow-up care in the appropriate care settings in select clinics.	• Documentation of follow up visits in all identified outpatient clinics	• Internal hospital records/documentation
15. Percentage of patients who were discharged with a targeted chronic disease diagnosis (e.g. heart failure, COPD, etc.) who answered that they agree or strongly agree to the question, "Did staff take my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I leave the hospital?"	• X percent increase in the number of patients who were discharged with a targeted chronic disease diagnosis (e.g. heart failure, COPD, etc.) who answered that they agree or strongly agree to the question, "Did staff take my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I leave the hospital?"	• Patient follow-up phone call responses

Project 2.2: Establish a Chronic Disease Registry

Project Goal

The goal of this project is to develop and implement a disease management registry for one or more patient populations diagnosed with a selected chronic disease. By tracking key patient information, a disease registry can help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care in order to prevent complications, which often lead to more costly care interventions.[39] A disease registry can assist physicians in one or more key processes for managing patients with a chronic disease, including:

1. Prompt physicians and their teams to conduct appropriate assessments and deliver condition-specific recommended care;
2. Identify patients who have missed appointments, are overdue for care, or are not meeting care management goals;
3. Provide reports about how well individual care teams and overall provider organizations are doing in delivering recommended care to specific patient populations; and
4. Stratify patients into risk categories in order to target interventions toward patients with the highest needs.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Identify one or more chronic disease patient populations that are at high-risk for hospital readmissions and high utilization of health care services.

B. Identify patient care registry system requirements relevant to the chronic disease patient population(s).

C. Assess existing IT platforms for possible patient registry functionality and/or interface.

D. Review current and future state of workflow and identify barriers to implementation.

E. Select an appropriate chronic disease registry solution that meets the needs of the patient population.

F. Educate and train clinical and/or administrative staff on use of chronic disease registry.

G. Implement and utilize disease management registry for target chronic disease populations.

H. Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps and reducing preventable acute care.

[39] 5 Million Lives Campaign. "Getting Started Kit: Improved Care For Patients with Heart Failure How- To-Guide." *Institute for Healthcare Improvement*. 2008.

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. Assess chronic disease registry functionality in electronic health record (EHR) systems.	• Review and analyze functionality and interface capability for EHR systems used by hospitals and affiliated physician practices to determine if they have necessary elements for a chronic disease registry. Necessary elements may include inpatient admissions, emergency department visits, test results, medications, weight, activity level changes and/or diet changes	• EHR systems
2. Develop an interface plan between EHR systems used by hospital and affiliated physician office practices.	• Production of interface model	• EHR systems
3. Issue Request for Proposal for a chronic disease registry.	• Analyze responses from top vendors to determine gaps in hospital/physician practice EHR systems to support a chronic disease registry	• Documentation of RFP
4. Select appropriate IT solution based on system functionality and procure a chronic disease registry.	• Procurement contract	• Documentation of contract
5. Evaluate workflow and use of chronic disease registry using Lean methodology.	• Review current and future state of workflow using chronic disease registry and identification of barriers to implementation	• Review of Lean event
6. Identify hospital and affiliated organization staff that will use the chronic disease registry.	• Develop list of users by location and by priority of use by functional area	• List of users

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. Develop an implementation plan for a chronic disease registry.	• Development of implementation plan	• Documentation of plan
8. Pilot test the selected chronic disease registry.	• Evaluate and identify gaps in information exchange in the registry within the hospital's identified staff and departments	• Implementation and testing plan
9. Identify target patient population with chronic disease to be entered into the registry.	• Document patients to be entered into the registry	• Internal hospital records/documentation
10. Develop and implement test plan to determine accuracy of information populated into the registry.	• Implement and document results of test plan	• Test plan
11. Educate and train staff on the chronic disease registry.	• Documentation of training materials/attendance	• Attendance list and educational content

Key Improvement 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. Go-Live – Enter patient information in the disease registry for target patient population with chronic disease.	• Identify gaps, via a review of the identified registry elements above, in treatments as identified Best Practices for the target patient population with a chronic disease	• Documentation of patients entered and gaps identified
2. Identify patients with chronic disease entered into registry who receive discharge instructions appropriate for their chronic disease such as: activity level, diet, medication management, etc.	• X percent increase of patients with chronic disease who receive appropriate disease specific discharge instructions.	• Chronic disease registry and hospital her

Project 2.3: Implement Improvements in Care Transitions

Project Goal

The goal of this project is to implement improvements in 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.[40] 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 long-term care facilities. High-risk patients often have multiple chronic diseases. 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.[41]The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmission. [42]The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following elements:

A. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.

B. 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[43]) tool) and patient interviews.

C. Identify baseline top readmission diagnoses and populations at high risk for readmissions, including mental health and substance abuse.

D. Review best practices from a range of models (e.g. RED[44], BOOST[45], STAAR, INTERACT[46], Coleman[47], Naylor[48], GRACE[49], BRIDGE[50], etc.).

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[40]Coleman 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

[41] 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

[42] 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

[43] 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.

[44] The Re-engineered Hospital Discharge, known as Project RED, is designed to re-engineer the hospital workflow

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following elements:

E. Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.

F. Implement one or more pilot 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:

   a. Discharge checklists

   b. "Hand off" communication plans with receiving providers

   c. Wellness initiatives targeting high-risk patients

   d. Patient and family education initiatives including patient self-management skills and "teach-back"

   e. Post-discharge medication planning

   f. Early follow-up such as homecare visits, primary care outreach, and/or patient call-backs.

G. Evaluate the intervention(s) impact on readmissions and patient care and identify "lessons learned," 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.

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.

[45] 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

[46] 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.

[47] 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 address continuity of care across multiple settings and practitioners.

[48] 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.

[49] 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.

[50] 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.

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. Establish Task Force or Team to support or lead project.	• Establishment of Task Force or Team	• Documentation of task force or team
2. Collect information and /or analyze data on factors contributing to preventable readmissions within 30 days.	Metrics may include: • Conduct a minimum of 10 interviews with patient/family members regarding an occurrence of a preventable 30 day hospital readmission • Review interview data conducted by multidisciplinary team • Improve electronic reporting of readmission data • Develop an electronic report on readmission data • Chart review Reports • Determine baseline metric for all cause 30 day readmission • Identification of key factors including primary and additional diagnoses such as CHF, DM, COPD and mental health/substance abuse that increase likelihood of preventable 30 day readmissions	• Documented summary of interview results • Report template on readmission • Minutes of meetings analyzing interview results • Report on readmission data • Report listing key contributing factors

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)**
3. Identify baseline high-risk Diagnostic-related Groups (DRGs) by analyzing 30-day readmissions for acute care and home care patients.	• Documentation of chart review (e.g., STARR Chart review report)	• Documentation of Chart Review Report
4. Hire clinician(s) with care transition/disease management expertise.	• Position offer letters	• Documentation of position of offer letters/ Human Resources records
5. Develop an assessment tool to identify patients who are at high risk for readmission.	• Multidisciplinary committee approves assessment tool	• Approved sample tool and meeting minutes
6. Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions.	• Selection of an evidence based framework	• STAAR meeting minutes displaying the selection of evidence based framework
7. Pilot test care management/ intervention approaches at selected provider sites (inpatient or outpatient).	Metrics may include: • Implementation of at least 2 evidence based interventions on a pilot unit; or • Implementation of pilot disease management program at one physician group practice	• Detailed implementation plan
8. Analyze pilot test results.	• Pilot report	• Copy 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)**
9. Develop plan (s) for a (1) hospital care transition process or (2) home-base disease management program for high-risk patients, or (3) to provide care management tools and health information exchanges with area physician groups and other post-acute providers.	• Care management tool and HIE Plan • Transition Process Improvement Plan • Home-base disease management plan	• Internal hospital records/documentation
10. Conduct study to determine feasibility of providing a wellness program on hospital campus for patients with high risk diagnoses.	• Hospital wellness plan	• Internal hospital records/documentation
11. Increase number of RN hours allocated to home-based disease management program.	• Increase RN hours for Home Care program	• Documentation of RN hours increase
12. Conduct baseline study and annual reassessments of at least X high-risk patients readmitted to hospital < 30 days to determine interval between hospital discharge and visit to PCP.	• Study of at least X high risk patients readmitted in less than 30 days to hospital in a given year	• Internal hospital records/documentation
13. Collect baseline patient-centered measures for X number of high-risk patients.	• Baseline report on high-risk patients	• Internal hospital records/documentation
14. Educate appropriate clinical staff on key contributing factors to preventable readmissions.	• Educational sessions with key clinical staff	• 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)**
15. Dedicate additional Advanced Practice RN resources to provide a bridge visit to high risk patients between hospital discharge and PCP visit.	• Advanced Practice RN position descriptions and work schedule	• Documentation of Advanced Practice RN position descriptions and work schedule
16. Re-engineer hospital discharge process for all admitted patients.	• Development of high-risk tool and discharge checklist	• Documentation of high risk tool and discharge check list
17. Develop reports and studies on lessons learned and share with health care community.	• Development of "Lessons Learned" report	• Internal hospital records/documentation
18. Implement enhanced assessment tool for inpatients with substance abuse and behavioral health issues.	• Multidisciplinary committee approves assessment tool	• Documentation of committee approval of tool
19. Identify community-based care transition partners.	• Number of care transition partners • Number of partner post-acute facilities	• Internal hospital records/documentation
20. Assess current knowledge / barriers to implementing evidence-based care transition tool or framework.	• Completion of survey or report	• Internal hospital records/documentation
21. Train hospital staff on standard use of evidence-based care transition tool or framework.	• X% of hospital staff trained	• Internal hospital records/documentation
22. Train post-acute partners on standard use of evidence-based care transition tool or framework.	• X% of post-acute partners trained	• 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)**
23. Document workflow protocol including use of evidence-based care transition tool or framework.	• Completion of written workflow protocol	• Internal hospital records/documentation
24. Implement workflow protocol including use of evidence-based care transition tool or framework.	• Dissemination of written workflow protocol to appropriate staff	• Internal hospital records/documentation
25. Establish baseline measure for the percentage of "High Risk" patients with customized care plans before discharge.	• Percentage of "High Risk" patients with customized care plans before discharge	• Report on "High Risk" patients with customized care plan before discharge
26. Creation of Patient Experience of Care Council	• Council creation • Meeting minutes	• Internal hospital records/documentation
27. Gap analysis regarding patient communication with doctors, nurses, and/or discharge information.	• Analysis complete	• Internal hospital records/documentation

Key Improvement 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 home-based disease management program for high-risk patients with enrollment target of X patients.	• Home health certification and plan of care signed by RN and patient's PCP	• Home health certification and plan of care
2. Implement trial use of warm handoffs (a clinician to clinician real time live communication) for adult inpatients being discharged to alternative care settings	• Warm Handoffs used for X percent of target population transitioned from adult inpatient units to alternative care settings (e.g., area	• Report on percentage of adult transfers to alternative care settings during which warm handoff occurred (e.g., area SNFS, Rehabs,

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
(.e.g., SNFs, Rehabs, and PCMH's).	SNFS, Rehabs, PCMH's)	PCMH's)
3. Expand warm handoffs on target patient population.	• Increase expand warm handoffs to X percent of target patient population	• Report on percentage of adult transfers to alternative care settings during which warm handoff occurred
4. Educate X % of selected hospital clinicians (e.g. RNs, hospitalists) on use of teach-back methodologies.	• X percent of targeted hospital clinicians are educated on teach-back methodology	• Minutes and attendance lists of meeting
5. Implement use of teach-back methodology for X percent of target high-risk patient group.	• Sample target high risk patient group to determine percentage who experience teach-back and assess impact on readmission rates	• Report on percentage of sampled high-risk patients who experienced teach-back methodology
6. Use of evidence-based care transition tool or framework by hospital staff.	• X% utilization by hospital staff	• Internal hospital records/documentation
7. Use of evidence-based care transition tool or framework by post-acute partner staff.	• X% utilization by post-acute staff	• Internal hospital records/documentation
8. Improve patient communication with doctors.	• Xth percentile in HCAHPS: Communication with Doctors	• Press Ganey
9. Improve patient communication with nurses.	• Xth percentile in HCAHPS: Communication with Nurses	• Press Ganey
10. Improve patient communication regarding discharge.	• Xth percentile in HCAHPS: Discharge Information	• Press Ganey
11. Improvement in percentage of "High Risk" patients with	• X percent improvement in percentage of "High Risk"	• Report on "High Risk" patients with customized

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
customized care plans before discharge	patients with customized care plans before discharge	care plan before discharge
12. Increase number or percent of target inpatient population screened for a substance abuse or mental health disorder that receive an enhanced assessment.	• X percent increase in target inpatient population screened for a substance abuse or mental health disorder who receive an enhanced assessment	• Social work log books
13. Increase number or percent of target inpatient population with a substance abuse or mental health disorder discharged to home who underwent an enhanced assessment for whom clinicians made follow up calls (two attempts) to review treatment plans and assess compliance.	• X percent increase in follow up phone contacts (at least 2 attempts) made by hospitals to target inpatient population with a substance abuse or mental health disorder discharged to home and underwent an enhanced assessment	• Social work logbooks
14. Reduce admissions from targeted post-acute population.	• X% reduced readmissions from specified post-acute population	• Internal hospital records/documentation
15. Reduce all-cause readmissions for post-acute settings.	• X% reduced all-cause readmissions from specified post-acute setting	• Internal hospital records/documentation

Project 2.4: 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.

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

A. Design and Implement Re-Engineered Discharge process for specified categories of patients

B. Educate the patient about diagnosis throughout the hospital stay.

C. Make appointments for follow-up and post discharge testing, with input from the patient about time and date.

D. Discuss and document with the patients any tests not completed in the hospital

E. Organize post discharge services.

F. Confirm the medication plan.

G. Reconcile the discharge plan with national guidelines and critical pathways.

H. Review with the patient appropriate steps of what to do if a problem arises.

I. Expedite transmission of the discharge summary to clinicians accepting care of the patient.

J. Give the patient a written discharge plan.

K. Assess the patient's understanding of the discharge plan.

L. Call the patient 2 -3 days after discharge to reinforce the discharge plan and help with problem solving.

M. Train clinicians and other staff to utilize new processes appropriately.

N. Perform data analysis to track readmissions for participating patients.

O. Identify common issues upon discharge from acute care setting.

P. Coordinate with post-acute care providers regarding discharge processes.

Q. Improve communication tools between acute and post-acute providers.

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 and staff a re-engineered discharge process plan (RED) for implementation with targeted adult medical patients at a hospital.	• Project RED staffing plan • RED program description • Project RED patient criteria	• CMS Readmissions criteria • Internal hospital records/documentation
2. Implement RED for X number of hospitalized adults from one Medicaid MCO.	• Copy of hospital's implementation plan • Copy of report on number of patients participating in RED	• Internal hospital records/documentation
3. Using one X# of payer(s)' claims data, establish baseline data to be used in tracking designated hospital patients receiving RED.	• Copy of baseline report	• Payer Data
4. Design process to streamline and implement RED with additional population in a designated hospital' unit for adult medical patients across all payers. Redesign staffing component to better integrate RED into the daily workflow of the inpatient unit.	• Copy of RED redesigned process description for new unit • Copy of RED staffing plan for new unit	• Internal hospital records/documentation
5. Using hospital data, establish baseline data to be used in tracking designated hospital patients from additional hospital unit who will be receiving RED.	• Copy of baseline report	• Internal hospital records/documentation
6. Based on results of Project RED demos, recommend hospital-wide strategy to reduce avoidable readmissions.	• Copy of Project RED cost-benefit analysis • Copy of hospital wide readmissions policy report	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.*		
7. Identify RED tool(s).	• Identification	Documentation of recommendation
8. Identify community-based partners.	• Internal records identifying partners	Internal hospital records/documentation
9. Provide staff training on RED tool(s).	• Documentation of training	Internal hospital records/documentation

Key Improvement 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. Increase number of patients in Project RED by X percent.	• Copy of hospital's Implementation Plan for new inpatient unit • Copy of Report on number of patients participating in RED through Medicaid MCO • Copy of Report on number of patients participating in RED through one designated hospital unit	• Hospital and Insurer Data
2. Track number of readmitted patients from X payer(s) that received project RED using a methodology similar to one used by CMS for counting "all cause readmissions" against established baseline.	• Copy of payer-specific all cause readmission for participating RED patients at hospital report comparing hospital readmission to Year X	• Payer data
3. Track number of participating RED patients from one hospital unit readmitted to same hospital against established baseline.	• Copy of readmissions report for participating RED patients at designated hospital unit comparing hospital readmission to Year X	• Internal hospital records/documentation
4. Hospital utilization of RED tool or procedure.	• X% utilization	• Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
5. Track and report on post-30, 60, and 90 day emergency room (ER) visit for patients discharged through Project RED.	• Copy of tracking report	• Internal hospital records/documentation

Project 2.5: 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 unnecessary 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), and/or patients who have an acute change in their medical, social or behavioral health condition. Primary care-based care management or complex care management teams will provide complex care management of medical conditions and behavioral health conditions as well as coordinate a range of social service supports such as effective patient engagement, housing, transportation, nutrition. These teams will also coordinate with inpatient, emergency department, and post-acute care management systems to facilitate a seamless care transition experience for patients.

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.[51] Development of primary care-based systems of care management has been linked to substantial improvements in quality of care and reduced cost.[52] 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, 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.

[51] Tang, N. et al. "Trends and Characteristics of U.S. Emergency Department Visits 1997-2007." *JAMA* (2010) 304(6): 664-670.
[52] Cosway R, et al. "Analysis of Community Care of North Carolina Cost Savings." *Milliman, Inc.* 2011.

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

A. Define population of patients determined to be at high risk for utilization of high-cost health care services based on available clinical and administrative data (e.g. payer data, emergency room and hospital discharge logs, health records or registries identifying patients with a poorly controlled chronic disease, etc.).

B. Develop a multi-disciplinary team-based framework for a primary care-based complex care management model for high-risk patients.

C. Identify competencies and qualifications required for members of the primary care complex care management team.

D. Develop and implement reports and/or EMR capabilities to designate high-risk patients.

E. Design, develop, and implement integrated care plans for use with high-risk patients enrolled in a primary care-based system of complex care management.

F. Enroll high-risk patients in primary care-based complex care management model in one or more primary care sites.

G. Evaluate the effectiveness of the initial or pilot site primary care-based complex care management model in areas that may include addressing treatment gaps, reducing missed appointments, inpatient or emergency care patterns or follow-up, improving patient engagement or satisfaction, and/or wellness/clinical indicators.

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 primary care-based complex care management program for high-risk patients including the methodology for identifying high-risk patients and the multi-disciplinary framework for the program.	• Submission of care management workgroup minutes and recommendations that include a multidisciplinary framework for a primary care-based care management program for high-risk patients	• 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)**
2. Develop a report of high-risk patients and deliver these in a timely way to primary care-based complex care management staff.	• Submission of sample multi-payer report delivered to participating primary care sites	• Internal records that incorporate payer data
3. Develop job requirements and/or identify competencies for members of the primary care complex care management team (such as community health workers, RN clinical care managers, social workers).	• Submission of revised job descriptions and/or competencies for community health worker, nurse and social worker with integration of care management competencies	• Internal hospital records/documentation

Key Improvement 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 primary care-based complex care management program for high-risk patients at X number of primary care sites. Hospital may increase the number of participating primary care sites over the demonstration years.	Metrics may include: • Create a way to designate high-risk patients in the EMR for participating primary care sites • Enroll high- risk patients into the complex care management program at X number of participating primary care sites • Create a report to identify the number of patients enrolled in the complex care management program • Create baseline reports for: ➢ the number of patients enrolled in the complex care management program at initial pilot sites and, ➢ the % of patients enrolled in the complex care management program who	• Submission of EMR screen shot illustrating patient identified as receiving complex care management • EMR reports • Care management report

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
	have a documented care plan during the measurement period at X number of initial participating primary care sites	
2. Expand primary care-based complex care management program for high-risk patients to X number of additional primary care sites.	• Increase number of primary care sites participating in the complex care management program for high-risk patients	• Care Management Report from EMR
3. Increase the number of patients enrolled in the complex care management program by X percentage increase at X primary care sites.	• Increase the number of patients enrolled in the complex care management program by X percent over the baseline established across the X primary care sites	• Care management report from EMR
4. Monitor care management plans developed for high risk patients enrolled in the complex care management program across participating primary care pilot site(s).”	• # and % of patients enrolled in the complex care management program that have a care plan that has been developed by the care manager with input from the care team during the measurement period.	• EMR

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
5. Evaluate the effectiveness of the initial or pilot site primary care-based complex care management model in areas that may include addressing treatment gaps, reducing missed appointments, inpatient or emergency care patterns or follow-up, improving patient engagement or satisfaction, and/or wellness/clinical indicators.	• Written report	• Internal hospital records/documentation

Project 2.6: Establish a Multi Disciplinary Education and Simulation Center

Project Goal

The goal of this project is to improve patient safety and quality and to improve the delivery of high-quality health care through education, training and research. Programs will utilize experiential, simulated scenarios and participatory courses to focus on effective communication, collaboration, crisis management and cultural competency. A multidisciplinary team approach—rather than a traditional, siloed approach—will be utilized to allow for training, in a true simulated environment, of all related hospital staff responsible for the care and treatment of patients (e.g. physicians, nurses, pharmacists, etc.). Curricula will be designed to reflect this multidisciplinary approach and to address the multicultural needs of a safety net population. The project will focus on continuous quality improvement and will consist of the creation of a state-of-the-art, centralized simulation and education center for its core community, including clinicians, residents, students, nurses, pharmacists, allied health professions and potentially the community at large for certification courses. The Simulation Center will accommodate the needs of multiple departments, including surgery, anesthesiology, nursing, pediatrics, medicine, and obstetrics/gynecology.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Design, staff, and open a dedicated, multi-disciplinary Simulation and Education Center.

B. Create a Simulation Center clinical implementation work group.

C. Identify training programs to be offered.

D. Develop curriculum and materials for multidisciplinary team training programs.

E. Train multidisciplinary team members across hospital.

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. Identify and design space for creation of a Simulation Center.	• Documentation that space has been identified • Documentation that the Center has been designed	• 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)**
2. Create Simulation Center clinical implementation workgroup and identify training programs to be offered; begin planning for implementation.	• Provide list of Simulation Center workgroup members and meeting agenda • Provide outline of recommended list of Simulation Center training programs for SFY 2013 and 2014	• Simulation Center Training Summary
3. Develop curriculum materials for initial Simulation Center training program after thorough review of the literature.	• Copy of curriculum materials • Summary of literature review	• Hospital Simulation Center training materials
4. Develop materials for additional training teams.	• Copy of additional training materials	• Hospital Simulation Center training materials

Key Improvement 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. Provide training to X number of clinical staff.	• Documentation of training to X number of clinical staff, including pre- and post-skills assessments, where applicable.	• Hospital Simulation Center attendance records

Project 2.7: Implement Process Improvement Methodologies to Improve Safety Quality and Efficiency

Project Goal

The goal of this project is to implement process improvement methodologies to improve safety, quality, and efficiency. Hospitals may design customized initiatives based on various process improvement methodologies such as Lean, Care Logistics, Nurses Improving Care for Healthsystem Elders (NICHE) among others.

For example, the Lean methodology as applied to medicine evaluates the use of resources, measures the value to the patient, considers the use of resources in terms of their value to the patient, and eliminates those that are wasteful. Using methodologies such as Lean that are proven to eliminate waste and redundancies and optimize patient flow, hospitals may customize a project that will develop and implement a program of continuous improvement that will increase communication, integrate system workflows, provide actionable data to providers and patients, and identify and improve models of patient-centered care that address issues of safety, quality, and efficiency. Implementation frequently requires a new "operational mindset" using tools such as Lean to identify and progressively eliminate inefficiencies while at the same time linking human performance, process performance and system performance into transformational performance in the delivery system.[53] The process improvement, as a further example, may include elements such as identifying the value to the patient, managing the patient's journey, facilitating the smooth flow of patients and information, introducing "pull" in the patient's journey (e.g. advanced access), and/or continuously reducing waste by developing and amending processes awhile at the same time smoothing flow and enhancing quality and driving down cost.[54]

Furthermore, projects designed and implemented using the Care Logistics™ patient-centered, care coordination model involves managing the simultaneous logistics of a patient moving through the hospital. It may be used to help hospitals transform their operations to improve patient flow into cross departmental hubs and provide 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.[55]

In addition, 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.[56]

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

[53] Oujiri J, Ferrara C. "The Phoenix Project – Integrating Effective Disease Management Into Primary Care Using Lean Six-Sigma Tools." *Duluth Clinic Presentation*. 2010.
[54] Bibby J. "Lean in Primary Care: The Basics – Sustaining Transformation." *Asian Hospital and Healthcare Management* (2011) 18.
[55] http://www.carelogistics.com/
[56] http://www.nicheprogram.org/

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

A. Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.

B. Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

C. Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.

D. Define key safety, quality, and efficiency performance indicators and develop a system for continuous data collection, analysis, and dissemination of results.

E. Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.

F. Implement software to integrate workflows and provide real-time performance feedback.

G. Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.

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. Senior hospital leadership collect information on a patient-centered flow management system (e.g., Care Logistics Model) to gain new ideas on best practices with qualitative and quantitative, evidence-based information.	• Site visit to hospital that has implemented the patient-centered flow management system	• Confirmation of visit
2. Senior hospital leadership attend educational seminars on a patient-centered flow management system (e.g., Care Logistics Model).	• Attendance on a seminar on the patient-centered flow management system	• Seminar attendance list
3. Hire vendor to implement a care management system at the hospital (e.g., Care Logistics Model).	• Agreement with system vendor	• Documentation of agreement

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)**
4. Conduct educational sessions for hospital leadership, executives, and other hospital staff on the care management system.	• Completion of education sessions	• Evaluation surveys
5. Define current state of care management at the hospital.	• Completion of reports	• Documentation of report
6. Define operational procedures needed to improve overall efficiencies in care management.	• Report on at least 2 new operational procedures needed to improve overall efficiencies in care management	• Report on two new operational procedures
7. Adopt new care coordination/management model.	• New care coordination model report	• Documentation of report
8. Implement new care management software (e.g., Care Logistics) to integrate workflows and provide real-time performance feedback.	• Installation of new care management software	• Health system HIT documentation
9. Train hospital staff on new care coordination model.	• Training schedule and attendance list	• Documentation of training schedule and attendance list
10. Define key performance indicators for the new care coordination/ management model.	• Report on new care management indicators • Conduct GIAMP study (Geriatric Institutional Assessment Profile)	• Documentation of report
11. Finalize communication plan on the new care coordination/ management model.	• Hospital Care Coordination Communication Plan	• Documentation of plan
12. Develop baseline rate of Emergency Department patients who leave without being seen.	• Report on ED patient throughput over a 6 month period	• 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)**
13. Implement a Lean Workplace Standardization class at primary care practices.	• Completion of Lean Workplace Standardization class at X primary care practices.	• On site verification
14. Complete a Lean Workplace goal setting process at primary care practices.	• Completion of Lean Workplace goal setting process at X primary care practices, including completion of: ➢ Develop a balanced score card with practice level goals for people, quality, and reduction of waste from the patient's perspective ➢ Develop patient safety cross for each practice	• Documentation of plan
15. Complete an employee suggestion system in X number of practices.	• Develop an employee suggestion system which identifies issues that impact the associate's work environment, quality, patient satisfaction, financial issues or practice growth, aligned with the balanced scorecard goals, done at minimal cost by the submitter and within the submitter's area of responsibility.	• On site verification
16. Collect baseline measurement in one or more of the following: documentation of BMI, smoking status, or medication reconciliation in X number of practices.	• Completion of baseline data collection for one or more of the following: documentation of BMI, smoking status, or medication reconciliation in X number of practices.	• Documentation of each metric at the pilot practices.

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)**
17. Complete a kaizen assessment.	• Implement at least one patient care centered process improvement project in X number of practices • Measure process by documentation of standard work for patient process improvement • Develop and use standard leader work for checking improvement success	• Kaizen event reports
18. Complete care improvement educational program.	• Number of staff completing • X% of staff completing educational program	• Course record
19. Certify nursing staff in geriatric care.	• Number of staff receiving ANCC certification • X% of staff receiving ANCC certification	• Documentation of certification
20. Conduct GIAP survey (Geriatric Institutional Assessment Profile).	• X% staff participating in survey	• Survey results
21. Establish baseline measures and set improvement targets on a minimum of X key performance indicators. Key performance indicators could include, but are not limited to: length of stay, patient flow times, discharge process times, ED patient holds.	• Report on baseline measures, key performance indicators and improvement targets.	• Documentation of report on baseline measures, key performance indicators and improvement targets

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)**
22. Complete clinical leadership training.	• Number of staff completing • X% of staff completing educational program	• Course record
23. Develop education and marketing on new care coordination models.	• Creation of educational / promotional materials	• Documentation of materials
24. Analysis of GIAP survey (Geriatric Institutional Assessment Profile).	• Completion of analysis identifying gaps and starting points for education	• Internal hospital records/documentation

Key Improvement 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. "Go-live" with the New Care Coordination Model.	• HIT system configuration confirmation	• Documentation of HIT system configuration confirmation
2. Reduce rate of ED patients who leave without being seen.	• X percent reduction from previous year baseline in ED patients who leave without being seen (measured over a 6 month period)	• Internal hospital records/documentation
3. Implement a minimum of X operational procedures needed to improve overall efficiencies in care management.	• Report on Implementation of New Operational Procedures to Improve Overall Efficiencies in Care Management	• Documentation of Report
4. Implement process improvement lessons from the pilot practices and achieve improvement in documentation of BMI, smoking status or medication reconciliation.	• X% improvement in documentation of BMI, smoking status or medication reconciliation in X number of pilot practices	• Pre-Kaizan assessment

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. Reduce rate of falls for target population.	• X % improvement in rate of falls • X falls per thousand patient days or fewer	• Internal hospital records/documentation
6. Achieve X percent improvement for a minimum of X key performance indicators. Key performance indicators could include, but are not limited to: length of stay, patient flow times, discharge process times, ED patient holds.	• Report on key performance indicators' improvement from baseline	• Documentation of report on key performance indicators' improvement
7. Reduce rate of pressure ulcers.	• X % improvement in rate of pressure ulcers	• Internal hospital records/documentation
8. Improved knowledge and attitudes.	• X% improvement in surveyed knowledge and attitudes	• Internal hospital records/documentation

Project 2.8: Provide an Alternative Care Setting for Patients who Seek Non-Emergent Department Care

Project Goal
The 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. 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. 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.[57]

Potential Project Elements *DSTI hospitals undertaking this project may select from among the following project elements:*
A. Identify the patient population that utilizes ED for non-emergent complaints. B. Design and implementation of process and methods to encourage the use of the new PCMH primary care site by patients who utilize the ER for non-emergent complaints. C. Documentation of process and methods to encourage and educate patients. D. Devise methodology to measure financial impact and cost savings associated with ED efficiencies using baseline 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)**
1. Analyze non-emergent ER complaints and identify patient population that utilizes ER for non-emergent complaints.	• Documentation of baseline data on most common non-emergent patient complaints for the most recent 12-month period stratified by patient demographic and PCP	• Baseline Data Report from Hospital Information Systems

[57] 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 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)**
	• Documentation of baseline number of patients with and baseline number of patients without PCPs who use ER for non-emergent care	
2. Design a screening tool for non-emergent care, which would serve as the method to identify the primary reason a patient sought non-emergent patients, and ultimately drive the determination of baseline population.	• Documentation of screening tool	• Internal hospital records/documentation
3. Perform an environmental scan to analyze reasons why patients seek ER care for non-emergent conditions, separate from the complaint itself, using a screening tool for non-emergent patients.	• Identify the top 5 reasons non-emergent patient seek care at the ER	• Documentation of top 5 reasons.
4. Design and implement a process and develop educational materials highlighting the value to patients of having a medical home and continuity of care, as well as encourages use of the new PCMH primary care site by target patient population who utilize the ER for non-emergent complaints.	• Documentation of process and methods to encourage and educate patients to use the new site	• Documentation of deliberations of ER and PCMH Practice Collaborative

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. Determine baseline number of target patient population to be educated and encouraged to use the PCMH site.	• Documentation of baseline number of patients to be educated	• Internal hospital records/documentation
6. Design and implement a process and method to educate patients without a PCP about its value to them and schedule a PCP appointment before they leave the ER.	• Report on baseline number of target patient population to be educated and to have an appointment with PCP scheduled	• Internal hospital records/documentation

Key Improvement 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 a PCMH primary care site within close proximity to Hospital ER (co-located). Staff the site, gaining approval (e.g. FTCA coverage etc.) from authorities.	• Alternative site open and operating.	• Documentation of site opening
2. Educate X percent of target patient population about the PCMH site.	• Educate X percent of target population	• Report of targeted population and educational efforts
3. Schedule PCP appointments for X percent of target patient population who do not have a PCP.	• Schedule PCP appointments for X percent of target population who do not have a PCP	• Documentation of appointments scheduled

Project 2.9: Reduce Variations in Care for Patients with High Risk Conditions

Project Goal

Develop and implement evidence-based clinical care pathways 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" for conditions with high risk of complication and/or readmission. Care pathways will span the continuum of care from inpatient to outpatient, post-acute care, and home care 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.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Identify one or more diagnoses at high risk for readmission, complications, co-morbidities, and/or variations in care.

B. Review and select evidence-based "best practices."

C. Define standards for expected duration of stay and use of tests and treatments.

D. Implement / develop evidence-based standardized clinical care pathways targeting the selected high risk condition(s). Elements of care pathways may include, but are not limited to:

   - Clinical care team roles
   - Medications
   - Nutrition
   - Patient teach back—to reinforce and assess if patient or learner is understanding
   - Patient self-management coaching
   - Expectations for follow-up care
   - Transitions from hospital to home, home care, nursing facility, or other post-acute care provider.

E. Examining care team roles to ensure most efficient and appropriate allocation of responsibility.

F. Improving patient satisfaction with care by educating patients and their families about the plan of care and involving them more fully in its implementation.

G. Identify "lessons learned," adopt refinements to clinical pathway, including special considerations for safety net patient populations.

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. Identify evidence-based frameworks that support improved care transitions and health care outcomes.	• Selection of an evidence based framework	• Care management and transitions protocol documentation
2. Develop evidence-based care pathways.	• Care pathway	• Documentation
3. Use evidence-based framework or pathway in patient care.	• X% utilization of care pathway	• Internal hospital records/documentation
4. Educate hospital clinicians (e.g. RNs, hospitalists) on use of teach back methodologies.	• X% of targeted hospital clinicians are educated on teach back methodology	• Internal hospital records/documentation
5. Pilot evidence-based framework or pathway in patient care.	• Use in multidisciplinary rounds	• Internal hospital records/documentation

Key Improvement 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. Complete patient teach back for targeted conditions / patient populations.	• X% completion of teach back for targeted population	• Internal hospital records/documentation
2. Decrease 30 day all cause readmissions.	• X% decrease in 30 day all cause readmissions	• Internal hospital records/documentation
3. Decrease CHF 30 day all cause readmissions.	• X% decrease in CHF 30 day all cause readmissions	• Internal hospital records/documentation
4. Decrease PN 30 day all cause readmissions.	• X% decrease in PN 30 day all cause readmissions	• Internal hospital records/documentation
5. Improve overall core measure compliance for CHF bundle.	• Xth percentile overall core measure compliance for CHF bundle	• Whynotthebest[58]

[58] The Commonwealth Fund's website Why Not The BEST? at www.whynotthebest.org, utilizes data derived from Medicare's Hospital Compare database

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
6. Improve overall core measure compliance for PN bundle.	• Xth percentile overall core measure compliance for PN bundle	• Whynotthebest
7. Improve overall core measure compliance for AMI bundle.	• Xth percentile overall core measure compliance for AMI bundle	• Whynotthebest
8. Expand pharmacy discharge interventions.	• X% pharmacy discharge interventions for targeted patient population	• Internal hospital records/documentation

30. **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.[59] [60]

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.[61] 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

[59] 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.
[60] Moore K, Coddington D. "The Work Ahead: Activities and Costs to Develop An Accountable Care Organization*." American Hospital Association and McMannis Consulting* 2011.
[61] *"Recommendations of the Massachusetts Special Commission on the Health Care Payment System."* *Massachusetts Special Commission on the Health Care Payment System.* July 16, 2009.

high concentration of Medicaid and low-income patient populations that present a set of unique characteristics, including multiple chronic health conditions.

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.[62] 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.[63] 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.[64]

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.[65]

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.

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[62] 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.
[63] 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.
[64] Moore K, Coddington D. "The Work Ahead: Activities and Costs to Develop An Accountable Care Organization*." American Hospital Association and McMannis Consulting.* 2011.
[65] 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.[66] [67]

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.[68]

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

DSTI hospitals undertaking this project may select from among the following project elements:

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.

B. Develop capabilities to work with risk stratification information to identify high-risk patients.

C. Conduct risk stratification for patients with the health risk and utilization indicators and/or

[66] 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.

[67] Moore K, Coddington D. "The Work Ahead: Activities and Costs to Develop An Accountable Care Organization." *American Hospital Association and McMannis Consulting.* 2011.

[68]. 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
DSTI hospitals undertaking this project may select from among the following project elements:

targeted chronic conditions.

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.

E. Expand risk stratification capabilities from an initial insurer population to one or more additional insurer populations.

F. Develop organizational plan to improve accuracy in hierarchical condition categories (HCC) data submissions to accurately reflect the health status of a patient population.

G. Deploy hospital resources to improve the quality and accuracy of patient records.

H. Develop reports to identify patients that require a scheduled provider visit.

I. Identify patients with chronic conditions requiring management or monitoring and prioritize those with high-cost cases.

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.

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. Obtain risk stratification information from X number of insurers for a target patient population(s), document payer-population-specific criteria for identifying the top X% high-risk patients, and produce risk scores for the top X% highest risk patients.	• Documentation that risk stratification information has been obtained • Document insurer-specific criteria for identification of top X % high-risk patients and identify or obtain top X% high-risk patients by applying the risk stratification methodology and producing risk scores for top X% payer-specific patients	• Internal hospital records/documentation and insurer 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)**
2. Identify patients in the target patient group who have not had an office visit in the prior year and/or have a chronic condition and contact X percent/number of them to schedule a PCP appointment/risk assessment.	• Number of patients in the target patient group and percent or number contacted to schedule a PCP appointment or risk assessment	• Payer data • Baseline risk adjustment factor • Medical record
3. Develop organizational plan to improve accuracy in hierarchical condition categories data submissions for a target patient population.	• Approved organizational protocol • # of Provider education sessions aimed at reviewing risk status of members and care management plan	• Internal hospital records/documentation
4. Hire a documentation specialist to review/audit medical records.	• Documentation specialist hired • Chart review by Documentation Specialist • Develop database to enter data reported by Documentation specialist	• Hospital internal records • Log of charts reviewed by documentation specialist • Payer data • Patient management report generated from hospital Data Warehouse
5. Conduct PCP educational sessions aimed at reviewing risk status of members and care management plans.	• Completion of PCP educational sessions aimed at reviewing risk status of members and care management plans	• Education log • Departmental minutes • Managed Care Portal educational summaries
6. Collect baseline data on target patients with diagnosis of diabetes mellitus in SFY12 identify patients who are in need of hemoglobin A1c testing.	• Completion of baseline data collection	• Payer Data • Patient management report generated from hospital Data Warehouse • Medical Record

Key Improvement 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)**

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
1. Number/percentage of target patient population contacted to schedule a PCP visit/annual risk assessment.	• X percent improvement of target patient population contacted to schedule a PCP visit/annual risk assessment	• Internal hospital records/documentation
2. Increase in the number of payer-specific initiatives that the hospital is undertaking related to alternative payment models and related risk stratification activities within the payer-specific patient population(s).	• Documentation that the hospital has initiated an increasing number of payer-specific initiatives that relates to related risk stratification activities within the payer-specific patient population(s).	• Internal hospital records/documentation
3. Assign top X% highest risk patients identified through risk stratification process to primary care site-based care management or centralized care management, as appropriate. Hospital may propose to increase the number of patients identified through risk stratification processes assigned to primary care-based care management or centralized care management, which may be achieved in a payer-specific cohort and/or as additional payer-specific populations are added to the initiative.	• Total number or percent of the top X % cohort of patient for that insurer assigned to primary care-based care management or centralized care management • Increase in the number of patients identified through risk stratification processes assigned to primary care-based care management or centralized care management	• Internal hospital records/documentation and/or insurer data
4. X% of selected population outreached and scheduled for PCP visit/annual risk assessment.	• % of risk Assessments completed vs. baseline total # patients identified in population	• Risk assessments identified by documentation specialists

Project 3.2: Design and Implement a Hospital-Based 360 Degree Patient Care Program

Project Goal

The goal of this project is to design and implement an innovative, comprehensive program to identify and manage the most seriously ill members of a defined managed care population, on the theory that "paying the best and brightest physicians to care for the sickest patients as simply and effectively as humanly possible"[69] will yield the best medical and psychosocial patient outcomes, yet decrease overall costs of care by eliminating that which is neither necessary nor desirable.

A novel, highly sophisticated managed care team, involving clinical and administrative team members, will be dedicated to working with the most severely ill members of the managed care population to enhance the care experience and ensure optimal care planning, coordination and integration. This hybrid of 360-degree Patient Care program [without the fees] and the patient-centered medical home[70], 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.

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

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.
B. Identify risk population to be served initially.
C. Implement 360 Degree Patient Care Program.
D. Coordinate complex care.
E. Validate arrived follow-up visits.
F. Coordinate with post-acute care, including visiting nurses.
G. Track and report on progress, such as number of co-managed patients, hospital admissions data.
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.

[69] Browne M. "Concierge and Primary Care Medical Home Hybrid Model of Care *Policy " Pershing Yoakley & Associates.* 2011.
[70] 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.

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. Establish a physician led-team at the hospital to design and begin implementation of a 360-Degree Patient Care program to identify and coordinate care for a cohort of severely and chronically ill high-risk patients enrolled in a managed care plan.	• Start-up team hired • Training started • Ability to identify the target population through emergency department registration developed • Team schedule reflects five day/week coverage of service • Call coverage schedule and contact numbers published • Contracts signed for continuum of care case/disease management • Communications expectations documented and met • Meetings occur regularly (with special exceptions) • Balanced scorecard created and maintained consistently	• Human resources: identification of team and orientation plan; communication plan • ED Tracker example (with personal identifiers removed) of identification of risk population members • Health Plans • Published schedules • Case Management Contract • Minutes of meetings • Balanced score card goal and measurement samples
2. Increase staffing for the 360-Degree Patient Care Program and implement a process to follow selected patients post hospital discharge.	• Clinical staff hired • Seven day/week coverage initiated by sample schedule • Follow up visits documented • Care coordination documented by samples with personal data obscured	• Human resources: identification of second nurse practitioner • Call coverage schedule • Sample ambulatory arrived visit notes (absent patient identifiers) • Care coordination documentation in 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)**
3. Hospital team for 360 Degree Patient Care Program will co-manage the patient cohort, implement a risk assessment tool, and track hospital admission rates.	• Number of co-managed patients during reporting period • Risk evaluation tool on file • Pathway for risk evaluation screening • Pathway for risk patient evaluation and intervention • Report on other potential areas for improvement	• Managed care team documents for co-managed panels, evaluation tools; sample pathway for risk patients • Hospital data warehouse
4. Create a pathway to evaluate and proactively intervene with patients deemed high-risk by the evaluation screening process.	List of patients evaluated and documentation of interventions for the identified population	• Managed care team documents for co-managed panels, evaluation tools; sample pathway for risk patients • Hospital data warehouse
5. Collect baseline measurement of percentage of target patients who complete a scheduled post-discharge visit with their PCP or specialist.	Completion of baseline data collection	• Appointment records

Key Improvement 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 outpatient follow-up visit process for certain discharged patients based on severity and complexity of illness.	• One month log documenting patients with outpatient management by the 360-Degree Patient Care Program Hospitalist team	• Internal hospital records/documentation
2. Develop process to coordinate care with SNF rounder, VNA, palliative care, hospice, primary and specialist physicians.	• Summary of case notes from 10 charts demonstrating the team's coordination with community resources	• Internal hospital records/documentation
3. Improvement in percentage of target patients who complete a scheduled post-discharge visit with their PCP or specialist.	• X percent of percentage of target patients who complete a scheduled post-discharge visit with their PCP or specialist over baseline	• Appointment records

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. Hospital-defined projects will focus on building blocks and key capabilities needed by the specific-hospital system to move along the continuum towards participating in new payment models. Key capacities may include creation of appropriate legal entities, operating agreements, completion of health information technology inventory, development of information management capabilities in preparation for accepting alternative payments, health information exchange capabilities, formalization of leadership models to manage the transition to new accountable care models, development of new care management and clinical care models, education of network physicians about local opportunities for managing cost and quality, and quality/cost benchmarking among others.

In addition, this project may evaluate models for an Accountable Care Organization (ACO) that take responsibility for providing care to a defined population, and establish 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.[71] 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.

[71] 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 *DSTI hospitals undertaking this project may select from among the following project elements:*
A. Develop expertise in preparation for transition to a risk-bearing Accountable Care Organization. B. Develop information management capabilities in preparation for accepting alternative payment methodologies. C. Formalize hospital leaders to manage transition to accountable care. D. Contract with outside parties to produce ACO development report and work plan. E. Begin implementation of appropriate consultant recommendations toward ACO development. F. Analyze data to create baseline and identify potential savings opportunities. G. Develop governance and legal entity that will be able to accept an array of alterative payment models across payers, including: (1) Governance documents; (2) Operational agreement; (3) Medical staff organization (4) Roles and responsibilities for all partners; and (5) Establishment of a clinical advisory council or steering group. H. Determine the health status, outcomes and disparities for the population(s) to be served. I. Complete health information technology inventory. J. Develop health information technology plan that includes care management and care management capacities. K. Complete gap analysis of global payment contracting and management system capacities. L. Determine model for clinical care delivery. M. Develop a pilot program, such as a proposal to a payer to serve dual eligible, Medicaid, or other population under an alternative payment arrangement.

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. Create new legal entity that may contract for an array of global payment systems across public and commercial payers.	• Certificate of organization filed with the Commonwealth of Massachusetts	• Document of submission
2. Develop operational agreement addressing roles and responsibilities for collaborating entities.	• Operational agreement	• Operational agreement
3. Select Health Information Exchange (HIE) platform to exchange data with physician groups in the community.	• Agreement/contract with HIE platform vendor	• Documentation of agreement/contract

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)**
4. Develop implementation plan for at least X number of HIE platform components, tools or applications.	• Implementation plan for 2 HIE Platform components	• Documentation of implementation plan
5. Establish baseline for the number of physician offices utilizing HIE platform components, tools or applications.	• The number of physician offices utilizing HIE platform components, tools or applications	• Health System IT Report
6. Develop plan to expand HIT care management and care coordination capacities.	• HIT expansion plan	• Documentation of plan
7. Survey a sample of collaborating physician groups to determine interest levels in participating in a dual eligible and/or Medicaid pilot.	• Report on physician survey result	• Documentation of report
8. Develop a pilot program proposal for payer to serve dual eligible and/or Medicaid population.	• Copy of proposal to payer	• Documentation of proposal
9. Establish Special Advisory Council to promote integration and coordination of care for beneficiaries.	• Special Advisory Council Membership list with representation across multiple specialty disciplines	• Documentation of Specialist Advisory Council membership list
10. Develop a plan on quality and cost performance.	• Quality and Cost Performance Incentive Plan	• Documentation of plan
11. Develop plan to institute quality and cost benchmarking, measurement, and reporting.	• Plan for Patient Quality and Cost Benchmarking Reporting measure	• Documentation of plan

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)**
12. Establish an Accountable Care Organization (ACO) steering committee and subcommittees that focus on Finance, Clinical, Quality, and Informational Technology.	• List of steering committee and subcommittee membership • Copies of steering committee and subcommittee meeting agendas • Documentation of attendance at ACO training/conferences	• Internal hospital records/documentation
13. Determine estimated number of primary care patients by payer at affiliated community health center sites.	• Copy of primary care patient report	• Internal hospital records/documentation
14. Prepare an ACO concept paper.	• Copy of paper	• Hospital and CHC data
15. Hire a consultant to assess ACO development needs.	• Documentation of consultant hired • Copy of consultant scope of work to include assessment of readiness to achieve NCQA ACO accreditation	• Hospital internal documents • NCQA ACO standards

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)**
16. Assess the current state of utilization and cost of care information and tools available to health care community to control costs and improve quality.	• Survey and review data available to hospital's key provider partners • Explore with both commercial payers and Medicaid MCOs the opportunities and criteria to secure data from existing sources • Plan and schedule educational seminars and written communications for provider community about health care transformation including opportunities to manage cost of care and utilize local clinical resources	• Survey sheets • Meeting minutes • Written documentation of communications to providers about educational programs
17. Hire a consultant to assist in ascertaining gaps in available information and types of data systems that would be required to administer and succeed and under alternative payment methodologies.	• Write an RFP to engage a consultant to assist and review data needs and planning process to move to alternative payments • Review proposals to choose the ideal candidate or group • Devise a work plan and timeframes to make investments in systems or processes for data collection on quality reporting and utilization that incorporates the health care community, including physicians, hospitals, and ancillary care providers.	• Documentation of RFP • Candidate interview evaluation form • Work plan for system investments

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)**
18. Produce an ACO development report (by consultant) and internal timeline for future ACO activity.	• Copy of consultant's report • Copy of implementation data	• Internal hospital records/documentation
19. Participation in ACO education sessions offered by nationally recognized entities (e.g. NCQA, Brookings/Dartmouth).	• Documentation of attendance at ACO educational sessions	• Internal hospital records/documentation • Vendor records
20. Steering Committee and Board review and approval of appropriate components of ACO consultant report.	• Copy of Steering Committee minutes • Copy of Board vote	• Internal hospital records/documentation

Key Improvement 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 plan to go "live" with at least one HIE component, tool, or application.	• Screen shot(s) of HIE component, tool or application	• Hospital IT system
2. Implement quality and cost benchmarking plan that includes elements of the Specialist Advisory Council Quality and Cost Performance Incentive Plan and the CMS-approved MSSP Quality Performance Standards.	• Copies of quality and cost benchmarking and measurement reports	• Documentation of quality and cost benchmarking reports
3. Increase the number of physician offices utilizing HIE platform components, tools, or applications by X offices over baseline.	• Increase by X the number of physician offices utilizing HIE platform components, tools or applications	• Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
4. Begin implementation of approved steps from consultant report toward achieving NCQA ACO Accreditation.	• Schedule of implementation • Documentation of implementation	• Internal hospital records/documentation
5. Implement systems or processes that will facilitate keeping care local, lowering cost, improving quality, and accepting alternative payment methodology.	• Implement Year One work plan to have access to a system to help manage utilization costs and quality improvement • Produce leakage reports that will define the types of care leaving the hospital community, the locations where that care is being delivered, and the cost of that care as compared to the cost at the hospital. Both quality and utilization data, measured against national standards, will be reviewed by committee in order to identify action plans including peer recommendations for identified outliers	• Workflow diagram, documentation of infrastructure investment, meeting minutes • Utilization and quality reports • Leakage Reports

Project 3.4: Develop an Integrated Care Organization to Enhance Capacity and to 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 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.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

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.

B. Develop associated organizational and governance requirements, such as Articles of Organization and bylaws.

C. Design the integrated ICO's organizational structure.

D. Build initial capacity, including essential personnel and systems, to administer the integrated ICO.

E. Identify and develop physician leadership for integrated ICO.

F. Devise work plan and timelines for ICO initiatives in systems and care coordination capabilities.

G. Design integrated ICO proposal for a payer population to accept an alternative payment method.

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. Restructure and redesign the hospital-related Physician Hospital Organization (PHO), referred to as an Integrated Care Organization (ICO), based	• Develop and file PHO Articles of Organization and By-Laws • Establish a governing board and hold at least one ICO Board meeting	• Secretary of State Filings • ICO Board 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)**
upon an investigation of successful regional affiliation models and structures to advance the integration of the hospital and local medical community.		
2. Continue to support E.H.R. implementation in community physician offices and evaluate options for connectivity between hospital and physician practices, allowing for greater patient safety by having more timely and accurate results.	• Provide project manager support and continue E.H.R. implementation • Pilot delivery of hospital laboratory results to one clinical information system in at least one physician practice • Create list of all ambulatory E.H.R. vendors in hospital's community physician practices	• E.H.R. project for all practices • System report of lab results delivery activity • Vendor list
3. Identify and develop physician leadership for ICO to lead clinical integration activities.	• Identify at least 3 prospective ICO physician leaders from among the local medical community • Provider leadership training for the prospective ICO physician leaders to assist in education of the entire physician community	• Meeting minutes • Proof of attendance at educational sessions
4. Design an organizational structure and build capacity to run initial critical functions of the ICO.	• Draft an organizational chart for approval by ICO Board that identifies the staffing disciplines and priority required to run the ICO • Hire at least two ICO personnel identified as high priority on the organizational chart who may include: care managers, data analyst, and	• Documentation of the hiring of organizational chart and ICO Board meeting minutes • Human Resources hiring record • Board meeting minutes and work plan

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)**
	administrative staff • Establish a Clinical Integration Committee responsible for devising a work plan and timeframes for additional investments in IT connectivity and care management initiatives, including creating a vehicle for enhanced communication from provider to provider	
5. Further develop infrastructure necessary to enhance capacity to respond to alternative payment systems.	• Implement critical components of Clinical Integration work plan to create seamless transfers between providers for the care of patients	• Documentation of work plan action and hiring of staff to help implement the work plan
6. Design an ICO alternative payment method proposal for a payer population.	• Present ICO proposal to at least one payer under an alternative payment method	• Documentation of proposal

Key Improvement 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 a clinical integration plan to include expanding E.H.R. implementation support and interface development.	• Achieve E.H.R. implementation with X practices or X percent of total practices, resulting in improved coordinated patient care • Extend opportunity to the X practices for electronic laboratory and radiology results delivery	• E.H.R. project plan for X practices • Documentation of opportunity offered

Project 3.5: Develop Administrative, Organizational, and Clinical Capacities to Manage the Care for Complex Patients

Project Goal

The goal of this project is to develop administrative, organizational and clinical capacities to manage the care of complex patients, including populations in a global payment environment. 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 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.

Potential Project Elements

DSTI hospitals undertaking this project may select from among the following project elements:

A. Determine the number of potentially eligible participants in the targeted service area.
B. Select a physical site for program operations and create a physical hub for health care and services in one convenient location in close proximity to the population to be served.
C. Develop a marketing/communication plan.
D. Strategic assessment of how this specific plan for care of the dual eligible population might fit into existing operations, including:
    1. Gap analysis of existing care coordination, HIT, and accounting systems;
    2. Primary, behavioral health and specialty care capacity;
    3. Long term and end-of-life care;
    4. Preventive and rehab services;
    5. Access to diagnostic and pharmacy services.
E. Develop plan for care and services based on strategic assessment, including:
    1. Identify capital requirements;
    2. Determine financial risk;
    3. Determine transportation needs;
    4. Select performance indicators
F. Determine organizational structure.
G. Develop comprehensive training and orientation program for workforce.

Potential Project Elements *DSTI hospitals undertaking this project may select from among the following project elements:*
H. Establish contracts for services as appropriate. I. Enroll first group of participants.

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. Select physical site for program operations.	• Hospital approves site	• Board of Trustee minutes
2. Develop program policies and procedures to align with requirements and specifications of insurance payers.	• Policies and procedures are developed to meet various requirements and specifications for dual-eligible population in global payment configurations	• Hospital policies and procedures
3. Finalize engineering study for site development.	• Engineering study	• Documentation of engineering study
4. Complete analysis of existing health system information technology, care coordination, cost management, and accounting systems in light of global payment and care management requirements").	• Analysis Report: Findings and Recommendations	• Gap Analysis Report
5. Identify the mix of health care and supportive services to be selected from, but not limited to: preventive, primary, acute, behavioral, pharmacy, long-term, end-of-life care, transportation, meals, safe housing.	• Plan for Health and Supportive Services Mix	• Plan for Health and Supportive Services Mix
6. Development of comprehensive training and orientation program on Complex Patient Program Philosophy and Clinical Model.	• Successful production of Comprehensive Training and Orientation Program	• Comprehensive Training and Orientation Program

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. Establish contracts for services to be provided.	• Agreements in place for services to be provided	• Hospital System Contracts
8. Train and orient employees on Complex Patient Program philosophy and clinical model.	• Completion of Complex Patient Training Program	• Copies of Employee Certificates of Completion
9. Develop report(s) on "lessons learned" to educate hospital system to foster innovative thinking in developing alternative models of patient-centered care.	• Lessons Learned Report(s)	• Documentation of Report (s)
10. Conduct baseline study on patients' experience of care and utilization.	• Study of patients' experience of care and utilization	• Documentation of study

Key Improvement 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 at least X number of recommendations from analysis report.	• Report on how at least X number of recommendations from analysis report on HIT, care coordination, cost management, and accounting system were implemented	• Report
2. Enroll first group of program participants.	• Enrollment forms	• Enrollment records
3. Deliver Comprehensive Training and Orientation Program on Complex Patient Program Philosophy and Clinical Model for a minimum of X employees.	• Completion of training and orientation program	• Training and orientation program curriculum/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?

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

A. Evaluate current data collection systems by performing a gap analysis to determine ability to respond to value-based purchasing and continuous quality improvement:
    1. Where is patient data collected?
    2. Who is collecting data?
    3. How is it collected and how is it used?
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.
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.
D. Identify human and capital resources needed to create and utilize data warehouse and business intelligence tools.
E. Develop a training and education plan for data warehouse and business intelligence tool users.
F. Implement population improvement projects that utilize data warehouse and business intelligence tools.
G. Develop dashboards and reports that enable quality improvement and respond to alternative payment methodologies.

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. Perform gap analysis of current data collection systems.	• Complete gap analysis and determine ability to respond to alternative reimbursement methodologies in a concurrent fashion	• 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)**
2. Identify current alternative reimbursement methodologies field requirements that are not captured electronically utilizing the data collection systems identified in the gap analysis.	• List of data fields not captured electronically for the alternative reimbursement methodologies requirements	• Gap analysis, requirements for alternative reimbursement methodologies, existing systems
3. Determine requirements for assessment of data warehouse and business intelligence vendor selection/approach.	• Requirements document for assessment of data warehouse and business intelligence software	• Quality, information systems
4. Post job description and identify resource to create and utilize data warehouse and business intelligence tools.	• Job description developed and posted	• Information Systems • Human Resources
5. Fill resource to create and utilize business intelligence tools.	• Resource hired	• Information Systems • Human Resources
6. Hire a data warehouse and business intelligence vendor.	• Vendor hired	• Documentation of vendor hired
7. Conduct staff training on business intelligence software and benefits, complexities, and challenges of developing a business intelligence environment.	• Evidence of training. • Training materials provided to the organization	• Business Intelligence Vendor • Quality Improvement
8. Implement, at a minimum, three targeted population improvement projects to respond to statewide transformation to alternative reimbursement methodologies.	• Identify baseline of the three targeted populations based on an assessment of high prevalence and/or high risk conditions or patient characteristics identified via the data warehouse	• Data warehouse • Business Intelligence Software

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)**
9. Using data, ID gaps in population-focused improvements.	• Percent of population-focused gaps in improvement of care	• Internal hospital records/documentation

Key Improvement 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. Create current alternative reimbursement methodologies requirement dashboards and reports.	• Documentation of dashboards and reports	• Quality, data warehouse • Business Intelligence Software
2. Design reporting of Emergency Department visits for patients with chronic diseases such as heart failure, COPD, diabetes, depression, etc.	• X percent decrease of the identified chronic disease patient population with Emergency Department visits	• Data warehouse
3. Design reporting of admissions for patients with chronic diseases such as heart failure, COPD, diabetes, depression, etc., by primary care physician.	• X percent decrease of admissions of the identified chronic disease patient population by primary care physician	• Data warehouse

Project 3.7: Develop Capacity to Address the Population Health of the Community Associated with the Triple Aim and Alternative Payment Models

Project Goal

The goal of this project is to develop the capacity to promote the Triple Aim goal of improved population health, the safety net hospital proposes a population health initiative to develop the capabilities and processes to assess, monitor, and eventually improve population health.
In order to prepare to accept alternative or global payment models, hospitals and health systems need to understand their overall patient population in the context of the communities they serve. Hospitals electing this population health project may not yet be reimbursed for these activities through alternative payment models, as these initiatives are being undertaken to prepare for future participation in alternative payment models that reward population health improvement. State and federal policymakers have expressed interest in developing indicators of progress for how new accountable care organizations and integrated care models are charting the course for improvements in the Triple Aim in this regard. One area that has been identified is the "measurement of and fixed accountability for the health status and health needs of designated populations."[72] It is recognized that "the 'actual' causes of mortality in the United States lie in the behavior that the individual health care system addresses unreliably or not at all, such smoking, violence, physical inactivity, poor nutrition, and unsafe choices."[73] [74] Hospitals undertaking this population health initiative need to build the functionality to understand their overall population, morbidities, and compare what is learned to the public health indicators of the population in our target communities. Thus, a more system-level approach is developed in addition to the panel management of patients managed under accountable care arrangements.

Upon identifying the major morbidities of the hospital system's population and its relationship to the population health of communities within the hospital's service area, the safety net hospital will embark upon the development and implementation of an evidence-based population health intervention, in areas that are locally developed and consistent with the Centers for Disease Control and Prevention's winnable battles. These "winnable battles" are those leading public health challenges and causes of death and disability that have large-scale impact and known, effective strategies to combat them such as tobacco use identification and cessation, obesity and physical activity, nutrition, and global immunization.[75]

Collaborations with community and public health organizations are integral to the development of population health capacity and initiatives. Over the three-year period, the hospital system will be able to evaluate the lessons learned to inform a future population health agenda. By developing initial capabilities to address these population health issues in its patient population, the hospital system will

[72] Berwick D, Nolan, T, Whittington J. " The Triple Aim: Care, Health, and Cost." *Health Affairs* 27 3 (May/June 2008): 759-769.
[73] Berwick D, Nolan, T, Whittington J. " The Triple Aim: Care, Health, and Cost." *Health Affairs* 27 3 (May/June 2008): 759-769.
[74] McGinnis J.M, Foege W.H. "Actual Causes of Death in the United States." *Journal of the American Medical Association* 270, no. 18 (1993): 2207-2212; and Mokdad, A.H. et al, "Actual Causes of Death in the United States, 2000." *Journal of the American Medical Association* 291, no. 10 (2004): 1238-1245.
[75] "Winnable Battles." Centers for Disease Control and Prevention. http://www.cdc.gov/winnablebattles/, retrieved on May 11, 2012.

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Project Goal
develop an ongoing capacity for population-based risk assessment and monitoring, aimed at making foundational and meaningful progress toward the Triple Aim goal of improving the health of the community.

Potential Project Elements
DSTI hospitals undertaking this project may select from among the following project elements:

A. Create a data tool for reporting on the hospital's population morbidities and social determinants of health.

B. Identify the leading morbidities in the primary care population and the health indicators of local communities.

C. Prioritize an intervention.

D. Develop a plan for intervention, which may include sites for intervention, baseline data, required patient care workflows, and electronic medical record tools to support the intervention.

E. Train providers on the protocol for identifying and documenting the specified at-risk population.

F. Implement and monitor the intervention, including reporting, which may include screening rates, clinical indicators, and/or interventions.

G. Document lessons learned and application/recommendations for future population health work associated with the Triple Aim.

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. Convene population health workgroup.	• Documentation of formation and implementation of Population Health workgroup as evidenced by workgroup charter, meeting minutes, and roster or participants	• Internal records of population health workgroup report to hospital leadership

Key Process Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
2. Design and develop initial data tool for reporting on the hospital's primary care population morbidities and behavioral risk factors The tool will help identify the major morbidities of the hospital's patient and will be compared to the behavioral risk factors and major morbidities of the community served by the hospital.	• Data analytic tool developed that can be used to assess and report on the morbidities of the patient population. This tool will draw from the hospital's data warehouse in real time	• Screen shot of the data tool and report listing numbers of patients with each morbidity
3. Review and analyze population health data and health indicators of local communities. Select an intervention for implementation.	• Criteria for potential intervention documented, findings from the analysis, identification of area for intervention, such as tobacco use prevention and cessation or another public health challenge such as those identified by the Centers for Disease Control and Prevention Winnable Battles	• Internal data, minutes from meetings, report on data from target communities
4. Develop intervention to address population health, such as tobacco use or other population health initiative in areas such as obesity, cardiovascular risk, behavioral health screening among others.	• Documentation of intervention plan which may include components related to the specific intervention such as those outlined below related to tobacco use prevention and cessation: ➢ Establish baseline data such as: percentage of primary care patients 18 years of age and older with tobacco use presenting at adult primary care sites (numerator is the	• Internal data and records and EMR report

Key Process Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
	number of patients 18 years of age and older with active tobacco use and denominator is the total number of patients 18 years of age and older at primary care sites) ➢ Identification of primary care sites for intervention ➢ Develop Intervention Workflow such as: Tobacco Verification and Counseling Workflow for primary care so that tobacco use is verified at primary care visit ➢ Develop tools in the Electronic Medical Record (EMR) for support of intervention	
5. Evaluate the population health process and report on lessons learned, including about collaboration with community and public health organizations, and application/recommendations for future and ongoing population health work associated with the Triple Aim.	• Documentation of recommendations from first three years of work on population health	• Internal hospital records/documentation and report

Key Process Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
6. Document baseline rate of Obesity – BMI Screening.	• Establish baseline percentage of adult primary care patient population with a clinical visit at participating pilot site(s) during the measurement period who have a BMI in the obesity category linked to NQF 421 or other measure	• Internal data from electronic medical record
7. Document baseline rate of Obesity - Adult Height and Weight Verification.	• Establish baseline percentage of adult primary care patient population with a clinical visit at participating pilot site(s) during the measurement period who received verification of height and weight	• Internal data from electronic medical record
8. Document baseline rate of Cardiovascular Risk Screening.	• Establish baseline percentage of adult primary care patient population with a clinical visit at participating pilot site(s) during the measurement period who were identified with cardiovascular risk factors linked to NQF 17 or other measure	• Internal data from electronic medical record

Key Process Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
9. Document baseline rate of Behavioral Health Screening.	• Establish baseline percentage of adult primary care patient population with a clinical visit at participating pilot site(s) during the measurement period who received an annual behavioral health screening using an approved screening instrument linked to NQF 418 or other measure	• Internal data from electronic medical record

Key Improvement 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 population health pilot intervention at X number of primary care sites. Hospital may propose to increase the number of primary care sites for the population health intervention.	• Documentation that X number of primary care sites' providers have been trained on the protocol for identifying and documenting the specified at-risk population • Establish baseline measure related to intervention at pilot sites, such as tobacco status verification, as measured by: ➢ Numerator: number of primary care visits for patients 18 and older where tobacco use verified at pilot primary care site(s) ➢ Denominator: total number of primary care visits for patients 18 years of age and older,	• Internal hospital records/documentation: EMR report, email instructions

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
	seen at pilot primary care site(s) during the previous month (Measure is a monthly measure of tobacco status verification, linked to NQF 0028a but with a different measurement period)	
2. Increase screening rates for population health intervention such as tobacco status verification, at first pilot site.	• Increase screening rate by X% above baseline for population health measure, such as tobacco status verification, at first pilot site	• Internal hospital records/documentation
3. Establish targeted population health indicator, such as tobacco prevention and cessation as an institutional improvement measure.	• Reports on population health matter verified during primary care visits, such as reports on tobacco use verification documented for all primary care sites ➢ Numerator: number of primary care visits for patients 18 and older where tobacco use status verified at primary care sites. ➢ Denominator: total number of primary care visits for patients 18 years of age and older, seen at primary care sites during the previous month ➢ (Monthly data will be aggregated for baseline comparison to future performance) • Establish baseline data on population health	➢ Internal hospital records/documentation

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
	intervention such as smoking cessation intervention measure across all primary care sites to inform future improvement work: ➢ Percentage of patients 18 years and older, identified as tobacco users, who received cessation intervention in the past 24 months, using the MA PCMHI measure (PCMHI 0028b) and NQF Measure (NQF 0028b) ➢ Numerator: patients 18 and older who are tobacco users who received a cessation intervention, including counseling, diagnosis, and/or medication intervention in past 24 months ➢ Denominator: all patients 18 and older who are identified as being tobacco users, who have had at least 2 visits to the primary care site in the past 24 months	
4. Improve rate of Obesity – BMI Screening.	• X percent increase over established baseline in the percentage of adult primary care patient population with a clinical visit during the	Internal data from electronic medical record

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
	measurement period who have a BMI in the obesity category at participating pilot site(s) (linked to NQF 421 or other measure)	
5. Improve rate of Obesity - Adult Height and Weight Verification.	• X percent increase over established baseline in the percentage of adult primary care patient population with a clinical visit during the measurement period who received verification of height and weight at participating pilot site(s)	Internal data from electronic medical record
6. Improve rate of Cardiovascular Risk Screening.	• X percent increase over established baseline in the percentage of adult primary care patient population with a clinical visit during the measurement period who were identified with cardiovascular risk factors at participating pilot site(s) (linked to NQF 17 or other measure)	Internal data from electronic medical record
7. Improve rate of Behavioral Health Screening.	• X percent increase over established baseline in the percentage of adult primary care patient population with a clinical visit during the measurement period who received an annual behavioral health screening using an approved screening instrument at participating pilot site(s) (linked to NQF 418 or other measure)	Internal data from electronic medical record

Project 3.8: 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 Medicaid patients. In particular for the selected safety net hospitals, it is important that infrastructure is 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 more 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.

Potential Project Elements *DSTI hospitals undertaking this project may select from among the following project elements:*
A. Collaborate with a payer(s) for state-subsidized low-income patients to develop and refine features of the demonstration. B. Develop data-sharing capabilities and execution of data-sharing agreement with payer(s). C. Execution of global payment contractual agreement with payer(s). D. Implement risk-based contracts with physicians and post-acute providers. E. Educate impacted physicians and post-acute providers.

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. Submit Letter of Intent to participate in / develop global/risk-based payment pilot.	• Submission of Letter of Intent	• Letter of Intent
2. Submit data use and/or data sharing agreement.	• Development / signing of formal data use and/or data sharing agreement	• Signed agreement
3. Assess physician and/or post-acute provider contracting for opportunities to align with global / risk-based structure.	• Completion of analysis or report on contracting and opportunities	• Internal hospital records/documentation

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Key Process Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
4. Amend physician and/or post-acute provider contracts to align with global / risk-based structure.	• Completion of contract amendments	• Amended contract/documentation
5. Develop education materials for physicians and/or post-acute providers in network regarding global / risk-based payment strategies.	• Completion of educational materials	• Documentation of educational materials
6. Conduct educational outreach to physicians and/or post-acute providers in network regarding global / risk-based payment strategies.	• Number of educational sessions held • Number of physicians and/or post-acute providers provided educational materials	• Internal hospital records/documentation
7. Provide preliminary quality data based on MSSP set to payer(s).	• Submission of preliminary quality report based on MSSP	• Documentation
8. Execute final agreement to accept global / risk-based payments for aligned patients.	• Signed agreement with payer(s) for reimbursement under global / risk-based arrangement	• Agreement

Key Improvement 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. Accept global / risk-based payment for increasing portion of aligned patient population.	• X% of aligned patient population reimbursed under global or risk-based payment arrangement	• Documentation
2. Reduce trend for aligned patient population.	• X% reduced trend in expenditures (total medical expense) year to year • Health status adjusted total medical expense trend X% below comparable patient population	• Performance report

Key Improvement Measures *DSTI hospitals undertaking this project may select from among the following measures, with their associated metrics and data sources.*		
3. Accept increasing level of risk for aligned patient population.	• X% risk sharing for achieved savings/loss • X% increase in risk sharing for achieved savings/loss	• Documentation

Project 3.9: 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 – or will develop a new learning collaborative designed to support its transformation goals. As an initial step, in the first year of the Demonstration period, eligible DSTI safety net hospitals will explore existing and/or potential new opportunities for participation in a learning collaborative.

Potential Project Elements

All DSTI hospitals must select from among the following project elements:

A. Explore existing and/or potential new opportunities for participation in a learning collaborative whose goals align with the Triple Aim and DSTI transformation objectives.
B. Select a learning collaborative in which to participate, which may consist of either:
    1. Identifying and joining an existing learning collaborative whose goals align with the Triple Aim and DSTI objectives; OR
    2. Developing a new learning collaborative structure designed to support the hospital's delivery system transformation goals and to align with the Triple Aim and DSTI objectives.
C. 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.
D. Participate actively in the selected or new learning collaborative.
E. Report on lessons learned from participation in a learning collaborative as they relate to the hospital's delivery system transformation goals under DSTI.

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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. DY 15: Explore existing and/or potential new opportunities for participation in a learning collaborative.	• Hospital meeting minutes and/or documentation of research findings on learning collaboratives	• Internal hospital documentation
2. DY 16 option: Select and join an existing learning collaborative (if selecting option 1 of Project Element B, above).	• Documentation of hospital joining learning collaborative	• Internal hospital documentation and/or learning collaborative documents
3. DY 16 option: Develop a new learning collaborative structure (if selecting option 2 of Project Element B, above).	• Documentation of new learning collaborative goals, structure and membership • Signed agreement with facilitator of new learning collaborative (if applicable)	• Learning collaborative documents • Agreement
4. DY 16 option: Establish and implement a new learning collaborative (if selecting option 2 of Project Element B, above).	• Documentation of learning collaborative activities	• Learning collaborative documents
5. DY 16 and DY 17: Participate actively in a learning collaborative.	• Documentation of attendance at and/or participation in learning collaborative activities	• Internal hospital documentation • Learning collaborative documents
6. DY 17: Report on lessons learned from participation in a learning collaborative as they relate to the hospital's delivery system transformation goals under DSTI.	• Hospital report on lessons learned	• Hospital report

31. **Category 4: Population-Focused Improvements**

This section includes a menu of Category 4 measures related to population-focused improvements. The purpose of Category 4 is to evaluate the impact of the investments and system changes described in Categories 1, 2 and 3 through population-focused measures. Category 4 metrics shall recognize that the population-focused objectives do not guarantee outcomes but result in learning, adaptation, and progress. As such, eligible safety net hospitals will measure and report on selected measures but will not have milestones associated with the achievement of specific improvements. Hospitals shall commence reporting Category 4 measures starting in Demonstration Year 16 (SFY 2013).

a) Common measures: All participating safety net hospitals will develop plans to report on a core set of Category 4 measures that are included below. Hospitals shall report on 11 Common Measures in Demonstration Year 16 (SFY 2013) and report on one additional Common Measure in Demonstration Year 17 (SFY 2014), for a total of 12 Common Measures in Demonstration Year 17.

b) Hospital-specific measures: For each project a hospital selects in its individual DSTI plan, the hospital shall elect at least one Category 4 hospital-specific measures up to a total of 15 Category 4 hospital-specific measures for all the hospital's projects on which the hospital will include a plan to report, selected from the list included in below. Project 3.9: Participate in a Learning Collaborative will not have associated Category 4 hospital-specific measures.

Hospitals must ensure that sampling procedures consistently produce statistically valid and useful data. If a hospital's denominator population for a given measure is not sufficiently large to produce statistically valid data, then hospitals shall not be required to report the data under Category 4 measures.

Introduction

As defined in the Massachusetts Section 1115 Demonstration Special Terms and Conditions, the purpose of Category 4 is to evaluate the population-focused objectives and improvements related to the projects selected by hospitals in Categories 1, 2, and 3. In recognition that the transformation projects do not guarantee outcomes but result in learning, adaptation, and progress, eligible safety net hospitals will measure and report on the population-focused measures outlined below but will not have milestones associated with the achievement of specific improvements.

Because this category involves evaluating the initiatives and system changes described in Categories 1, 2, and 3 through population-focused objectives, the common measure set is organized around the Triple Aim:

- **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 population by supporting proven interventions and enhancing the quality of care delivered.

- **Cost-Effective Care:** Improve cost-effectiveness of care through improved care delivery for individuals, families, employers, and the government.

Table 1: Category 4 Common Measures[76]

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.[77] 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 Care also includes a focus on care in Emergency Departments. Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. Overcrowding and heavy emergency resource demand have led to a number of problems, including prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes.

[76] Hospitals must ensure that sampling procedures consistently produce statistically valid and useful data. If a hospital's denominator population for a given measure is not sufficiently large to produce statistically valid data, then hospitals shall not be required to report the data under Category 4 measures.
[77] 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.

Better Care Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.1 Care Transitions Measure Set (CTM-3) *Voluntary HCAHPS questions* *Data Source: Hospital vendor or Hospital Compare as available*	Not applicable in DY16. Requires new data capture.	Not applicable in DY16. Requires new data capture.	07/01/12 – 06/30/13	7/31/14
4.2: Patients who reported that staff "Always" explained about medicines before giving it to them. *HCAHPS Composite (Questions 16 & 17)* *Data Source: Hospital Compare*	01/01/11 – 12/31/11	1/31/13	01/01/12 – 12/31/12	1/31/14
4.3: Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home. *HCAHPS Composite (Questions 19 & 20)* *Data Source: Hospital Compare*	01/01/11 – 12/31/11	1/31/13	01/01/12 – 12/31/12	1/31/14
4.4: ED Wait Time: Door to Diagnostic Evaluation by a Qualified Medical Personnel *CMS IQR measure (OP-20)* *Data Source: Hospital Compare*	01/1/2012 - 06/30/12	1/31/13	07/1/2012 - 06/30/13	1/31/14

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 4 common measures share a focus on examining population dynamics. Two CMS Inpatient Quality Reporting/Joint Commission measures report on proven immunization interventions that can improve the health of

hospitalized populations following discharge—preventing subsequent care interventions.[78] Two other ambulatory- sensitive measures examine acute admissions for chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) patients—two patient populations of particular concern given their chronic care needs. A fifth measure looks at maternal and child health—examining the incidence of low-birth weight children, a leading determinant of newborn health especially important for Medicaid populations.

Better Health Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.5: Pneumonia Immunization *CMS IQR/Joint Commission measure* *IMM-1a* [79] *Data Source: Hospital Compare*	01/01/12 – 06/30/12	01/31/13	07/01/12 – 06/30/13	01/31/14
4.6: Influenza Immunization (seasonal measure) *CMS IQR/Joint Commission measure* *IMM-2* [80] *Data Source: Hospital Compare*	01/01/12 - 03/30/12	01/31/13	10/01/12- 03/30/13	01/31/14
4.7: Percent of discharged patients under age 75 who were hospitalized for Chronic Obstructive Pulmonary Disease (Ambulatory Sensitive-Condition Admissions Measure) *Modified AHRQ PQI-5: denominator modified to include only discharged hospital inpatients* *Data Source: Hospital billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14

[78] See Specifications Manual for National Hospital Inpatient Quality Measures for selected references on clinical effectiveness of immunizations. Available at http://www.qualitynet.org

[79] CMS and the Joint Commission began collecting this measure effective with January 1, 2012 discharges. IMM-1a includes all inpatients.

[80] CMS and the Joint Commission began collecting this measure effective with January 1, 2012 discharges. IMM-2 includes all inpatients.

Better Health Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.8: Percent of discharged patients under age 75 who were hospitalized for Congestive Heart Failure (Ambulatory Sensitive-Condition Admissions Measure) *Modified AHRQ PQI-8; denominator modified to include only discharged hospital inpatients* *Data Source: Hospital billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14
4.9: Low Birth Weight Rate: number of low birth weight infants per 100 births[81] *AHRQ PQI-9* *Data Source: Hospital records*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14

Cost-Effective Care: Improve cost-effectiveness of care through improved care delivery for individuals, families, employers, and the government. 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. Similarly, many pediatric asthma emergency department visits are potentially avoidable with concerted outpatient management and care plans; therefore, an ambulatory-care sensitive pediatric asthma measure, relevant to Medicaid populations, has been included. Lastly, a measure of early elective delivery examines a practice of care for which the evidence-base suggests can lead to unnecessary newborn complications and health care costs.[82]

[81] Hospitals without maternity services are exempted from this measure.
[82] Clark, S., Miller, D.,et al. "Neonatal and maternal outcomes associated with elective delivery." *Am J Obstet Gynecol*. (2009) 200:156.e1-156.e4.

Cost-Effective Care Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.10: Hospital 30-day, all-cause readmission rate to the index hospital following a hospitalization for all patients 18 and older (not risk adjusted) *See CMS IQR Readmissions Measures (AMI, CHF, and Pneumonia) for a list of standard exclusions, including: 1) index admissions for patients with an in-hospital death, 2) patients transferred from the index facility to another acute care facility, and 3) patients discharged against medical advice.*[83] *Data Source: Hospital billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14
4.11: Percent of Emergency Department visits for children age 18 or less with a primary diagnosis of asthma--Ambulatory Sensitive-Condition *See AHRQ PDI-14 for numerator specification. Denominator specification includes children ages 2 to 17 with an ED visit* *Data Source: Hospital ED billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14
4.12: Percent of patients with elective vaginal deliveries or elective cesarean sections at greater than or equal to 37 weeks and less than 39 weeks of gestation completed[84] *MassHealth Maternity Measure-3* *Data Source: MassHealth Quality Exchange(MassQEX)*	07/01/11-06/30/12	1/31/13	07/01/12-06/30/13	1/31/14

[83] In addition, if a patient has one or more admissions within 30 days of discharge from the index admission, only one is counted as a readmission. No admissions within 30 days of discharge from an index admission are considered as additional index admissions. The next eligible admission after the 30-day time period following an index admission will be considered another index admission.

[84] Hospitals without maternity services are exempted from this measure.

Category 4 Hospital-Specific Measures

In addition to the common measures listed in Table 1 above, hospitals must select hospital-specific measures on which to report according to the projects they have selected in Categories 1-3. Hospitals must select for reporting in Category 4 a minimum of one measure per project up to a total of 15 Category 4 hospital-specific measures for projects selected in Categories 1-3. Project 3.9: Participate in a Learning Collaborative will not have associated Category 4 hospital-specific measures. Hospitals shall choose from the options listed below in Table 2, which are associated with the project in Categories 1-3 to which they pertain.[85]

Given the innovative nature of delivery system transformation and its highly-specific application relative to the existing needs, capacities, and opportunities for improvement at each DSTI hospital, some Category 4 hospital-specific measures include customized measurement to appropriately and meaningfully evaluate the progress and improvements related to projects hospitals have selected in Categories 1, 2, and 3. In the case of some DSTI projects, the program of activities does not lend itself to standard measures. In other cases, such measures are not a fit with the specific transformation goals of the project and/or reporting capabilities of the hospital based on the data available to them. Therefore, the menu of hospital-specific measures includes a blend of nationally recognized measures and hospital-specific customized measures. In many cases, the hospital-specific measures are customized to the nature of the transformation project, the patient population, available payer-specific data, the measurement period, and/or hospital data capabilities including whether hospital systems include employed physicians or ambulatory care. Additionally, customized measures provide feasible data collection opportunities while providing valuable evaluative information on transformation goals. Each hospital, in their hospital-specific plan, will include a narrative on the hospital-specific Category 4 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.

Table 2 Category 4: Hospital-Specific Measures

Project 1.1 Patient Centered Medical Home	
ID	**Measure**
PCMHI 0033	Average third next available appointment (wait time) for the practice
PCMHI 0035	Average panel size for the practice
Press Ganey	Medical practice satisfaction: overall rating score on Medical Practice Survey for two large medical practices
NQF 0031	Percent of eligible women 40-69 who receive a mammogram in a two-year period

[85] Hospitals must ensure that sampling procedures consistently produce statistically valid and useful data. If a hospital's denominator population for a given measure is not sufficiently large to produce statistically valid data, then hospitals shall not be required to report the data under Category 4 measures.

Customized Measure	Percent of patients with a minimum of one chronic disease in each adult and pediatric practice
Customized Measure	Hospital 30-day, all-cause readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a diagnosis of diabetes
Customization of Patient Continuity of Care	Continuity of Care Measure: measures visit continuity for patients with their primary care physician or the primary care physician and/or the primary care team
Project 1.2 Integrate Physical Health & Behavioral Health	
ID	**Measure**
NQF 0575	Percent of patients 18–75 years of age with diabetes (type 1 or type 2) who were screened for depression using PHQ-2 or other approved screening instruments during the measurement period.
NQF 0712	Percent of patients 18 years of age and older receiving depression screening through the use of PHQ-2 or other approved screening instruments within the measurement period.
Customized Measure	Percent of Emergency Department patients who screen positive for substance abuse using Screening, Brief Intervention, and Referral to Treatment (SBIRT) Protocol
Customized Measure	Average length of Emergency Department stay for mental health/substance abuse patients in hospital Emergency Department
Customized Measure	The rate of ED patients who leave without being treated by a Licensed Independent Practitioner
Customized Measure	The percentage of patients 18 years and older with a new episode of depression and started on an anti-depressant medication in primary care, who have had a 50 percent reduction in their PHQ9 Score during the 16-week acute phase, at pilot site(s).
1.3 Further Develop Integrated Care Network for Primary and Specialty Care	
ID	**Measure**
Customized Measure	Urgent Care Volume
Customized Measure	Volume of patients obtaining care in hospital-based Express Care as it relates to total Emergency Dept visits. Report as change in percentage of hospital-based Express Care visits compared to total visits for patients at ambulatory based Urgent Care during operational hours.

Customized Measure	Number of primary care physician FTEs and attributed patients
Customized Measure	Percent of hospital's non-emergent Emergency Department patients sampled that are unable to identify a Primary Care Physician
Customized Measure	Using survey sampling techniques, determine time to first appointment and time to third next appointment for patients seeking care with PCP
1.4 Establish Health Data Exchange Capability to Facilitate Integrated Patient Care	
ID	**Measure**
USPHTF	Baseline compliance with USPHTF measure for 2 providers for ALL of the following: BP screening Br CA screening Cervical CA screening Cholesterol screening (M and F) Colon CA screening Osteoporosis screening Tobacco Screening
Customized Measure	Percent of providers with integrated Electronic Health Records into the Health Information Exchange whose patients had a duplicate or unnecessary test.
1.5 Practice Support Center	
ID	**Measure**
Press Ganey	Medical practice satisfaction: percent of patients surveyed answering "good" or "very good" to Press Ganey survey question regarding "ease of getting clinic on phone"
Press Ganey	Medical practice satisfaction: percent of patients surveyed answering "good" or "very good" for Press Ganey survey questions regarding "ease of scheduling appointments"
1.6 Implement Patient Navigation Services	
ID	**Measure**
Customized Measure	Frequent User ED Visits
Customized Measure	Unnecessary ED Visits

1.7 Develop Integrated Acute and Post-Acute Network Across the Continuum of Care	
ID	**Measure**
Customized Measure	X% reduced hospital 30-day all-cause readmissions from prior year baseline
Customized Measure	X% reduced readmissions from specified post-acute setting from prior year baseline
2.1 Implement Care Management Interventions for Patients with Chronic Diseases	
ID	**Measure**
NQF 0575 with adjustment to measurement period	Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0% during the measurement period at implemented pilot sites.
NQF 0059 with adjustment to measurement period	Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c > 9.0% during the measurement period at implemented pilot sites.
NQF 0061with adjustment to measurement period	Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg during the measurement period at implemented pilot sites.
NQF 0064 with adjustment to measurement period	Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL C <100mg/dL during the measurement period at implemented pilot sites.
NQF 0055 with adjustment to measurement period	Percent of adult patients with diabetes (type 1 or type 2) who had eye exam at least once during the measurement period at implementation sites.
NQF 0057	Percent of patients 18-75 of age with diabetes who received one or more A1c test(s) per year
NQF 0062	Percent of adult patients with diabetes (type 1 or type 2) who had micro-albumin screening at least once during the measurement period at implemented pilot sites.
NQF 0018	The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement period at implementation sites.
Customized Measure	Repeat ED visit rate

Modified NQF 0330	Hospital 30-day, all-cause, readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a primary diagnosis of heart failure
Customized Measure	Hospital 30-day, all-cause, readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a primary diagnosis of chronic obstructive pulmonary disease (COPD)
Customized Measure	Percent of patients enrolled in Heart Failure disease management program with evaluation of LVS function
Customized Measure	Percent of LVSD patients enrolled in Heart Failure disease management program prescribed ACEI or ARB at discharge
Customized Measure	Percent of patients who smoke and are enrolled in Heart Failure disease management program who receive adult smoking cessation advice/counseling
Customized Measure	Percent of patients enrolled in Heart Failure disease management program contacted within 24 hours post discharge
Customized Measure	Percent of targeted chronic disease patients who received a follow up appointment within 7 days of being discharged from the hospital with PCP
Customized Measure	Percent of Tele-health eligible patients enrolled in Heart Failure disease management program with Tele-health capabilities post discharge
Customized Measure	Percent of patients enrolled in Heart Failure disease management program discharged with home support post discharge
Customized Measure	Percent of adult patients with diabetes (type 1 or type 2) who had a hospitalization at the index hospital at least once during the measurement period at implemented pilot sites.
Customized Measure	Percent of COPD patients who go home with their inhaler if it is "continued" on their medication discharge instructions.
2.2 Establish a Chronic Disease Registry	
ID	**Measure**
Customized Measure	Percent of patients enrolled in the Chronic Disease Registry who are given a referral for specialist treatment of a chronic disease
Customized Measure	For patients enrolled in the Chronic Disease Registry, average turn-around time of referral report for specialist treatment of chronic disease

Customized Measure	Percent of patients with identified chronic disease who did not keep follow-up appointments with Primary Care Physician
Customized Measure	Percent of patients with identified chronic disease who are referred to attend smoking cessation counseling from a certified smoking cessation counselor.
2.3 Implement Improvements in Care Transitions	
ID	**Measure**
HCAHPS	HCAHPS Discharge Information
Modified NQF 0330	Hospital 30-day, all-cause, readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a primary diagnosis of heart failure
Customized Measure	Hospital 30-day, all-cause readmission rate to the index hospital following a hospitalization for high-risk patients (as defined by STARR High Risk Tool) 18 and older
HCAHPS	Percent of Patients who reported that their nurses "Always" communicated well
2.4 Develop or Expand Projects to re-Engineer Discharge Processes	
ID	**Measure**
Customized Measure	Hospital 30-day, all-cause readmission rate to the index hospital following a hospitalization patients ages 18 – 65, admitted for medical care (non-surgical and non-maternity) and are MassHealth or Commonwealth Care members of the BMC HealthNet Plan, who are served by re-engineered discharge process to reduce readmissions
Customized Measure	Percent of patients ages 18 – 65, admitted for medical care (non-surgical and non-maternity) and are MassHealth or Commonwealth Care members of the BMC HealthNet Plan, who are served by re-engineered discharge process to reduce readmissions
Customized Measure	Percent of parents or caregivers of patients ages 18 – 65, admitted for medical care (non-surgical and non-maternity) to a specific cohort, who receive a hospital after care plan at discharge

2.5 Implement Primary Care-Based System of Complex Care Management for High Risk Population(s)	
ID	**Measure**
PCMHI 0012	Percent of hospitalized patients who have clinical, telephonic, or face-to-face follow-up interaction with the care team within 2 days of discharge during the measurement month at sites with implemented complex care management.
PCMHI 0013	Percent of patients who have been seen in the Emergency Room with a documented chronic illness problem, who have clinical telephonic or face-to-face follow-up interaction with the care team within 2 days of ER visit during the measurement month at sites with implemented complex care management.
2.6 Establish a Multi-Disciplinary Education and Simulation Center	
ID	**Measure**
Customized Measure	Percent of infants delivered vaginally with shoulder dystocia
AHRQ PSI 39	Failure to Rescue Rate: Deaths per 1,000 patients having developed specified complications of care during hospitalization.
2.7 Implement Process Improvement Methodologies to Improve Safety, Quality and Efficiency	
ID	**Measure**
BCBS AQC	Percent of patients aged 18 through 85 enrolled in the Blue Cross Blue Shield Alternative Quality Contract who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90)
Standard measure	Falls per thousand patient days
Standard measure	Average Length of Stay for all Inpatients
Customized Measure	Percent of registered Emergency Department Patients leaving Emergency Department without being seen
CDC CLASBI	Central Line Associated Blood Stream Infections

2.8 Provide an Alternative Care Setting for Patients who Seek Non-Emergent Department Care	
ID	**Measure**
Customized Measure	Average monthly non-emergent Hospital emergency department volume that is level, 3, 4, and 5 on the ESI scale, separately, as a percentage of the total ER volume
Customized Measure	Measure average monthly visits at new co-located PCMH primary care site
2.9 Reduce Variations in Care for Patients with High Risk Conditions	
ID	**Measure**
Customized Measure	30-day all-cause readmissions
3.1 Develop Risk Stratification Capabilities for Patient Populations and Alternative Payment Models	
ID	**Measure**
Customized Measure	Estimated total costs avoided due to interventions triggered by X percent highest risk patient identification and care management in specific payer cohort
Customized Measure	Admits/1,000 (Tufts Medicare Preferred population)
Customized Measure	Acute Admits/1,000 from a SNF (Tufts Medicare Preferred population)
3.2 Design and Implement a Hospital-Based 360 Degree Patient Care Program	
ID	**Measure**
Customized Measure	Admits/1,000 (Tufts Medicare Preferred population)
3.3 Develop Governance, Administrative, and Operational Capacities to Accept Global Payments/Alternative Payment	
ID	**Measure**
NQF 0036	Percentage of patients who were identified as having persistent asthma and who were dispensed a prescription for either an inhaled corticosteroid or acceptable alternative medication during the measurement year
NQMC-1976	Heart failure: percentage of patients aged greater than or equal to 18 years with diagnosed heart failure (HF) who also have left ventricular systolic dysfunction (LVSD) who were prescribed angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy.
NQMC-6217	Comprehensive diabetes care: percentage of members 18 through 75 years of age with diabetes mellitus (type 1 and type 2) whose most recent hemoglobin A1c (HbA1c) level is greater than 9.0% (poorly controlled).

Customized Measure	For a targeted population, the percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months.
Customized Measure	Report of claims based utilization data for targeted population and service lines compared to benchmarks
Customized Measure	Average Length of Stay for existing Mercy/Physician Group Medicare Advantage "Virtual" ACO beneficiaries
Customized Measure	Percentage of existing Mercy/Physician Group Medicare Advantage "Virtual" ACO beneficiaries readmitted < 30 days
3.4 Develop an Integrated Care Organization to Enhance Capacity and to Respond to Alternative Payment Systems	
ID	**Measure**
Customized Measure	Number of physicians in new ICO
Customized Measure	Number of patients attributed to PCPs in ICO
Customized Measure	Percent of primary care physicians who successfully qualify for a Medicare or Medicaid EHR Incentive Program payment
Customized Measure	Count of patients represented by PCPs in the original PHO organization, prior to redesigning it to become the ICO.
3.5 Develop Administrative, Organizational, and Clinical Capacities to Manage the Care for Complex Patients	
ID	**Measure**
Customized Measure	Number of Dual Eligible Inpatient Admissions
Customized Measure	Number of Dual Eligible ED visits
Customized Measure	Percent of Dual Eligible Patients readmitted all cause < 30 days

3.6 Establish an Enterprise-Wide Strategy for Information Management and Business Intelligence	
ID	**Measure**
Customized Measure	Identify top 5 most costly providers compared to 30 day readmission rates for HF
Customized Measure	Percent of identified "high risk" for readmission patients who are scheduled a follow up visit prior to discharge using nationally recognized evaluation tool (e.g. STAAR) for identifying high risk patients for readmission.
Customized Measure	Percentage of times critical information is transmitted at the time of discharge on identified high risk patients to the next site of care, i.e., home health, LTC, rehab and/or PCP office
3.7 Develop Capacity to Address the Population Health of the Community Associated with the Triple Aim and Alternative Payment Models	
ID	**Measure**
NQF 0028a with adjustment to measurement period	Percent of patients 18 years and older who were queried about tobacco use in the past 24 months (at implementing pilot site(s))
NQF 0028b with adjustment to measurement period	Percent of patients 18 years and older, identified as tobacco users, who received cessation intervention in the past 24 months (at implementing pilot site(s))
Obesity – BMI Screening (linked to NQF 421)	Percent of adult primary care patient population with a clinical visit during the measurement period who have a BMI in the obesity category during the measurement period (at implementing pilot site(s))
Obesity - Adult Height and Weight Verification	Percent of adult primary care patient population with a clinical visit during the measurement period who received verification of height and weight during the measurement period (at implementing pilot site(s))
Cardiovascular Risk Screening (linked to NQF 17)	Percent of adult primary care patient population with a clinical visit during the measurement period who were identified with cardiovascular risk factors during the measurement period (at implementing pilot site(s))
Behavioral Health Screening (linked to NQF 418)	Percent of adult primary care patient population with a clinical visit during the measurement period who received an annual behavioral health screening using an approved screening instrument during the measurement period (at implementing pilot site(s))
3.8 Global Payment Pilot Project	
ID	**Measure**
Customized Measure	X% of aligned patient population reimbursed under global payment arrangement
3.9 Participate in a Learning Collaborative	
N/A	N/A

ATTACHMENT J
RESERVED FOR MASTER DSTI PLAN AND REIMSBURSEMENT AND FUNDING PROTOCOL

XI. DSTI EVALUATION

32. **State Process for Developing an Evaluation of DSTI**

A draft design for the evaluation of DSTI will be included in the draft evaluation design for the 1115 Medicaid Demonstration, to be submitted in accordance with STC section 84. 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 external evaluator to develop an evaluation plan in accordance with STCs 84-86.

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.