

COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
OFFICE OF MEDICAID

**Section 1115 Demonstration  
Project Extension Request**

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## I. EXECUTIVE SUMMARY

MassHealth, the Massachusetts Medicaid and Children’s Health Insurance Program, provides health coverage to more than 2 million, approximately 30 percent, of the Commonwealth’s residents. MassHealth is key to maintaining Massachusetts’ level of coverage at over 97 percent, the highest in the nation.<sup>1</sup> MassHealth is requesting a five-year extension of its current 1115(a) demonstration, which is set to expire on June 30, 2022.

Since 1997, when MassHealth first received approval for its 1115 demonstration (“the demonstration”), the demonstration has been an important vehicle for coverage expansion, delivery system reform, and innovative approaches to improve health outcomes for members. The demonstration has enabled the development of new and effective delivery models, including managed and accountable care, supported providers throughout the Commonwealth via the Safety Net Care Pool, and expanded coverage for millions of the Commonwealth’s most at-risk residents.

The current demonstration period, for the years 2017 – 2022, has enabled the most significant delivery system reforms in the MassHealth program in over two decades. These reforms have restructured the MassHealth delivery system towards integrated, valued-based, accountable care, with the goals of improving quality, outcomes, and member experience, and establishing greater control over spending growth. Under the current demonstration, CMS authorized \$1.8 billion in Delivery System Reform Incentive Program (DSRIP) funding, which has supported critical investments in the Commonwealth’s transition toward accountable care.

MassHealth’s current demonstration aims to achieve the following goals:

1. Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care;
2. Improve integration of physical, behavioral, and long-term services;
3. Maintain near-universal coverage;
4. Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals;
5. Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services;
6. Ensure access to Medicaid services for former foster care individuals aged 18 through 26 who previously resided in another state; and
7. Ensure the long-term financial sustainability of the MassHealth program through refinement of provisional eligibility and authorization for SHIP Premium Assistance.

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<sup>1</sup> “Findings from the 2019 Massachusetts Health Insurance Survey.” Massachusetts Center for Health Information and Analysis, April 2020. <https://www.chiamass.gov/assets/docs/r/survey/mhis-2019/2019-MHIS-Report.pdf>.

Among other important reforms, the current demonstration has enabled health system restructuring efforts leading to the establishment of Accountable Care Organizations (ACOs) – health care organizations that take on accountability for improved population-level health outcomes, lower cost, and improved member experience – in which more than 80% of eligible MassHealth members have now been enrolled. In partnership with ACOs, the creation of the Behavioral Health and Long-Term Services and Supports Community Partners (CP) program – community-based organizations who provide wrap-around expertise and support for members with complex behavioral health and long-term services and supports needs – has enabled MassHealth to improve the provision of whole-person, integrated, and member-centric care for its members. In parallel, the launch of the Flexible Services Program has established the ability for ACOs to provide targeted housing- and nutrition-related supports to better address MassHealth members' health-related social needs. MassHealth has simultaneously made substantial investments in substance use disorder services to address the ongoing opioid epidemic, and restructured the Safety Net Care Pool to support critical safety net providers while linking funds to ACO participation and performance.

Currently, three years into the implementation of this demonstration, delivery system restructuring initiatives show promising early results, including that ACOs are strengthening MassHealth members' connection to primary care, reducing preventable acute utilization, and improving clinical quality. Similarly, Community Partner organizations are engaging some of the most highly complex MassHealth members. MassHealth has also expanded substance use disorder treatment throughout the Commonwealth, including expansion of residential services and inclusion of Recovery Coach and Recovery Support Navigator services in the MassHealth benefit. Continuing its history of nearly universal health coverage, Massachusetts has also maintained over 97% coverage for its residents during this period. These results are described further in the Introduction (see Section II).

Despite these early promising results, important opportunities remain to continue the path of system restructuring towards accountable, value-based care. Among those opportunities is the critical need to reduce health disparities that persist when stratifying key measures by race, ethnicity, language, disability, sexual orientation, and gender identity.

As the current demonstration period ends, MassHealth is at an important transition point. Given the important early successes of the current demonstration, and demonstrated progress towards delivery system reform, MassHealth proposes to continue certain key initiatives that began as part of the DSRIP program through new demonstration authorities (see Section III), while transitioning other aspects of the program to other authorities. In parallel, MassHealth is committed to continuing to refine the program to improve upon services for residents across the Commonwealth.

The extension of the demonstration provides a critical opportunity to maintain the gains Massachusetts has made and make further progress to improve care delivery and outcomes for MassHealth members. Massachusetts proposes its next demonstration period, beginning in 2022, will focus on the following goals:

**Goal 1: Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model**

MassHealth requests authority to continue the Accountable Care Partnership Plan program (Model A) and Primary Care ACO program (Model B), while sunseting the Managed Care Organization (MCO)-Administered ACO program (Model C). MassHealth intends to re-procure the ACO program, maintaining the same core pillars and requirements while implementing improvements based on lessons learned during the current demonstration. Such improvements would include strengthening expectations of integration in the Model A ACO program and adjusting the relative financing of Models A and B in ways that re-affirm each model's important role and hold them to comparable expectations to deliver value to the Medicaid program. Improvements would also include standardizing and clarifying ACOs' requirements to provide whole-person, integrated, and member-centered care coordination to all members. To further improve member and provider experience, the ACO program will streamline administration of particularly complex areas of the program, including behavioral health and pharmacy. For example, ACOs will be expected to meet standard requirements for the administration of the behavioral health benefit, including streamlining provider credentialing and enrollment, aligning utilization management practices, and strengthening networks and member protections around access to and continuity of care. In addition, MassHealth will implement a fully unified pharmacy formulary across its fee-for-services and managed care programs, and requests authority to standardize its 340B payment methodologies across delivery systems.

In parallel, MassHealth intends to re-procure the Behavioral Health and Long-Term Services and Supports Community Partners (CP) programs, transitioning them to sustainable financing and a more accountable structure, and expanding and investing in the Long-Term Services and Supports CP program in particular. Time-limited DSRIP funding was critical to the start-up and early success of the ACO and CP programs. With DSRIP ending, high-impact DSRIP-funded activities would transition to become core elements of the MassHealth program. MassHealth aims to transition approximately 80% of current DSRIP funding into sustainable base funding for primary care, health-related social needs, and care coordination (e.g., supports for members with disabilities, embedded Community Health Workers and peers in primary care practices, the CP program).

**Goal 2: Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care**

MassHealth is committed to making significant investments to achieve improvements in primary care and behavioral health services in the next demonstration period. MassHealth requests authority to transition primary care payment in the ACO program to a new sub-capitation payment model to support and incentivize enhanced care delivery expectations (e.g., behavioral health integration) and more flexibility, while moving providers off the “fee-for-service treadmill.”

MassHealth will also invest in expanding behavioral health access and integration as part of the Commonwealth’s *Roadmap for Behavioral Health Reform*<sup>2</sup>. To support the *Roadmap*, MassHealth requests authority to bolster behavioral health workforce retention and diversity initiatives, expand diversionary behavioral health services to members in MassHealth’s fee-for-service program, and continue Massachusetts’ current substance use disorder waiver and pending serious mental illness waiver to maintain these critical services in the Commonwealth.

In addition, recognizing the unique needs of children, youth, and families, MassHealth will bring enhanced clarity, expectations, and investments to care coordination for children, including the addition of a new Targeted Case Management benefit through the State Plan. In addition, MassHealth’s proposed changes to the Flexible Services program would also be tailored to better recognize and serve the needs of this children and families.

**Goal 3: Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals**

MassHealth seeks to introduce significant accountability for health care providers and ACOs to measure and close health disparities over the five-year demonstration period, with a focus on the quality of services and outcomes stratified by race, ethnicity, language, disability status, sexual orientation, and gender identity. Specifically, MassHealth requests authority to launch a five-year, \$500 million incentive program for ACO-participating hospitals, targeted primarily toward safety net hospitals, and introduce substantial equity-focused performance incentives for ACOs and their participating providers. This funding will be distinct from the Safety Net Care Pool (see Goal 4). Hospitals and ACOs will be accountable for measuring, reporting, and closing gaps in care across an aligned slate of measures.

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<sup>2</sup> More information available at: <https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform>

MassHealth also requests authority to continue the promising Flexible Services Program, with certain improvements, to provide evidence-based supports for members with nutritional and housing supports needs. Reflecting lessons learned from Flexible Services in the current demonstration, MassHealth also requests authority to expand the Community Support Program (CSP) benefit to support members with behavioral health needs who are experiencing or at risk of homelessness.

MassHealth's demonstration proposal also focuses specifically on significant health disparities faced by justice-involved populations. As one striking example, formerly incarcerated adults in Massachusetts are 120 times more likely to die from an opioid overdose than individuals who have never been incarcerated.<sup>3</sup> In order to improve outcomes for justice-involved members, Massachusetts requests authority to provide Medicaid benefits to eligible individuals in carceral settings, including County Correctional Facilities (CCFs) and state Department of Corrections (DOC) Facilities. MassHealth would also offer transitional supports to justice-involved populations, including pre- and post-release care management and connection to health care services. MassHealth anticipates that these changes could demonstrably improve the health outcomes for this population, including by reducing post-release substance use and mortality, and ultimately achieving both improved quality and cost goals. Additionally, as Black and Hispanic individuals are disproportionately represented at higher rates than white individuals in the Massachusetts justice-involved population – 7.5 times and 4.3 times respectively<sup>4</sup> – the provision of services to this population would lead to important progress in improving health equity in the Commonwealth.

Addressing well-documented national and local disparities in maternal health will also be a key focus of MassHealth's health equity strategy. MassHealth has proposed in an amendment to its current 1115 demonstration to allow postpartum members, regardless of immigration status, to receive 12 months of eligibility designed to ensure seamless coverage and care during this vulnerable period, effective upon approval (MassHealth then intends to take up the American Rescue Plan Act postpartum coverage option through the State Plan when it goes into effect starting April 1<sup>st</sup>, 2022). MassHealth also plans to make doula services available as a covered benefit for pregnant members through a State Plan Amendment. Additionally, through ACO and Managed Care Organization (MCO) contractual mechanisms, MassHealth plans to make

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<sup>3</sup> "An Assessment of Opioid-Related Overdoses in Massachusetts 2011-2015." Massachusetts Department of Public Health, August 2017. <https://www.mass.gov/doc/chapter-55-data-brief-2017/download>.

<sup>4</sup> Bishop, Elizabeth Tsai, Brook Hopkins, Chijindu Obiofuma, and Felix Owusu. "Racial Disparities in the Massachusetts Criminal System." Harvard Law School Criminal Justice Policy Program, September 2020. <https://hls.harvard.edu/content/uploads/2020/11/Massachusetts-Racial-Disparity-Report-FINAL.pdf>.



available increased care coordination supports for those pregnant members at high risk of adverse outcomes during pregnancy and in the postpartum period.

**Goal 4: Sustainably support the Commonwealth’s safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care**

Ensuring the stability and sustainability of the Commonwealth’s safety net is a core priority of the demonstration extension. Massachusetts requests authority to continue its Safety Net Care Pool, which provides essential funding support for both safety net and public, state-owned providers through the Disproportionate Share Hospital (DSH) and Uncompensated Care Pools. As part of the Safety Net Care Pool, Massachusetts proposes to expand Safety Net Provider funding to nine additional hospitals to reflect up-to-date information on hospitals’ public payer mix and increase support for providers that became newly eligible for Safety Net Care Pool funding during the current demonstration period. MassHealth’s demonstration proposal also supports the safety net by allocating a significant portion of new funding linked to advancing health equity to safety net providers (the \$500 million incentive program described in Goal 3). Of note, the Commonwealth remains in active dialogue with the provider community around the parameters of these critical funding streams.

**Goal 5: Maintain near-universal coverage including updates to eligibility policies to support coverage and equity**

To maintain Massachusetts’s nation-leading 97% health coverage rate, MassHealth requests authority to continue current eligibility and coverage policies, including authority for expenditures through its state-funded program to provide premium and cost sharing subsidies for lower income individuals enrolled in Health Connector plans. MassHealth also requests authority to make targeted updates that expand eligibility and advance equity, including updating eligibility requirements and processes for CommonHealth for disabled adults; implementing 3-month retroactive eligibility for children and pregnant members; and maintaining 12- month or 24-month continuous eligibility for members who are post-release from County Correctional Facilities or DOC Facilities, or who are homeless, respectively.

## II. INTRODUCTION

### Background

MassHealth is the Massachusetts Medicaid and Children's Health Insurance Program that provides health coverage to more than 2 million Massachusetts residents, representing approximately 30% of the Commonwealth's population. MassHealth is key to maintaining the Commonwealth's overall level of coverage at greater than 97%, the highest in the nation. MassHealth covers some of the Commonwealth's most vulnerable residents - of those covered, 32% are non-disabled children, 44% are low-income non-disabled adults, and 24% are people with disabilities and/or seniors. In a 2019 survey, one in ten MassHealth enrollees faced homelessness or unstable housing in the past year.<sup>5</sup> With the global COVID-19 pandemic, the health status, access to health care services, and financial stability of Massachusetts residents have become further strained, with MassHealth's rosters increasing by over 311,000 people.

Since it was first approved in 1997, MassHealth's demonstration has been an important vehicle for health care innovation and delivery system reform at the state level. Through the demonstration, MassHealth has established managed care, supported providers through Safety Net Care Pool (SNCP) funding, simplified eligibility processing by eliminating face to face interviews and asset tests and using Express Lane Eligibility, and expanded coverage for people with disabilities, with HIV or with breast or cervical cancer, and expanded coverage of behavioral health and substance use disorder (SUD) services. The demonstration has provided authority for premium assistance for members with private insurance and for the provision of Medicare Savings Program benefits to eligible members without requiring an asset test. The demonstration also provided federal authority and funding for the state's major health coverage reforms in 2006, which established models for coverage and marketplace strategies that served as the model for the Affordable Care Act's coverage provisions, and have resulted in the Commonwealth's high levels of health insurance coverage.

On November 4, 2016, CMS approved MassHealth's current demonstration extension, effective July 1, 2017, through June 30, 2022. This demonstration has continued many of the authorities from the previous demonstration period, such as those authorizing managed care, support for safety net providers, coverage for expansion populations, coverage of expanded services, and state subsidies to help defray the cost of marketplace premiums. Additionally, this extension has sought to restructure both the delivery of care and payment models, with the goals of promoting integrated, coordinated care, and holding providers accountable for the quality and

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<sup>5</sup> "Faces of MassHealth: Portrait of a Diverse Population." Blue Cross Blue Shield of Massachusetts Foundation, May 2019. [https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2020-09/BCBSF\\_FacesofMassHealth\\_ChartPack\\_Final.pdf](https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2020-09/BCBSF_FacesofMassHealth_ChartPack_Final.pdf).

total cost of care as well as improving the integration of physical, behavioral, and long-term services and supports.

During the current demonstration period, MassHealth has partnered with newly-formed Accountable Care Organizations (ACOs) and Community Partners (CPs) to create a new system of whole-person, integrated, and member-centric coordinated care to improve outcomes for MassHealth members. With \$1.8 billion in Delivery System Reform Incentive Program (DSRIP) funding, MassHealth has established the ACO and CP programs, and invested in statewide infrastructure and workforce capacity to continue to support the shift to accountable care. The current period also authorizes the coverage of additional populations, including disabled working members over 65 through the CommonHealth program and former foster care (FFC) youth who aged out of foster care in another state, provides authority for Premium Assistance for the Student Health Insurance Program, and limits the use of Provisional Eligibility by adults other than those who are pregnant or have HIV. MassHealth has also made significant investments in substance use disorder treatment in order to address the ongoing opioid epidemic in the Commonwealth, and has restructured the Safety Net Care Pool, supporting critical providers while linking funds to ACO participation and performance.

### **Current Demonstration Period (2017-2022)**

#### **Goals**

As described in MassHealth's Section 1115 Demonstration Project Amendment and Extension Request (submitted July 22, 2016), and approved by CMS in 2017, MassHealth's current demonstration aims to achieve the following goals:

1. Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care;
2. Improve integration of physical, behavioral, and long-term services;
3. Maintain near-universal coverage;
4. Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals;
5. Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services;
6. Ensure access to Medicaid services for former foster care individuals aged 18 through 26 who previously resided in another state; and
7. Ensure the long-term financial sustainability of the MassHealth program through refinement of provisional eligibility and authorization for SHIP Premium Assistance.

Results from the first three performance years of the current demonstration highlight early promising results, and lessons learned for how MassHealth can continue to evolve to better

serve MassHealth members. The *MassHealth Delivery System Restructuring: 2019 Update Report* (<https://www.mass.gov/doc/masshealth-aco-year-2-report/download>) provides additional context and detail on progress to date. For the proposed demonstration extension, to begin in 2022, MassHealth seeks to build on the successes from the current demonstration, as well as make changes based on lessons learned.

### **Delivery System Restructuring in the Current Demonstration**

Under the demonstration, eligible MassHealth members have access to services through one of three managed care enrollment options, including traditional managed care organizations, the Primary Care Clinician Plan, or Accountable Care Organizations.

MassHealth Managed Care Organizations (MCOs) provide care through their own provider networks that include primary care providers (PCPs), specialists, behavioral health providers, and hospitals. MassHealth members select or are assigned a primary care provider within the MCO's network and must also live in a region covered by the MCO.

The MassHealth Primary Care Clinician (PCC) Plan is a managed care enrollment option, where MassHealth members select or are assigned a PCC from a network of MassHealth-contracted PCCs. Members can use the MassHealth network of hospitals and specialists to receive care as coordinated with their PCC and receive behavioral health services through the provider network of MassHealth's managed behavioral health vendor.

In addition to maintaining MassHealth's traditional MCO and PCC plans, the current demonstration authorized the implementation of three models of ACOs: Accountable Care Partnership Plans (ACPPs, or "Model A"), Primary Care ACOs (PCACOs, or "Model B), and MCO-Administered ACOs (MCO-ACOs, or "Model C"). These ACO programs are structured as follows:

- **Accountable Care Partnership Plan (Model A)** is an integrated partnership of a provider-led ACO with a health plan (MCO). Members enroll in ACPPs, which serve as their health plan as well as their provider system. ACPPs are responsible both for administrative health plan functions (such as claims payment and network development), and for coordinated care delivery for the full range of MassHealth ACO-covered services. Like MCOs, ACPPs are paid capitation rates and bear insurance risk for enrolled members' cost of care. The ACO is then responsible for making payments to providers, in accordance with MassHealth requirements around provider enrollment, directed payments, utilization management, and other criteria. The ACO is held accountable for quality via their performance upon measures included in the ACO Quality Slate, which impacts their potential shared gains or shared losses. Annually, MassHealth reconciles the paid capitation against actual cost and utilization, creating shared gains or shared losses for the ACO. ACPPs must be licensed carriers in accordance with state law and are subject to federal managed

care regulations as MCOs. With the flexibility afforded by a capitation, ACPPs can pilot different value-based payment arrangements, maintain close provider relationships, access real-time claims data, and leverage enhanced administrative dollars. As of June 2021, 660,000 MassHealth members were enrolled in ACPPs.

- **Primary Care ACO (Model B)** is a Primary Care Case Management Entity that is an advanced provider-led entity. PCACOs contract directly with MassHealth and deliver well-coordinated care and population health management. MassHealth serves as the health plan for enrolled members, maintaining the provider network and authorizing services. Members enroll in PCACOs through their choice of a PCP, which participates in that specific ACO. PCACO-enrolled members have access to MassHealth's fee-for-service network for medical care and receive behavioral health services through enrollment in the MassHealth managed behavioral health vendor. PCACOs are paid a monthly administrative rate and must have a repayment mechanism to ensure they can bear the financial responsibilities of the ACO risk model. Medical providers serving members enrolled in PCACOs are paid in accordance with the MassHealth fee schedule. Behavioral health providers serving members enrolled in a Primary care ACO are paid by MassHealth's managed behavioral health vendor. The ACO is held accountable for performance on quality based upon measures included in the ACO Quality Slate, which impacts their potential shared savings or shared losses. Annually, MassHealth reconciles the PCACO payments against a total cost of care benchmark, sharing savings or losses with each PCACO. As of June 2021, approximately 450,000 MassHealth members were enrolled in PCACOs.

- **MCO-Administered ACO (Model C)** is a provider-led ACO that contracts directly with MassHealth MCOs. Members enroll in MCOs, and the MCO serves as their health plan and is responsible for contracting provider networks and paying providers for MCO-covered services for these members. MCO members are attributed to MCO-Administered ACOs based on primary care relationships. At the end of each performance year, each MCO shares savings and losses with the ACO based on the total cost of care for the MCO's enrolled members who are attributed to the ACO. As of June 2021, approximately 11,000 MassHealth members were enrolled in MassHealth's one MCO-Administered ACO.

The current demonstration also authorized creation of the Community Partners (CP) program, where community-based entities procured as CPs are responsible for coordinating and managing care for individuals with significant behavioral health and/or Long-Term Services and Supports (LTSS) needs. CP supports are available to certain members enrolled in ACOs and MCOs and a subset of members who are also clients of the Massachusetts Department of

Mental Health. MassHealth has contracted with 27 CPs, including eighteen Behavioral Health Community Partners (BH CPs) and nine Long-Term Services and Supports Community Partners (LTSS CPs). The program launched in July 2018, and has a monthly average enrollment of 42,000, with a total cumulative enrollment 140,000 MassHealth members as of June 2021. MassHealth also provided infrastructure and capacity-building funds for CPs and 19 Community Service Agencies, entities that currently provide State Plan intensive care coordination services to eligible MassHealth members under 21 years of age with Serious Emotional Disturbances.

A third key feature of the current demonstration is the Flexible Services Program (FSP), which provides funding to help address certain health-related social needs, including nutritional and tenancy supports for ACO-enrolled members. The Flexible Services Protocol was not approved until nearly 2 years after initial approval of the demonstration and the launch of other demonstration-approved elements (e.g., ACOs and CPs). ACOs' Flexible Services Programs also launched at the beginning of the COVID-19 pandemic, which caused additional implementation delays, while also enabling the Flexible Services Program to support MassHealth members' growing pandemic-related challenges, including worsening housing and food security. The still-nascent Flexible Services Program is demonstrating early promising results (see Section III.1.3), though the program requires further time to evaluate.

A fourth feature of the demonstration leverages \$115 million of the DSRIP program to fund eight Statewide Investments intended to build and strengthen healthcare infrastructure and workforce capacity across Massachusetts and to support the success of ACOs, Community Partners, and Community Service Agencies. Statewide Investments promote new opportunities for primary care and behavioral health providers to practice within communities; novel initiatives to coordinate and integrate care across settings; and pioneering provider strategies to manage performance and population health. These investments address current gaps in the statewide delivery system and strengthen its capacity to deliver integrated, high quality care for all members.

Statewide Investments include:

1. *Building and Training the Primary Care and Behavioral Health workforce*: This set of investments aims to support recruitment, retention, and training of primary care providers, behavioral health providers, and the frontline healthcare workforce in community-based settings.
2. *Capacity Building for ACOs, CPs, and Providers*: This set of investments aims to provide direct technical assistance and shared learning opportunities for ACOs and CPs, as well as support for providers who are not yet participating in alternative payment methods to prepare for APM adoption in the future.

3. *Initiatives to Address Statewide Gaps in Care Delivery:* This set of investments aims to improve the care provided to members with specific behavioral health and accessibility needs through technology solutions and grant funding opportunities.

#### Successes of the Current Demonstration

The elements described above were designed to restructure the MassHealth delivery system towards an integrated, value-based, and accountable care system, leveraging the approved demonstration authority. Early results indicate that the reforms are largely working to achieve the goals set forth for this demonstration, including:

- The MassHealth ACO program launched in 2018 with accountability for total cost of care, quality, and member experience. Seventeen of the state's largest provider systems have become ACOs, more than 80% of eligible MassHealth members are now enrolled in an ACO, and 100% of Safety Net Hospitals now participate in an ACO.
- Early results from the ACO program demonstrate:
  - ACOs are strengthening connections to primary care, with primary care visits increasing 2% from 2018 to 2019, and 12% higher for ACO-enrolled members than non-ACO-enrolled members.
  - ACOs are reducing preventable acute utilization, with reductions in avoidable admissions by 11% from 2018 to 2019, as compared to a 2% reduction for non-ACO-enrolled members.
  - ACOs are improving clinical quality, with 2018 quality scores high (performance year 1), which increased in 2019 for a significant majority of quality measures.
  - ACO care coordination programs funded by the DSRIP program are working, with 70% of programs demonstrating improved results.
  - While current experience pre-COVID is too limited to estimate overall cost reductions driven by the shift to ACOs, promising early utilization trends provide confidence that the program has already begun to bend the cost curve.
- Behavioral Health and Long-Term Services & Supports Community Partners programs are providing enhanced care coordination for the highest-risk MassHealth members.
  - BH and LTSS CPs have actively engaged approximately 20,000 of MassHealth's hardest-to-reach members, with promising early progress demonstrating a more than 3-fold increase in member engagement in 2019 from 2018.
- The Flexible Services Program has enabled ACOs to partner with social service organizations, establishing 38 new ACO-social service organization partnerships,

providing housing and nutritional supports aimed at improving health outcomes and/or reducing health care costs.

- Massachusetts continued to have the highest rate of insurance in the nation at 97%, with 98.7% of children under 18 insured as of 2019,<sup>6</sup> as well as among the lowest exchange premiums in the nation during the 2018-2021 time period.<sup>7</sup>

Further detail on experience in the ACO, CP, and Flexible Services Program can be found in the *MassHealth Delivery System Restructuring: 2019 Update Report*.<sup>8</sup>

In parallel, MassHealth has engaged an independent evaluator to conduct both an interim and a final evaluation of the current demonstration. Interim evaluation results reflect findings from the first portion of the demonstration (July 2017-December 2020); the full report is attached (see Attachment 3). These findings parallel those documented in the *MassHealth Delivery System Restructuring: 2019 Update Report*, and thus far have generally been positive, including that:

- ACOs have taken positive actions during 2018 – 2020 to transform care and move towards an accountable and integrated care model, using DSRIP funding to hire dedicated staff for care coordination, and engage clinical providers in delivery system change.
- Community Partner organizations have taken specific actions during this same period and targeted resources to develop capacity to operate under an accountable and integrated care model, including using DSRIP resources to develop and strengthen relationships among participating organizations and build partnerships with ACOs.
- MassHealth members have reported their behavioral health and LTSS needs were well met during the early DSRIP implementation, and that their access to physical care, behavioral health care, and LTSS supports were timely.
- Quality measures of care processes improved from 2018 to 2019, including timeliness of prenatal care (78% to 81%) and immunizations for children and adolescents (43% to 56% and 39% to 44%, respectively).
- During 2018 and 2019, there appear to be favorable shifts in service use among adult ACO members, with increasing rates of primary care visits and decreasing rates of inpatient, post-acute, and low-value care.

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<sup>6</sup> “Health Insurance Status.” Health Coverage & Uninsured. Kaiser Family Foundation State Health Facts, 2019. <https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/>.

<sup>7</sup> “Average Marketplace Premiums by Metal TIER, 2018-2021.” Kaiser Family Foundation State Health Facts, December 10, 2020. <https://www.kff.org/state-category/health-coverage-uninsured/>

<sup>8</sup> Available at <https://www.mass.gov/doc/masshealth-aco-year-2-report/download>.



- Program-wide, ACO expenditures on healthcare services (which do not include DSRIP investments) were close to policy benchmarks set by MassHealth during the first year of the program (2018).
- Preliminary results of the impact of safety net funding investments on safety net hospitals' quality performance and financial sustainability has been mixed. With an increasing proportion of SNCP payments tied to performance, providers were making efforts to improve their performance during the first two years of the demonstration period, but it may be too early to see broad impacts over time. In addition, safety net providers continue to experience uncompensated care costs.
- Substance use disorder treatment has been expanded in the Commonwealth, including the expansion of Residential Rehabilitation Services (RRS) and the development of Co-Occurring Enhanced Residential Rehabilitation Services network. Additionally, the inclusion of Recovery Coach and Recovery Support Navigator services in the MassHealth benefit has expanded access to peer services for MassHealth members. Interim findings show all overdoses and opioid overdoses decreased in 2018 relative to baseline trends and the number of inpatient visits per member-quarter decreased, but there was also a slight reduction in initiation and engagement of treatment rates from 2018 to 2019.
- Approximately 70% of former foster care youth were continuously enrolled on an annual basis during the evaluation period and former foster care youth exhibited a higher level of continuous enrollment compared to non-former foster care youth in FY2018 and early evidence shows that former foster care youths' healthcare utilization is similar to their non-former foster care counterparts in 2018 and 2019.
- The SHIP premium assistance program resulted in significant savings to MassHealth during the 2017-2020 time period while ensuring MassHealth student members had the same or better health benefits as what they would have received from MassHealth directly and a majority of students surveyed in 2019 expressed satisfaction with the MassHealth SHIP premium assistance program. However, MassHealth sunset the program at the end of the 2019-2020 academic year, in order to prevent all students receiving health care coverage through their school's SHIP from experiencing untenable premium increases. While the program generated significant savings for MassHealth since its inception in academic year 2016-2017, those savings eroded due to increasing SHIP premiums. Sunsetting the program had no fiscal impact on MassHealth and ensured that all students maintained affordable health care coverage and allowed for continuous MassHealth coverage for MassHealth members.

## Extension Proposal (2022-2027)

### Delivery System Reform Opportunities

The progress made in the current demonstration has already led to important improvements in care for MassHealth members and laid a foundation for ongoing delivery system reform to improve health outcomes and slow growth in the total cost of care. Much of this progress has been supported by the \$1.8 billion of DSRIP funding authority that will expire in 2022.

However, while the current program is demonstrating success in certain domains, there remain areas in which new or amended authorities could allow for further improvement, including:

- Primary care providers within ACOs are still primarily reimbursed fee-for-service, incentivizing volume rather than driving health systems and providers further towards value.
- Certain behavioral health services and delivery models require significant investment and reform. Opportunities exist for expanding the populations eligible for diversionary behavioral health services, strengthening the behavioral health workforce, and integrating behavioral health within primary care.
- Health disparities exist across the MassHealth population, but insufficient data makes it challenging to reliably assess and stratify these disparities in a nuanced way, and to evaluate the effectiveness of different interventions.
- The still-nascent Flexible Services Program requires further standardization of program design and more time to rigorously evaluate outcomes.

Moving forward, MassHealth seeks to transition ~80% of annual DSRIP funding to base program funding to sustainably support successful programs built under DSRIP that will continue to provide high-quality primary care, care management, and Flexible Services within the ACO program. MassHealth will continue to refine these programs, and these targeted investments will be standardized and more streamlined for ACOs and providers to administer.

### Health Equity and Reducing Disparities

The events of 2020 underscored the need for further focus and targeted investment to address health equity. The COVID-19 pandemic and the movement for racial justice shone a spotlight on health inequities experienced by subpopulations defined by race, ethnicity, language, disability status, sexual orientation, and gender identity, which were long-standing and persistent in the pre-pandemic era. Population-level risk factors suggest many MassHealth members are at high risk for experiencing such health inequities including in prevalence of chronic conditions and underutilization of healthcare services.

As in other states, there is significant opportunity for MassHealth and the delivery system to drive reductions in health disparities experienced by Massachusetts residents. These include examples, such as:

- Black Massachusetts residents' severe maternal morbidity rate is more than 2.3 times higher than White residents;<sup>9</sup>
- Hispanic and non-Hispanic Black Massachusetts residents have asthma hospitalization rates 3.5 times higher than non-Hispanic White residents;<sup>10</sup>
- Massachusetts adults with disabilities were more likely to report 15 or more days of poor physical health (31%) than those without disabilities (3%);<sup>11</sup> and,
- Black Massachusetts residents have more than twice the rate of emergency visits for non-traumatic dental conditions (9.6 per 1,000) as compared to White residents (3.5 per 1,000).<sup>12</sup>

MassHealth has long aimed to reduce health inequities for its members, including through efforts such as the Disability Access Incentive, a program promoting access to medical and diagnostic equipment for members with disabilities in acute care hospitals, and the incorporation of community-level social determinants of health into managed care risk adjustment.<sup>13</sup>

In the next demonstration period, MassHealth proposes to employ a multi-pronged strategy to address health inequities, including programs requiring demonstration authority, and others that will be operationalized via other means, such as state-level contractual mechanisms. Across its programs and policies, MassHealth will apply a health equity lens, with a goal of understanding and solving for impact on vulnerable populations. For example, proposed interventions in primary care will be designed to reduce barriers for MassHealth members, and changes to care coordination will explicitly prioritize care coordination supports for traditionally

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<sup>9</sup> Somerville, Nicholas J., Timothy C. Nielsen, Elizabeth Harvey, Sarah Rae Easter, Brian Bateman, Hafsatou Diop, and Susan E. Manning. "Obstetric Comorbidity and Severe Maternal Morbidity among Massachusetts Delivery Hospitalizations, 1998–2013." *Maternal and Child Health Journal* 23, no. 9 (2019): 1152–58. <https://doi.org/10.1007/s10995-019-02796-3>.

<sup>10</sup> "Health Equity Dashboard, (2017)." Massachusetts Department of Public Health, based on MA 2017 Health Assessment. <https://www.mass.gov/service-details/2017-state-health-assessment>  
Data from the Massachusetts Hospitalization Discharge Database courtesy of CHIA.

<sup>11</sup> Mitra, Monika, Christine Clifford, and Lauren Smith. "Health Needs Assessment of People with Disabilities in Massachusetts, 2013." University of Massachusetts Medical School Center for Health Policy and Research, 2013. <https://www.mass.gov/doc/health-needs-assessment-of-people-with-disabilities-in-massachusetts-2013-0/download>.

<sup>12</sup> "Datapoints, Issue 20: Oral Health Access and Equity in the Commonwealth." Massachusetts Health Policy Commission, 2021. <https://www.mass.gov/info-details/hpc-datapoints-issue-20-oral-health-access-and-equity-in-the-commonwealth>.

<sup>13</sup> "FAQs for MassHealth's 2017 Payment Model." MassHealth, 2017. [www.mass.gov/doc/social-determinants-of-health-sdh-faq-1/download](http://www.mass.gov/doc/social-determinants-of-health-sdh-faq-1/download).

underserved and under-resourced populations (e.g., members with substance use disorders, members experiencing homelessness, and members with disabilities) and leveraging community-based organizations with unique cultural and linguistic competencies.

Health equity will also be a central component of the ACO accountability framework, including through proposed new investment in ACOs and ACO-participating hospitals directly tied to measuring and closing health disparities, and stratification by member characteristics in clinical quality measurement, including by race, ethnicity, language, disability, sexual orientation, and gender identity (see Section III.3.1). Over the course of the demonstration period, health equity accountability will increasingly shift from pay-for-reporting to pay-for-performance, with new investment tied to demonstrated progress on both measuring and closing health disparities. In parallel, MassHealth proposes to continue the Flexible Services Program to address members' health-related social needs through nutrition and housing supports (see Section III.3.2).

The Commonwealth's broader strategy for promoting health equity within the MassHealth program includes these initiatives as well as a complementary set of initiatives that do not require 1115 demonstration authority. For example, to address maternal health inequities, MassHealth will add doula services as a covered benefit under its State Plan; require ACOs and MCOs to offer enhanced care coordination for their members with high-risk pregnancies (e.g., SUD, heart disease, diabetes, depression); and provide 12 months of postpartum eligibility for members.<sup>14</sup> MassHealth also recognizes the critical role that data and infrastructure play in identifying and addressing health disparities, and will use contractual levers to strengthen race, ethnicity, language, disability, sexual orientation, and gender identity data collection. ACOs will have enhanced expectations for bolstering their infrastructure to identify and monitor inequities, and to ensure member and community voices continue to be incorporated in ACO decision-making.

Further detail is provided on MassHealth's proposed health equity initiatives requiring 1115 authority in Section III.3.

### Goals

The next demonstration provides a critical opportunity to further Massachusetts' shift towards accountable, value-based care, while simultaneously closing gaps in health disparities for communities of color, people with disabilities, and other historically marginalized MassHealth members. MassHealth proposes its next demonstration focus upon the following five goals and strategies:

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<sup>14</sup> MassHealth intends to leverage the SPA option effective 4/1/22 and has proposed through a recent amendment to implement 12-months postpartum eligibility sooner and without regard to immigration status

1. Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model;
2. Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care;
3. Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals;
4. Sustainably support the Commonwealth’s safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care; and
5. Maintain near-universal coverage including updates to eligibility policies to support coverage and equity.

**Stakeholder Engagement**

The strategy proposed in this document is the result of several months of robust stakeholder engagement.

Between October 2020 and May 2021, MassHealth solicited feedback and input on the focus of its proposed demonstration extension for the period of 2022 – 2027. This process included twenty meetings of procured stakeholder work groups and five public listening sessions, as well as engagement with other state government agencies. Due to the ongoing COVID-19 pandemic, all meetings were held virtually. MassHealth used the input from the sessions in shaping the next phase of its restructuring work. The three procured work groups involved approximately 100 individuals, bringing experience from nearly 100 organizations throughout the Commonwealth. Members of the work groups were solicited through an open and public nomination process and represented a diverse array of stakeholders from across the state, including MassHealth members, advocates, payers, providers, and academics.

Each of the three work groups met six or seven times, for a total of 20 work group sessions. The table below shows the scope of design dimensions that were discussed in each of the work groups.

*Table 1: Procured 1115 demonstration workgroups*

<b>Work Group</b>	<b>Scope of Discussion</b>
Strategic Design	Discussed the overall approach to the delivery system and payment model for MassHealth managed care programs, with specific consideration for accountable and integrated care and payment models, including further moving the health care system out of fee-for-service reimbursement

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	constructs. The work group also considered topics such as increasing focus on children, youth, and families in the ACO program, addressing health equity, and supporting sustainable financing for safety net providers.
Care Coordination	Discussed baseline care coordination expectations for ACOs, Community Partners and other providers, populations requiring extra support, as well as accountability, financing, and future modifications to current care coordination programs. This work group’s focus included the evolution of the Community Partners program for individuals with significant behavioral health and/or long-term services and supports needs. In addition, the work group considered the role of MassHealth and its ACO program in coordinating support for health-related social needs.
Primary Care Technical Advisory Group	Discussed care delivery and financing approaches for a proposed sub-capitation model for primary care designed to support innovation and practice transformation, including further integration of behavioral health care in the primary care setting.

MassHealth used the discussions from each of the work groups as input to its policy development process. Stakeholders provided robust oral and written feedback which highlighted the transparent, inclusive, and collaborative nature of the endeavor. In addition, MassHealth held 5 public meetings to solicit broad feedback from the community.

**Public Process**

MassHealth also notified tribal organizations of the upcoming submission of this demonstration proposal. In addition, on July 15, 2021, MassHealth posted a summary of the proposed changes on a public website, in a commitment to a transparent process.

The publication of this proposal marks the start of the Commonwealth’s 30-day public comment period, including tribal consultation and two public hearings conducted at least 20 days before the demonstration application is submitted to CMS.

Following its submission of this proposal to CMS, MassHealth will continue to engage stakeholders through 2021 and 2022, leading up to implementation.

### III. NARRATIVE

This section describes MassHealth’s proposed strategy to achieve the demonstration goals:

**Goal 1: Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model**

#### 1.1 Accountable Care Organizations

##### A. Statement of Request

MassHealth requests the authority to continue the Accountable Care Organization program, without change, through the end of Contract/Performance Year 5 (2022) and until the launch of the new ACO program.

Starting in 2023, MassHealth seeks the authority to continue its Accountable Care Organization program, as authorized under the most recent demonstration. Specifically, MassHealth is proposing to continue the ACP (Model A) and PCACO (Model B) programs and to discontinue the MCO-Administered ACO (Model C) program. MassHealth will make refinements based on lessons learned that will allow ACOs to further advance progress on goals of quality improvement, overall cost reduction, member experience, and provider experience. Separately, MassHealth will also continue the long-standing Primary Care Clinician Plan and Managed Care Organization program authorized under the 1115 demonstration.

##### B. Background and Goals

#### *ACOs in the Current Demonstration*

ACOs are provider-led organizations that are held contractually responsible for the quality, coordination, and total cost of members’ care. The ACO program was authorized and approved by CMS with the intent to move MassHealth providers from a primarily fee-for-service system that pays for volume to one that rewards value. As such, ACOs are accountable and at financial risk for the total cost of members’ care, as well as for quality measures across multiple domains. Members are attributed to ACOs based on primary care; members choose or are assigned their primary care provider (PCP) and are assigned to the plan in which that provider is enrolled. In the MassHealth ACO program a given PCP may only participate in one ACO (known in the program as “primary care exclusivity”), though may additionally serve members in fee-for-service MassHealth, a Senior Care Options plan, or a One Care plan (dual-eligible demonstration plan), as well as in the Program of All-inclusive Care for the Elderly (PACE).

#### *Progress To-Date*

The first years of the ACO program have led to significant changes in the MassHealth delivery system. The majority of MassHealth health care providers now participate in an ACO,

representing a diverse range of hospitals, community health centers, group practices, independent practices, and community-based organizations, who have all joined in an effort to improve cost, quality, and experience for MassHealth members. As of June 2020, of the approximately 1.2 million MassHealth members eligible for ACOs,<sup>15</sup> over 1.1 million (over 80%) were enrolled in an ACO.

Data from the first two performance years of the current demonstration show positive early signs, including growth and retention in ACO enrollment, strong and improving clinical quality, and examples of ACOs successfully implementing population health initiatives that have resulted in controlling avoidable utilization and cost, and improving outcomes. Further data from future program years will be necessary to more comprehensively evaluate the impact of MassHealth's accountable care model - particularly due to limited pre-COVID experience.

Some promising results from the first two years of the ACO program include:

- Members enrolled in the ACO program experienced an ~11% reduction in potentially avoidable admissions; in comparison, members enrolled in the traditional MCO and PCC Plan programs experienced a ~2% reduction in potentially avoidable admissions;
- Median ACO quality scores surpassed the attainment threshold for 12 of 13 quality measures;
- Clinical quality consistently improved in 2019 (performance year 2) versus 2018 (performance year 1), with 9 of 13 clinical quality measures increasing in score, while member experience held relatively stable; and
- Of 76 DSRIP-financed innovative care management programs ACOs implemented that were evaluated as of December 2019, 53 (70%) demonstrated improvement in at least half of outcomes measured, while only 23 (30%) demonstrated limited or no conclusive improvement. Given that DSRIP is a demonstration, these findings are aligned with MassHealth's goals of testing innovations to determine which ones show evidence of success, acknowledging that not all will.

Assessment and comparison of MassHealth's different ACO programs relative to their performance on quality and cost goals remains preliminary as data is only available for the first two performance years.

The MCO-Administered ACO (Model C) program was created with an intention of offering a more accessible entry point for providers with less experience with risk-based contracts. In practice, the vast majority of providers opted to create and join ACPP (Model A) and PCACO

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<sup>15</sup> In general, only members under 65 that do not have other health insurance (e.g., are not dually eligible for MassHealth and Medicare) are eligible to enroll in ACOs.



(Model B) programs with greater accountability. Therefore, implementation of the Model C program has been sub-scale, with only one active ACO representing 1% of overall ACO membership. Due to the lack of interest in the market, as well as challenges in operationalization, MassHealth will not seek authority to continue this model. Additional detail on the experience, progress, and lessons learned from the ACO program can be found in *The MassHealth Delivery System Restructuring: 2019 Update Report* (<https://www.mass.gov/doc/masshealth-aco-year-2-report/download>) and in the Interim Evaluation (Attachment 3).

### C. Program Design

MassHealth requests authority to continue the current ACO program, and plans to leverage the ACO re-procurement and contracts to build upon successes while making targeted changes to promote the goals of this demonstration. To achieve this, MassHealth anticipates making the following enhancements to the ACO program.

#### *Improving value in ACO program delivery*

MassHealth plans to re-procure the ACO program, making refinements to the model based on lessons learned. All ACOs will need to meet increased standards across various domains, including but not limited to:

- value-based payment (e.g., participating in the proposed primary care sub-capitation payment model (see Section III.2.1), additional value-based contracting for network providers for ACPPs);
- enhanced care coordination and population health programming (e.g., improved tracking and monitoring of care management enrollment, addressing health-related social needs);
- strengthening expectations around network access (e.g., behavioral health continuity); and
- cost growth management (e.g., demonstrated success in managing trend across years, clinical efficiency).

#### *Expanding investment and focus on Primary Care, Behavioral Health and Pediatrics*

While the Massachusetts delivery system as a whole has made progress in moving away from fee-for-service payment, the experience of individual providers is still often that they are paid for volume and not value. MassHealth proposes implementing a primary care sub-capitation payment model (see Section III.2.1) that will bring payment reform to the provider level, while continuing to incentivize excellence in care delivery.

In line with the Commonwealth's recently released *Roadmap for Behavioral Health Reform*,<sup>16</sup> ACOs will be responsible for implementing a variety of changes resulting in expanded access and services in behavioral health. Among these will be contracting with newly created state-specific Community Behavioral Health Centers, which will be procured in 2021 as a part of the Commonwealth's *Roadmap*, and serve as an entry point for timely, flexible, person-centered, high-quality mental health and addiction treatment on an urgent and ongoing basis. ACOs will also need to provide access to new State Plan peer supports services for their members.

ACOs will further be required to better address the unique needs of children, youth, and families. As part of the primary care sub-capitation program, ACOs will be required to invest in staffing and resources at primary care practices serving children, to ensure robust, team-based care focused on the needs of families. ACOs will also offer enhanced care coordination support services for a subset of children with rising or moderate medical complexity, and contract to provide a new Targeted Case Management benefit, to be authorized via the State Plan, for the highest risk, most medically complex children. In addition, ACOs will further need to ensure a portion of their Flexible Services programs address youth and family needs, and that these programs consider not just the member, but the entire family constellation.

#### *Quality Accountability*

MassHealth requests authority to implement an incentive payment arrangement in both the ACPP and PCACO program in which ACOs may earn an incentive payment based on the ACO's combined performance on quality and health equity indicators. The aggregate score will be comprised of quality measures at the overall ACO level and measures stratified by demographic characteristics. MassHealth anticipates that an ACO would be eligible to earn an incentive payment defined as a percentage of its monthly capitation payment or total cost of care benchmark based on performance on the aggregate score. In the ACPP program, MassHealth will implement this construct via an incentive payment pursuant to 42 CFR 438.6(b).

MassHealth requests demonstration authority to mirror this construct in the PCACO program to allow the state to make incentive payments to PCACOs, in addition to the PCACO monthly administrative payments and shared savings/shared losses payments.

Finally, a key lesson from the current demonstration has been the ongoing challenges that both MassHealth members and providers/plans face in care coordination. For providers and plans,

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<sup>16</sup> The Commonwealth's Roadmap for Behavioral Health is a multi-year blueprint, based on listening sessions and feedback from nearly 700 individuals, families, providers, and other stakeholders who identified the need for expanded access to treatment, more effective treatment, and improved health equity. See more details here: "Roadmap for Behavioral Health Reform." MassHealth, 2021. <https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform>.

these challenges can include identifying members in need of care coordination and delivering that coordination and management in an efficient and effective way. For members, these challenges can include navigating the various care coordination offerings and resources and accessing supports that meet their cultural and linguistic needs. MassHealth will focus its care coordination strategy in the next demonstration on ensuring all members receive foundational, clearly-defined care coordination support; ensuring that high- and rising-risk members continue to receive a robust set of member-centered care coordination support; streamlining care coordination programs and providers, such that each member has a single lead entity to serve as their “care coordination home;” and standardizing approaches to care coordination (see Section III.1.2).

## **1.2 Care Coordination**

### **A. Statement of Request**

MassHealth requests the authority to continue the Community Partners program under the current DSRIP construct, without change, through the end of Contract/Performance Year 5 (2022) and until the launch of the new Community Partners (CP) program. MassHealth anticipates launching an evolved CP program in 2023, making key reforms to strengthen and sustain the best aspects of this program, and the proposed extension would minimize disruption for members and ensure they do not lose access to trusted supports during this period.

This evolved CP program will include several refinements that incorporate learnings from the current CP demonstration. Most notably, MassHealth will shift the program’s structure from a state-managed demonstration to a core requirement of the ACO contract. Under this new structure, ACOs and MCOs will contract with and pay CPs directly for the supports they provide, subject to certain requirements (e.g., minimum program enrollment and rate levels) to ensure the program’s continued viability. Because the payments for CPs will be funded through administrative payments to ACOs and MCOs, which will be set accounting for ACOs’ and MCOs’ required payments to CPs, the Commonwealth does not believe that specific expenditure authority is needed for this updated CP program. In addition to creating sustainable post-DSRIP funding for proven community-based care coordination models, this shift in the program’s structure also advances the important policy goal of making the CP program more flexible and more accountable to providing value within the ACO framework.

Additionally, MassHealth will introduce and expand a targeted new benefit under the State Plan (Targeted Case Management, further described in Section III.2.3) and proposes further new benefits under 1115 authority for certain high-risk members requiring additional specialized support (Community Support Program, further described in Section III.1.2).

## B. Background and Goals

The current 1115 demonstration focuses on two primary models of care coordination for members: care coordination delivered by ACOs (often through DSRIP-funded complex care management programs), and care coordination delivered by CPs (also fully DSRIP-funded), both of which address current demonstration goals 1 and 2 (see Section II). Across both models, MassHealth is seeing promising early results from DSRIP initiatives and investments. In the first years of the demonstration, nearly three-quarters of DSRIP-funded ACO care coordination programs have demonstrated positive outcomes, including reductions in unnecessary emergency department and hospital utilization as well as improved clinical outcomes.<sup>17</sup> Similarly, CPs' rates of success in finding and engaging MassHealth's highest-risk members increased from 6% to 53% between the first and second year of the program, and certain CP organizations have also demonstrated early promising results in improving primary care engagement and decreasing rates of hospitalization.<sup>17</sup>

These successes have been possible due to substantial DSRIP investments in ACOs and Community Partners to enable them to build the staffing, resources, skills, and practices needed to efficiently and effectively coordinate care for MassHealth members. As DSRIP funding ends, MassHealth intends to sustainably fund proven elements of these programs going forward. Additionally, experiences and results to-date indicate that, in spite of promising early results, opportunities remain to improve existing care coordination programs. For example, the current landscape of care coordination programs is varied and often confusing for members and providers, and it is not always clear which provider or team is the lead coordinator for a given member. In addition, ACOs have implemented a highly varied array of care coordination programs, consistent with DSRIP's intentional flexibility for innovation; while many programs have been impactful, some programs have exhibited inconclusive results to-date and others have failed to robustly engage their target populations.

## C. Program Design

### *Overview – Baseline, Enhanced, and Specialized Care Coordination*

MassHealth therefore proposes an evolution of current care coordination in the demonstration extension, with a focus on leveraging lessons learned, while standardizing and sustainably funding initiatives with demonstrated success. In the next demonstration period, MassHealth aims to build on infrastructural investments from the current demonstration, while streamlining care coordination experience for providers and members. MassHealth aims to

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<sup>17</sup> "MassHealth Delivery System Restructuring: 2019 Update Report." MassHealth, July 2021. <https://www.mass.gov/doc/masshealth-aco-year-2-report/download>.

strengthen accountability for specific care coordination activities and outcomes matched to member risk and/or complexity.

The proposed care coordination strategy for the next demonstration period will streamline the existing landscape of care coordination programs by implementing a three-tiered framework:

- **Baseline:** All MassHealth members in managed care, regardless of risk, will receive a baseline level of care coordination through their primary care provider. This baseline care coordination will include foundational supports such as an assigned primary care clinician, care needs screenings and referrals, and assistance with transitions of care;
- **Enhanced:** High- and rising-risk members (as identified by ACOs and MCOs, with key input from members, providers, and CPs – anticipated to be ~10% of the ACO/MCO population) will receive an enhanced level of care coordination from a provider that suits their needs. This enhanced care coordination will include supports such as a comprehensive assessment, multi-disciplinary care team, and additional assistance with transitions of care and navigation to social services. Members who need this enhanced level of care coordination may receive it from their ACO or MCO, a CP (with which ACOs and MCOs will partner and to which they will refer eligible members), or a Targeted Case Management provider (further detail in Section III.2.3);
- **Specialized:** Certain eligible members will receive additional, episodic care coordination that complements rather than duplicates the above types of care coordination. Eligible members may include, for example, those experiencing homelessness or post-release from incarceration. This specialized care coordination includes targeted services that are part of the MassHealth benefit, including the Community Support Program (CSP), which MassHealth is proposing to expand (further detail in Sections III.2.2 and III.3.2).

MassHealth will require ACOs and MCOs to work with members, families, and providers (including CPs), to identify which of these three tiers is the best fit for each of their enrollees. ACOs and MCOs will be responsible for ensuring that each of their enrollees has a clearly identified, single lead entity to serve as their “care coordination home.” These requirements will advance the important policy goal of streamlining the landscape of care coordination providers for members and their care teams.

Additionally, within the baseline and enhanced care coordination tiers, MassHealth will further standardize approaches to care coordination, while still enabling ACOs and MCOs to retain appropriate flexibility to implement certain programs that address their population’s specific challenges. This standardization will include elements such as target populations (e.g., to ensure that children with medical complexity receive the care coordination they need), minimum required elements (e.g., consistent requirements for assessment and care planning), and a common framework for quality and outcomes monitoring to ensure that all care

coordination programs are being held to comparable standards for the value they provide to members and to the MassHealth program. These requirements will transition from the current, disparate approaches to care coordination in the DSRIP demonstration environment to more sustainable, well-defined elements of the MassHealth program going forward.

MassHealth will fund ACPPs and MCOs through non-medical administrative funding at actuarially-sound levels to support ACPPs' and MCOs' care coordination responsibilities, including responsibilities to fund and implement their own care management programs as well as responsibilities to make downstream payments to CPs under the evolved CP program (described in Section III.1.2). MassHealth will mirror this funding and these requirements for PCACOs through their monthly administrative payments and contracts. To support these expectations, which include functions currently funded primarily by DSRIP, MassHealth expects non-medical administrative funding to be at higher levels than in the current program.

#### *Overview – Community Partners*

MassHealth intends to sunset the current CP program and seamlessly replace it with an evolved CP program starting in 2023. The goals for this new Community Partners program are to:

1. Reaffirm MassHealth's commitment to a community-based model of outreach and care coordination for high-risk members;
2. Simplify and streamline ACO/MCO-CP relationships;
3. Set higher, clearer, and more standardized expectations of CPs (both related to their role in care coordination and for their accountability for outcomes); and
4. Continue to incentivize strong partnerships among providers across physical health, behavioral health, long-term services and supports, and health-related social needs.

Rather than the current program design in which MassHealth pays CPs directly for their activities using DSRIP funding, MassHealth instead intends to require ACOs/MCOs to contract with and pay CPs as part of their care coordination requirements under the contract, and in turn MassHealth intends to fund ACOs/MCOs appropriately for these expectations as part of non-medical rates. MassHealth expects this new payment structure will make the CP program more flexible and will increase CPs' accountability to provide high-quality care coordination to MassHealth members, and value to ACOs/MCOs. MassHealth intends to define guard-rails for ACOs' and MCOs' contracting with CPs to ensure CPs continue to receive sufficient eligible member volume and rates of payment to remain viable.

#### *Behavioral Health Community Partners (BH CPs)*

The new Behavioral Health Community Partners program will be defined by the following program elements:

- **Target population:** Adult members with predominant behavioral health needs such as serious mental illness (SMI), substance use disorder (SUD), or co-occurring SMI/SUD. Within these guardrails, ACOs/MCOs will have discretion in how to identify members for the program utilizing administrative data, clinical data, referrals (including member self-referral), or other approaches. BH CPs are anticipated to serve 3-4% of the ACO/MCO population (approximately 30,000 – 40,000 members).
- **Support:** In partnership with ACOs/MCOs, BH CPs will provide community-based enhanced care coordination, as well as outreach and engagement with hard-to-reach members, connecting them to resources. BH CPs will be expected to establish and maintain high-functioning partnerships not only with ACOs/MCOs, but also with other providers and community and social service organizations serving MassHealth members, such as organizations with expertise serving members experiencing homelessness. BH CPs will be the lead responsible entity and care coordination home for their enrolled members.
- **Providers:** MassHealth will procure qualified BH CPs, with an emphasis on expertise in serving a population with a range of behavioral health complexity. Further details on MassHealth's requirements of BH CPs will be detailed in that procurement. BH CPs will generally either be designated Community Behavioral Health Centers or include Community Behavioral Health Centers as affiliated partners, ensuring alignment between members' care coordination home and behavioral health treatment home, where appropriate. BH CPs will have increased expectations for clinical staffing and co-location with services than are in place today. These expectations will support better treatment access for the highest risk members, more clinically robust care planning, and better communication between the BH CP and other providers involved in the member's care (e.g., primary care providers, acute hospitals).
- **Partnerships and Accountability:** ACOs and MCOs will be required to contract with a minimum number of BH CPs to deliver MassHealth-defined supports, and ACOs and MCOs will be required to pay BH CPs directly. ACOs, MCOs, and CPs will be empowered to establish a mutually agreed upon accountability framework within guidelines established by MassHealth. MassHealth intends to define acceptable payment methodologies, including a minimum per-member per-month rate. BH CPs will be held accountable for performance to a sub-set of the ACO quality measures, emphasizing outcomes over processes, to ensure MassHealth and ACOs are paying for high-value supports that positively impact member experience and health.

*Long Term Services and Supports Community Partners (LTSS CPs):*

The new Long-Term Services and Supports Community Partners program will be defined by the following program elements:

- **Target population:** Members with predominant LTSS needs such as significant functional impairments, a history of high and sustained LTSS utilization, or related diagnoses. This population may include members with physical disabilities, members with acquired or traumatic brain injury, and members with intellectual or developmental disabilities. As in the current LTSS CP program, this eligible population will include both adult and child members that meet these criteria (although children with significant medical complexity who meet criteria for the TCM program described in Section III.2.3 may be better served through that program instead, and will have the option to do so). Within these guardrails, ACO/MCOs will have discretion in how to identify members for the program utilizing administrative data, clinical data, referrals (including member self-referral), or other approaches. LTSS CPs are anticipated to serve 1-2% of the ACO/MCO population (approximately 10,000 – 20,000 members).
- **Support:** In partnership with ACOs/MCOs, LTSS CPs will provide community-based enhanced care coordination, as well as outreach and engagement with hard-to-reach members, connecting them to resources. Unlike the current demonstration, in which LTSS CPs support only care coordination related to LTSS, LTSS CPs in the new model will be accountable for outreach, engagement, assessment, and care planning, much like BH CPs are in the current demonstration. LTSS CPs will be the lead responsible entity and care coordination home for their enrolled members. This increased role for LTSS CPs is a result of learning from the current demonstration, in which several LTSS CPs have voluntarily entered into arrangements with ACOs/MCOs to take on some of these enhanced functions as subcontractors to the ACO/MCO. It also will support the integration of LTSS and medical care, as well as direct much-needed additional investment towards supporting a model of care coordination that is fully informed by independent living philosophy for this important population.
- **Providers:** MassHealth will procure qualified LTSS CPs. LTSS CPs will be community-based entities and must bring the qualifications necessary to serve the target population, such as capacity to serve members with a range of LTSS needs, a demonstrated community living philosophy, and the skills and staff necessary to serve members with high complexity and risk. Further details on MassHealth's requirements of LTSS CPs will be detailed in that procurement. LTSS CPs may be a "lead entity" with partnered affiliates to ensure the proper expertise, geographic reach, and scale, as in the current CP program. LTSS CPs will have substantially higher expectations for clinical staffing than in the current demonstration, which will align with expectations in the BH



CP model, such as dedicated nurse staffing to support clinically supported assessment and care planning. These expectations will support more clinically robust care planning and better communication between the LTSS CP and other providers involved in the member's care (e.g., primary care providers, specialty providers).

- **Partnerships and Accountability:** ACOs/MCOs will be required to contract with a minimum number of LTSS CPs to deliver MassHealth-defined supports, and ACOs will be required to pay LTSS CPs directly. ACOs/MCOs and CPs will be empowered to establish a mutually agreed upon accountability framework within guidelines established by MassHealth. MassHealth intends to define acceptable payment methodologies, including a minimum per-member per-month rate. LTSS CPs will be held accountable for performance to a sub-set of the ACO quality measures, emphasizing outcomes over processes, to ensure MassHealth and ACOs/MCOs are paying for high-value supports that positively impact member experience and health.

### *Specialized Care Coordination*

MassHealth proposes that a subset of high- and rising-risk members meeting specific medical necessity criteria, including behavioral health, substance use disorder, and/or social needs, receive specialized care coordination. Specialized care coordination provides short-term, targeted support, and as such is expected to episodically supplement, but not necessarily replace, a member's lead care coordination entity. Specialized care coordination is therefore intended to work alongside any baseline care coordination members may be receiving from their primary care provider, or any enhanced care coordination they may be receiving from an ACO or CP, for example.

Specialized care coordination is often provided through a MassHealth covered service (benefit). Examples include the Community Support Program (CSP), which provides short-term, intensive outreach and care management services to support individuals at risk of repeated psychiatric hospitalizations and or inpatient substance abuse treatment programs. The CSP for Chronically Homeless Individuals program tailors CSP services specifically to the needs of members who are chronically homeless. Recovery Support Navigator services provide care management and navigation for members with a substance use disorder and/or co-occurring mental health disorder.

MassHealth is also seeking to expand on the success of existing specialized care coordination to address health inequities, while reducing total cost of care and improving health outcomes. For example, MassHealth submitted a request to CMS on June 8, 2021, to amend the current demonstration by authorizing CSP for members with justice involvement. If approved, MassHealth would seek to continue that service during the demonstration extension. Additionally, MassHealth proposes adding two new housing related CSP services in the

upcoming demonstration. These proposed benefits are CSP for Homeless Individuals (CSP-HI), which would replace the current CSP-CHI, and CSP Tenancy Preservation Program (CSP-TPP) (see further detail Section III.2.2).

### **1.3 Flexible Services**

As a key piece of building on the current demonstration's successes in restructuring the MassHealth delivery system and orienting towards value, MassHealth also proposes continuing the Flexible Services Program. This program, which has been well-received by members and providers, offers nutrition or housing supports for members experiencing health-related social needs. Flexible Services was only implemented in January of 2020 but is beginning to show promising early results. The Flexible Services Program and requested authority are further discussed in Section III.3.2.

### **1.4 Pharmacy**

#### **A. Statement of Request**

MassHealth seeks authority to update its payment methodology for 340B drugs for providers in order to enhance consistency and align incentives across its fee for service (FFS) and managed care delivery systems while maintaining its important role in supporting safety net providers.

#### **B. Background and Goals**

Currently, the methodologies MassHealth uses for paying for 340B drugs differ between MassHealth's FFS/FFS-like programs (including MassHealth's PCC Plan, and PCACOs) and certain managed care entities. MassHealth's current 340B payment methodologies can result in large differences in revenue for providers with significant 340B volume, depending on whether they participate in ACPPs or PCACOs. These differences can mean certain providers would face significant revenue reductions if they were to join a PCACO rather than an ACPP, an unintended artifact that does not serve the state's delivery system policy goals and creates an unequal incentive for these providers, potentially distorting decisions about ACO model participation. As required by CMS, MassHealth FFS programs pay actual acquisition cost (AAC) plus a dispensing fee for most 340B drugs. In contrast, MassHealth has historically required its managed care organizations and ACPPs to pay for 340B drugs in the same way they pay for non-340B drugs (i.e., at a higher rate than 340B AAC), which generates substantial margins on 340B drugs for some providers.

MassHealth would like to move toward a more uniform and equitable payment methodology across its delivery systems, while minimizing financial impact on safety net providers with significant 340B utilization are not affected financially.

### C. Program Design

MassHealth proposes implementing a new payment methodology that ties payment for 340B drugs to a covered entity's provider category instead of its MassHealth delivery system, creating consistency in payment across both the FFS and Managed Care Entity (MCE) delivery systems.

Across both FFS and MCE delivery systems, 340B providers would be classified in two tiers, with the first tier receiving higher payment rates for 340B drugs (likely between 340B AAC and NADAC/WAC, plus dispensing fee). Tier 2 providers would be paid at 340B AAC (plus dispensing fee) for 340B drugs. Tier 1 would include specifically designated safety net providers that meet certain criteria, such as serving a patient population that has a high percentage of MassHealth members, ACO participation, and strong clinical-pharmacy integration.

This proposal would require targeted waiver authority to pay for 340B drugs at a price higher than the actual acquisition cost in MassHealth's FFS and FFS-like delivery systems. MassHealth expects this policy change to be budget neutral.

**Goal 2: Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care**

#### 2.1 Primary Care

##### A. Statement of Request

MassHealth seeks authority to implement a primary care sub-capitation payment model for all participating primary care practices in the ACO program. By shifting primary care payment away from volume-based, fee-for-service payment to a more value-based paradigm, a sub-capitation payment model would catalyze improvements in care delivery and result in better population health outcomes for MassHealth members.<sup>18, 19</sup> Primary care sub-capitation would build on progress achieved over the first years of implementing the ACO model by further investing in

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<sup>18</sup> Berenson, Robert, Suzanne Delbanco, Divvy Upadhyay, and Roslyn Murray. "Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care." Urban Institute, December 5, 2020. <https://www.urban.org/policy-centers/health-policy-center/projects/payment-methods-and-benefit-designs>.

<sup>19</sup> Basu, Sanjay, Russell S. Phillips, Zirui Song, Asaf Bitton, and Bruce E. Landon. "High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care." *Health Affairs* 36, no. 9 (September 2017): 1599–1605. <https://doi.org/10.1377/hlthaff.2017.0367>.

high-quality, integrated primary care delivery situated within the overall cost and quality accountability of MassHealth's ACO program.

To implement the proposed sub-capitation payment model, MassHealth specifically requests authority to:

- 1) Direct ACPPs to make capitated payments to primary care providers pursuant to 42 CFR 438.6(c), and to require payments made by PCACOs to providers to be structured in the same way
- 2) Allow PCACOs to pay participating PCPs at actuarially developed rates calculated to account for enhanced clinical expectations and anticipated utilization instead of at State Plan rates
- 3) Allow ACOs to make sub-capitation payments without conducting a reconciliation of prospective payments to actual utilization (excepting where such calculations are necessary to determine required prospective payment system (PPS) wrap payments for participating FQHCs)

#### B. Background and Goals

In the current demonstration, MassHealth has significantly changed how payment, risk, and financial incentives are structured for providers, through the delivery system restructuring to ACOs. In primary care settings, these changes have facilitated improvements in care delivery, supported in part by DSRIP investments, including:

- Transitioning to a primary care model of attribution;
- Increasing capacity in the primary care setting to screen for, and address, behavioral health needs and health-related social needs;
- Hiring community health workers and other paraprofessional team members to better coordinate care, address health-related social needs, and provide care navigation for members;
- Establishing data systems and workflows between hospital providers and primary care and specialty outpatient providers to improve transitions of care for members; and
- Creating the health IT and infrastructure required for ACO-based population health programs that target high and rising risk members.

While such large-scale changes under the current demonstration continue to be evaluated, there are promising early signs demonstrating positive progress. For example, primary care utilization increased by 2% from 2018 to 2019, and is 12% higher for ACO members than non-ACO members, suggesting that ACOs are having success in engaging members with primary care. Member experience survey results also indicate that primary care scores increased for

engagement in behavioral health, adult self-management and support, pediatric prevention, and child development, and in the overall helpfulness and courtesy of staff.

However, primary care providers continue to report their day-to-day experience frequently feels more focused on volume than value, which current fee-for-service incentives perpetuate. This fee-for-service model – still in place across many provider organizations – leads to limited flexibility for providers to tailor their services to more value-based approaches, including team-based care, integrating behavioral health into the primary care setting, and focusing on population health outcomes rather than volume.

To address these challenges, MassHealth proposes a new payment model for primary care providers in ACOs. Primary care sub-capitation will shift the chassis of primary care payment away from fee-for-service to capitation in a way that can meaningfully change service delivery and incentivize population health improvements. A primary care sub-capitation will provide flexible and predictable revenue via a prospective, risk-adjusted, panel-based payment. As part of a shift to sub-capitation, MassHealth will design expectations for participating primary care practices to incentivize specific care delivery improvements, including:

- integrating behavioral health within the primary care setting, including mental health and substance use disorder services (including medication-assisted treatment);
- enhancing team-based models of primary care by leveraging paraprofessionals to improve member engagement (e.g., Community Health Workers, peers, family partners, recovery coaches);
- expanding patient access to “meet members where they are” via multiple modalities, including expanded evening and weekend hours, telehealth, e-communication, and e-consults, and by increasing focus to address the unique needs of children, youth, and their families; and
- bolstering care coordination services for members, and addressing preventive health including screening and referral for behavioral health, oral health, and health-related social needs.

Importantly, the proposed shift to primary care sub-capitation is aligned at a high level with ongoing value-based payment initiatives among Massachusetts-based commercial payers, as well as CMS programs, including the Primary Care First and Direct Contracting models. Studies suggest that for capitation to drive changes in care delivery at the practice level, a high percentage of a provider’s payer mix must be via aligned capitation mechanisms.<sup>19</sup> As a result, in parallel to efforts in both the commercial and Medicare markets, MassHealth anticipates that shifting primary care payment within MassHealth ACOs across the Commonwealth would further catalyze an on-the-ground shift towards value-based care delivery by enabling a higher

percentage of providers' payer mix to be in capitation, ultimately leading to improved cost and quality goals for MassHealth members.

### C. Program Design

#### *Structure*

MassHealth's proposed sub-capitation program is designed to sit within the existing ACO program - primary care provider participation with a MassHealth ACO would be a pre-requisite to take part in the sub-capitation program, and conversely participation in the sub-capitation payment model would be a new requirement of ACO-participating primary care practices. Accountability for total cost of care and quality is created by the ACO program, and the proposed sub-capitation model would extend value-based purchasing down to the level of the provider. In both the ACPP and PCACO models, ACOs would continue as today to hold primary care providers financially accountable for the ACO's performance and for the primary care provider's contribution to that performance, with potential for the primary care provider or group to share gains from savings or share financial responsibility for losses. As today, primary care providers would be required to experience a meaningful portion of their annual Medicaid patient service revenue opportunity as tied to value-based performance measures. This value-based payment structure will include federally qualified health centers (FQHCs)—which are essential providers of primary care for some of the most vulnerable MassHealth members, while still ensuring that they are paid at or above their PPS rates as required under the federal Benefits Improvement and Protection Act of 2000 (BIPA).

Currently, in the ACPP program, MassHealth pays a prospective capitation to the health plan, which in turn pays providers for covered services. MassHealth annually reconciles the paid capitation with actual cost and utilization, mediated by a risk corridor. The providers and the plan (that together make up the ACPP) are jointly responsible for their share of losses, if costs exceed payment, or for their share of gains, if the ACO has been successful in keeping costs down. In the proposed primary care sub-capitation model for ACPPs, MassHealth would direct ACPPs to make prospective sub-capitation payments to their participating primary care providers, in line with MassHealth's prescribed model.

For the PCACO program, which is a Primary Care Case Management (PCCM) construct in which the ACO is the PCCM entity, MassHealth currently calculates a prospective benchmark for the ACO, and makes fee-for-service payments to providers at State Plan rates (plus a PCCM add-on fee to support care coordination expectations). Annually, MassHealth reconciles actual utilization against this adjusted benchmark, which is adjusted retrospectively, and the ACO is responsible for any shared losses or shared savings. In the proposed primary care sub-capitation model, MassHealth would make capitation payments for certain primary care services to the ACO (i.e., the PCCM entity), which will then be required to make prospective

sub-capitation payments to their participating primary care providers, in line with MassHealth's prescribed model. MassHealth would no longer make fee-for-service payments for a defined set of primary care services delivered to PCACO-enrolled members by PCPs that receive capitated primary care payments from a PCACO.

The sub-capitation program would be fully integrated into the existing ACO structure, building on the quality and performance accountability providers experience today. As a part of MassHealth's ACO program, both ACPPs and PCACOs are held accountable to the ACO quality slate (as described in Section II), which includes several primary care-based measures. Primary care providers will be at risk for their quality performance as well as the ACO's overall quality performance, through their share in the ACO's quality incentive. MassHealth anticipates allowing individual ACOs to implement additional quality incentive programs with their participating primary care providers.<sup>18</sup>

#### *Clinical Model and Expectations*

The proposed sub-capitation program would include three tiers with differing expectations of primary care service delivery. Practices would qualify for a specific tier based upon their site-specific service capabilities. Tier 1 site expectations would target primary care practices earlier in their journey of practice improvement and be achievable by the majority of primary care providers by 2023, when the new ACO contracts are anticipated to be effective. Tier 1 would enable broad participation in the sub-capitation program, while simultaneously incentivizing participating practices to further improve care delivery. Tier 2 and Tier 3 practices would have increasingly higher clinical expectations, and would receive proportionally higher rates, reflecting the more comprehensive and intensive set of clinical services available to members. As practices develop additional clinical capacities, they would have the opportunity to participate in higher tiers, through an anticipated annual process.

Care delivery expectations in the proposed sub-capitation program would focus on the following key areas:

- **Behavioral Health Integration:** The sub-capitation program would promote a team-based model in primary care settings to support members with mild-to-moderate mental health and substance use disorder conditions. As a baseline requirement for participation, practices in all tiers would need to be able to offer services such as behavioral health screening. To qualify for higher tiers, practices would need to provide additional supports and services within the primary care setting, including expanded staffing, diagnostic and therapeutic services, and more robust medication-assisted treatment services. Of note, MassHealth plans to add preventive behavioral health services for children to the State Plan; a portion of such care would be included under the sub-capitation payment.

- **Care Coordination and Health-Related Social Needs:** Building off the investments made in care coordination and health-related social needs in the current demonstration, MassHealth aims to further enhance and streamline the set of these supports and services that are best delivered in the primary care setting. All primary care practices will also be expected to screen and provide referrals for adult and pediatric oral health services, behavioral health, and health-related social needs. In addition to the core care coordination services expected of providers in all tiers, higher-tier practices would need to meet staffing requirements for roles designed to provide these types of supports to MassHealth members (e.g., community health workers).
- **Unique Needs of Children, Youth and Families:** Acknowledging that children and youth populations access health care services differently than adult populations, MassHealth aims to give practices tools and supports to further tailor care to meet the unique needs of these individuals and their families. Additionally, all practices will be expected to provide fluoride varnish to children to better address preventive oral health. To qualify for higher tiers, practices would need to meet additional requirements, such as employing certain staff roles with the appropriate expertise and training to provide support for pediatric patients and their families or care givers.
- **Expanded Access:** All practices would be expected to provide appropriate access and culturally and linguistically appropriate care to their members. Higher-tier practices would also be expected to meet enhanced access standards, such as offering more evening and weekend availability, expanded telehealth capabilities, and developing capacity for e-consults.

### *Payment*

Payment for the primary care sub-capitation program would be calculated on a per member per month basis, based on the attributed population and a defined set of services/codes, consistent across tiers, with appropriate risk adjustment. Rates would reflect the enhanced clinical expectations for providers participating in the sub-capitation program, and would increase for higher tier practices, commensurate with the expanded care delivery expectations. MassHealth anticipates that the opportunity for increased investment would not only appropriately support the enhanced services and supports provided, but also incentivize providers and ACOs to make practice improvements in order to qualify for higher tiers, ultimately driving improvements in care delivery and quality.

To meaningfully move the focus of primary care practices away from fee-for-service incentives, and towards value in primary care, the proposed primary care sub-capitation model would not include a back-end reconciliation against utilization, except to the extent required to calculate and ensure appropriate PPS payment for FQHCs. Rather, ACOs and providers would continue to



hold accountability for the quality and total cost of care. MassHealth would incorporate appropriate risk mitigation, especially in the first years of the program, to ensure unanticipated shifts in utilization are accounted for in primary care providers' revenue.

## 2.2 Behavioral Health

### A. Statement of Request

MassHealth requests: 1) expenditure authority for the renewal and expansion of diversionary behavioral health and substance use disorder services, as described in the current demonstration's Special Terms and Conditions Table C and Table D, respectively; and 2) expenditure authority to implement a student loan repayment program specific to behavioral health clinicians.

MassHealth also has a demonstration amendment currently pending with CMS to provide services to individuals with serious mental illness in all inpatient levels of care that meet the federal definition of institutions for mental disease (IMDs). If approved, MassHealth would seek to continue this authority under the proposed demonstration period that begins in 2022.

### B. Background and Goals

Behavioral health has been a key priority in the demonstration during and prior to the current demonstration period. The demonstration has provided long-standing authority for expanded behavioral health services. In the current demonstration period, MassHealth was among the first states to implement a substance use disorder waiver, and integration of behavioral health was a core principle of MassHealth's delivery system restructuring.

In 2021, the Commonwealth introduced the *Massachusetts Roadmap for Behavioral Health Reform* to ensure the right treatment where and when people need it.<sup>16</sup> With investments totaling over \$200 million per year over the next several years, the Commonwealth will significantly strengthen the delivery of outpatient, urgent, and crisis treatment, and improve the integration of behavioral health care with primary care. While many components of the *Roadmap* do not require any new demonstration authority and are not included in this proposal, MassHealth seeks to implement the requests outlined below via 1115 demonstration authority.

#### *Diversionary Services*

The current demonstration authorizes a set of expanded behavioral health services known as "diversionary behavioral health services." Diversionary behavioral health services are designed to assist members with substance use and/or mental health needs in maintaining their community tenure and avoiding inpatient hospitalization, particularly during acute episodes or crises. Diversionary services are also provided to support an individual's return to the

community following a 24-hour acute admission. There are two categories of diversionary services authorized under the demonstration: those provided in a 24-hour facility, and those which are provided on an outpatient basis:

- **24-hour diversionary services** include:
  - Short-term, intensive mental health services for adults and children as an alternative to hospitalization (Community Crisis Stabilization and Community Based Acute Treatment (CBAT) for Children and Adolescents);
  - 24-hour addiction treatment (Acute Treatment Services and Clinical Support Services for Substance Abuse); and
  - Services for children and youth who are in the custody of the Department of Children and Families and who are transitioning from an inpatient hospitalization to a residential program (Transitional Care Unit Services);
- **Outpatient and community-based (non-24-hour) diversionary services** include:
  - Mental health crisis intervention (Emergency Services Program)
  - Clinically intensive day and outpatient treatment programs for mental health and/or addiction (Intensive Outpatient Program, Structured Outpatient Addiction Program, Partial Hospitalization Program, and Psychiatric Day Treatment);
  - Ongoing community-based treatment, rehabilitation and support services for adults with severe and persistent mental illness to engage in an individual process of recovery (Program of Assertive Community Treatment); and
  - An array of services (e.g., outreach, supportive services) delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals for members with significant mental health and/or addiction needs (Community Support Program (CSP), including CSP for Chronically Homeless Individuals).

Currently, all of these services are authorized through the 1115 demonstration for the managed care delivery system, and a subset are also authorized through the State Plan for members in fee-for-service. The fee-for-service population includes adults who are dually eligible for Medicare and MassHealth, as well as those with other third-party liability (e.g., primary commercial insurance through an employer, with MassHealth as a secondary payer).

Diversionary services support member goals of staying safely in the community, and thereby also reducing costs. For example, a recent study of MassHealth managed care members found that engaging with the diversionary behavioral health service CSP for Chronically Homeless Individuals (also known as the Community Support Program for People Experiencing Chronic

Homelessness, or CSPECH) in Massachusetts was associated with up to an \$11,914 reduction in annual per-person health care costs.<sup>20,21</sup>

### *Substance Use Disorder Services*

In its most recent demonstration, MassHealth expanded the array of substance use disorder and recovery diversionary services available to members by adding Residential Rehabilitation Services (including Co-Occurring Enhanced Residential Rehabilitation Services), Recovery Coach Services, and Recovery Support Navigator services to the benefit. In partnership with the Bureau of Substance Addiction Services at the Department of Public Health, approximately 18 Co-Occurring Enhanced Residential Rehabilitation Service programs have been established under the current demonstration, adding a total of 374 rehabilitation beds to the substance use disorder continuum of care in Massachusetts. Additionally, over 100 sites across the Commonwealth now provide access to Recovery Coach and Recovery Support Navigator Services. As a result of these expansions, MassHealth now covers treatment at ASAM Levels 1; 2.1; 3.1; 3.5; 3.7, and 4. Implementation of ASAM Level 3.3 remains in the planning process, to ensure that this service adequately meets the needs of this specialized population upon launch.

Early findings from the Interim Evaluation (see Attachment 3) have shown encouraging results, indicating that members with substance use disorder, including opioid use disorder, are increasingly utilizing Residential Rehabilitation Services, Recovery Coach Services, and Recovery Support Navigator services. The increased utilization of Recovery Coaches and Recovery Support Navigators in particular suggests smoother transitions between levels of care and higher levels of continuous engagement. During the evaluation period of July 1, 2017, through December 31, 2020, there was a slight reduction in initiation and engagement of treatment rates; however, opioid and other overdoses decreased relative to baseline; the ratio of medication-assisted treatment prescribers per member with any substance use disorder diagnosis (including opioid use disorder) increased relative to the baseline period; and the number of inpatient visits per member-quarter decreased.

MassHealth has been working closely with stakeholders and the Bureau of Substance Addiction Services to continuously improve and strengthen the continuum of community-based ASAM

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<sup>20</sup> Byrne, Thomas, and George Smart. "Estimating Cost Reductions Associated with the Community Support Program for People Experiencing Chronic Homelessness." Blue Cross Blue Shield of Massachusetts Foundation, March 8, 2017. <https://www.bluecrossmafoundation.org/publication/estimating-cost-reductions-associated-community-support-program-people-experiencing>.

<sup>21</sup> Brennan, Kevin, Kathryn Bruggs, Pete Zuckerman, Singumbe Muyeba, Alexis Henry, John Gettens, and Parag Kunte. "THE PREVENTIVE EFFECT OF HOUSING FIRST ON HEALTH CARE UTILIZATION AND COSTS AMONG CHRONICALLY HOMELESS INDIVIDUALS: New Evidence Using Propensity Score Analysis." Blue Cross Blue Shield of Massachusetts Foundation, December 2020. [https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2020-12/Housing%20First\\_report\\_FINAL.pdf](https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2020-12/Housing%20First_report_FINAL.pdf).

levels of care through enhanced expectations for providers in assessment planning, capacity to care for individuals with co-occurring physical health and mental health disorders, and competences in and access to medication-assisted treatment. MassHealth and the Bureau of Substance Addiction Services are evaluating the performance of these providers through an analysis of readmission rates, assessment for treatment (inclusive of co-occurring disorders), and medication-assisted treatment protocols, initiation, and engagement. Continuation of these diversionary substance use disorder services within the MassHealth benefit would allow for multiple pathways to treatment, which MassHealth anticipates resulting in increased rates of identification, initiation, and engagement in substance use disorder treatment.

### *Behavioral Health Workforce*

A robust and diverse workforce is essential for the success of the *Roadmap for Behavioral Health Reform*, as addressing behavioral health needs requires skilled, compassionate providers and staff who can provide culturally responsive, evidence-based treatment. As is the case across the country, the Commonwealth is experiencing a dire shortage of behavioral health clinicians, including prescribers, who accept public or private insurance, and the need is especially great in the Medicaid space. In a 2018 survey, almost 40% of low-income Massachusetts respondents who sought mental health or substance use disorder treatment reported that they were told by a behavioral health provider that the provider did not accept their insurance.<sup>22</sup>

Under the current demonstration, DSRIP-funded student loan repayment programs have shown efficacy in achieving retention in high-Medicaid community-based behavioral health settings. Awarded behavioral health providers in these settings receive student loan repayment up to \$50,000 in exchange for a four-year service commitment. Preliminary results show that 94% of primary care and behavioral health providers receiving awards in 2018 and 2019, and 98% of masters-prepared behavioral health providers receiving awards in 2018, remained employed in community-based settings.<sup>23</sup>

### C. Program Design

#### *Diversionary Services*

MassHealth seeks to renew existing expenditure authority for the diversionary behavioral health services, described in Table C of the current Special Terms and Conditions. In addition, MassHealth requests authority to extend certain diversionary services to the fee-for-service population, including the Program of Assertive Community Treatment, the 24-hour diversionary services (e.g., Community Crisis Stabilization (CCS), Acute Treatment Services for Substance

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<sup>22</sup> “Massachusetts Health Care Reform Survey” Blue Cross Blue Shield of Massachusetts Foundation, 2018 .

<sup>23</sup> Internal MassHealth Data

Abuse (ATS), Clinical Support Services for Substance Abuse (CSS)),<sup>24</sup> the Community Support Program (CSP), and CSP for Chronically Homeless Individuals. MassHealth also requests that the proposed specialized CSP programs described in Section III.3.2 (CSP for Homeless Individuals, CSP Tenancy Preservation Program, and a CSP for Justice Involved individuals), to be available in both the managed care and the fee-for-service delivery systems.

As a complement to this proposal, MassHealth anticipates expanding access to Structured Outpatient Addiction Program and Intensive Outpatient Program to members in fee-for-service through the State Plan.

### *Substance Use Disorder Services*

MassHealth seeks to renew its existing expenditure authority for SUD services described in Table D of the current Special Terms and Conditions. In addition, in a recent demonstration amendment, MassHealth has also requested authority to extend coverage of ATS and CSS to the fee-for-service population and to deliver Level 4 detoxification services in facilities that meet the definition of IMDs. MassHealth seeks to continue these authorities under the extension period for coverage of these services when delivered in IMDs.<sup>25</sup>

MassHealth intends to continue strengthening programmatic expectations to address the needs of members with co-occurring mental health and substance use disorders. These enhanced expectations are moving the substance use disorder continuum from providing treatment that is ‘co-occurring capable,’ with limited capacity to treat moderate to severe psychiatric conditions, to ‘co-occurring enhanced,’ which increases capacity to provide care that better matches the needs of members. Expectations include requiring consistent application of the ASAM criteria across the continuum to ensure that members’ multidimensional needs are adequately identified and met.

### *Behavioral Health Workforce*

MassHealth proposes two student loan repayment programs, which would engage an estimated 90 new providers per year for four years. Student loan repayment is a promising tool in addressing health care workforce challenges,<sup>26</sup> which are particularly acute for diverse and culturally competent behavioral health clinicians. Awards would prioritize clinicians with cultural and linguistic competence to better reflect and serve the needs of the MassHealth

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<sup>24</sup> Fee-for-service authority for these 24-hour diversionary services was also requested in MassHealth’s pending SMI demonstration amendment.

<sup>25</sup> MassHealth’s current demonstration approval preceded the announcement of the opportunity in SMDL # 17-003. MassHealth seeks to extend its SUD authority either as currently approved or pursuant to SMDL # 17-003.

<sup>26</sup> Covino, Nicholas. “Developing the Behavioral Health Workforce: Lessons from the States.” *Adm Policy Ment Health*, 46, 6 (November 2019): 689–695. <https://doi.org/10.1007/s10488-019-00963-w>.

population, and this effort to diversify the workforce will be a key piece of the agency's health equity strategy.

The first program would repay student loan obligations up to \$50,000 for licensed behavioral health clinicians or Masters-prepared social workers intending to obtain licensure within one year of the award. Participants would be obligated to a four-year commitment to working in community-based settings that serve a significant number of MassHealth members. The second program would repay up to \$300,000 per clinician for psychiatrists or nurse practitioners with prescribing privileges that make a four-year commitment to maintaining a panel that is at least 40% MassHealth members. This program will be part of larger *Roadmap* efforts to bolster the cultural competence of the behavioral health workforce and improve access to high-quality treatment. MassHealth will also make targeted rate increases for certain services and providers, as well as introduce Certified Peer Specialist services under the State Plan.

### *Serious Mental Illness Demonstration*

Pursuant to CMS's formal opportunity,<sup>27</sup> MassHealth recently submitted a demonstration amendment request for authority to provide services to individuals with serious mental illness in inpatient levels of care that meet the federal definition of IMDs, which is currently pending with CMS. If approved, MassHealth would seek to continue that authority under the extension period for coverage of these services when delivered in IMDs.

## **2.3 Children, Youth, and Families**

MassHealth recognizes that children, youth, and their families have unique needs that sometimes differ from those of adult members. It is a key part of the MassHealth's strategy to ensure that initiatives systematically recognize these unique needs and appropriately tailor health services. In addition to the child-specific components outlined in this demonstration proposal (e.g., differentiated clinical expectations for practices serving children in the primary care sub-capitation model, modifications to the Flexible Service program recognizing the family unit), MassHealth is prioritizing and implementing a variety of child and family-focused initiatives that do not require demonstration authority.

For example, for the highest-risk children with medical complexities, MassHealth will introduce a Targeted Case Management (TCM) benefit under the State Plan to support well-coordinated care that utilizes a family-centered approach in which the family is an active member of the care team. In response to stakeholder feedback, this service will be embedded in specialty or specialized primary care settings where these youth and their families receive medical care. These providers will coordinate across the health, educational, state

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<sup>27</sup> See SMDL # 18-011.

agency, and social services systems in order to optimize support for these highly vulnerable children and youth. Targeted Case Management will meet a specific need for this population, but will not replace or duplicate other forms of enhanced care coordination for children, such as the Community Partners program or services under the Children’s Behavioral Health Initiative.

Additionally, the *Commonwealth’s Roadmap for Behavioral Health Reform* includes several child- and family- specific components. MassHealth will begin allowing qualified clinicians to provide preventive behavioral health services to youth who screen positive for behavioral health symptoms, but who do not meet the clinical threshold for diagnosis and treatment. Community Behavioral Health Centers will be required to have the capacity to treat children with specific evidence-based practices, and will need to include clinical and peer roles with expertise in working with children and families. MassHealth is also developing criteria for community-based crisis stabilization services for youth, with a goal of increasing the Commonwealth’s capacity to divert children from psychiatric hospitalization.

MassHealth is further partnering with other state agencies to on the shared priorities of health equity and support for children and families. For example, MassHealth is collaborating with the Department of Public Health (DPH) Title V Maternal and Child Health program on a range of maternal and child health efforts; partnering with the Department of Children and Families (DCF) to optimize health care delivery for children in foster and congregate care; and working across state agencies to develop a pilot program to proactively connect transition age youth who have aged out of state custody with stable housing, education and employment supports and other benefits.

**Goal 3: Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals**

**3.1 Health Equity Incentives**

**A. Statement of Request**

As part of MassHealth’s commitment to addressing structural racism and reducing health disparities, the agency seeks the expenditure authority to implement health equity incentive payments for Accountable Care Organizations, ACO-participating acute hospitals, and non-state-owned public hospitals.

**B. Background and Goals**

In the next demonstration, MassHealth proposes building on past efforts through significant new incentives for health care provider organizations and plans tied to addressing structural

racism and reducing health disparities. This innovative proposal goes beyond most existing quality programs, reflecting a growing interest in the Commonwealth and nationally to advance health equity as an essential tenet of high-quality care. For example, the EOHHS Quality Measure Alignment Taskforce, convened in 2017 with the primary goal of building consensus on an aligned measure set for public and private payers in Massachusetts, has identified health equity measurement as a primary focus and has proposed stratification of measures by social risk factors beginning in 2022. The National Committee for Quality Assurance has proposed stratification by race and ethnicity of a subset of HEDIS measures beginning in 2022,<sup>28</sup> among other interventions. The National Quality Forum's Health Equity Program, launched in 2019, aims to drive health equity through identification of disparities, development of new performance measurement approaches and guidance on effective interventions including payment reform.<sup>29</sup> CMS, in its FY2022 Medicare Hospital Inpatient Prospective Payment System and Long Term Care Hospital Rates Final Rule, sought stakeholder input on ideas to enhance reporting of health disparities based on social risk factors (including race and ethnicity) more comprehensive and actionable.<sup>30</sup>

Through this effort, MassHealth aims to gain more insight at the state and ACO level into health and health care disparities experienced by its members in order to make measurable progress toward closing identified disparities within the waiver period. To that end, MassHealth seeks to implement incentive payments for ACOs and ACO-participating hospitals that achieve the following:

- Complete and accurate social risk factor data for MassHealth members;
- Periodic, stratified reporting on quality performance indicators by social risk factors;
- Significant annual reductions in health inequities.

Incentives will be designed to ensure providers serving disproportionately socially-at risk populations will not be disadvantaged by the introduction of incentives. This incentive proposal complements other investments MassHealth proposes in the health equity space, including student loan repayment for behavioral health clinicians in high-Medicaid practices, and strategies to address health-related social needs.

### C. Program Design

MassHealth seeks to implement an incentive payment arrangement in which ACOs, ACO-participating hospitals, and the non-state-owned public hospital may earn payments based on

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<sup>28</sup> National Committee on Quality Assurance. Webinar: [The Future of HEDIS: Health Equity](#). June 22, 2021.

<sup>29</sup> National Quality Forum. "NQF's Health Equity Program: Improving Health and Healthcare Quality for All through Advancements in Health Equity." January 2019.

<sup>30</sup> CMS. Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F).



health equity performance. MassHealth anticipates that ACOs will be eligible to earn an incentive payment, defined as a percentage of their monthly capitation payment or total cost of care benchmark, based on health equity performance. ACO-participating hospitals will be eligible to receive incentive payments totaling \$100 million annually across the hospital class, while non-state-owned public hospitals will be eligible to earn up to \$90 million dollars annually for health equity performance. Of note, the Commonwealth remains in active dialogue with the provider community around the parameters of these new health equity performance payments.

To advance health equity, MassHealth proposes health equity incentives consisting of three health-equity related subcomponents, detailed below. Program design will be guided by existing and emerging relevant evidence/guidance including from the U.S. Department of Health and Human Services,<sup>31</sup> National Quality Forum,<sup>32</sup> and other expert bodies.

*Subcomponent 1: Collection of complete, accurate, and self-reported social risk factor data*

Complete and accurate social risk factor data will be essential to identifying inequities, informing interventions, and monitoring progress over time. To that end, MassHealth seeks to incentivize ACOs, ACO-participating hospitals, and non-state-owned public hospitals to increase understanding of, and attention to, inequities through collection and reporting of member-level data on social risk factors, defined as individual-level social attributes or exposures that increase the likelihood of poor health<sup>33</sup> (such as socioeconomic position; race and ethnicity; gender, gender identity, and sexual orientation; social relationships; and residential and community context).<sup>34</sup>

This investment in data collection is essential and foundational to success in reducing health inequities. What is known about member-level social risk factor data among MassHealth entities indicates highly variable levels of completeness by provider entity and social risk factor. For example, completeness of race and ethnicity data is relatively high for many Massachusetts hospitals and community health centers, due to pre-existing regulatory and/or programmatic

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<sup>31</sup> “Developing Health Equity Measures.” United States Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, May 19, 2021. <https://aspe.hhs.gov/reports/developing-health-equity-measures>.

<sup>32</sup> “A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity.” National Quality Forum, September 2017. [https://www.qualityforum.org/Publications/2017/09/A\\_Roadmap\\_for\\_Promoting\\_Health\\_Equity\\_and\\_Eliminating\\_Disparities\\_The\\_Four\\_I\\_s\\_for\\_Health\\_Equity.aspx](https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx).

<sup>33</sup> Green, Katie, and Megan Zook. “When Talking about Social Determinants, Precision Matters: Health Affairs Blog.” Health Affairs, October 29, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>.

<sup>34</sup> “Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors.” *The National Academies of Sciences, Engineering, and Medicine*, 2016. <https://doi.org/10.17226/21858>.

initiatives, and is often collected in a manner consistent with existing federal standards;<sup>35</sup> it is much lower for many ambulatory providers. For other social risk factors, including self-reported disability status, sexual orientation, and gender identity, data completeness levels among providers are similarly variable and aggregation and interpretation is complicated by the use of highly variable data standards for collection. MassHealth anticipates that increasing standardization and data completeness will be resource intensive for ACOs, ACO-participating hospitals, and non-state-owned public hospitals to achieve systems enhancements necessary to collect and report on such data for members.

MassHealth intends to set ambitious performance targets for data completeness in order to facilitate sufficient levels for analysis of disparities. The agency recognizes that without sufficient completeness, stratified reporting of performance will not be valid and therefore will hinder identification, action, and evaluation of interventions on those inequities. Self-reported data will be prioritized in completeness thresholds. However, to support earlier identification of disparities in performance, MassHealth will consider the use of imputed social risk factor data as needed to avoid undue delay in identifying and monitoring disparities for action.

#### *Subcomponent 2: Identify and monitor health and health care inequities through stratified reporting*

For this subcomponent, MassHealth aims to offer incentives for ACOs, ACO-participating hospitals, and non-state-owned public hospitals that can demonstrate the capacity to identify inequities, including through stratification of quality performance data by social risk factors. MassHealth plans to prioritize stratification of metrics for which there is a conceptual and/or empirical link between the targeted risk factor and the outcome of interest that would support an intervention, evaluating measures for this “disparities-sensitivity” using an approach consistent with methodology defined by the National Quality Forum for this purpose.<sup>36</sup> MassHealth has intentionally designed its quality measure slate for ACOs, ACO-participating hospitals, and non-state-owned public hospitals to include measures that are disparities-sensitive.

MassHealth intends to require stratification on a subset of measures by a subset of social risk factors in the first year of the demonstration period, recognizing that this may precede attainment of data completeness targets for some ACOs, ACO-participating hospitals, and non-state-owned public hospitals, but will be essential to establishing capacity in analyzing and

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<sup>35</sup> “Standards for the Classification of Federal Data on Race and Ethnicity.” Office of Management and Budget, August 28, 1995. [https://obamawhitehouse.archives.gov/omb/fedreg\\_race-ethnicity](https://obamawhitehouse.archives.gov/omb/fedreg_race-ethnicity).

<sup>36</sup> “Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment.” National Quality Forum, November 15, 2012. [https://www.qualityforum.org/Publications/2012/11/Healthcare\\_Disparities\\_and\\_Cultural\\_Competency\\_Consensus\\_Standards\\_Disparities-Sensitive\\_Measure\\_Assessment.aspx](https://www.qualityforum.org/Publications/2012/11/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards_Disparities-Sensitive_Measure_Assessment.aspx).

interpreting data in anticipation of data completeness thresholds being reached. In each subsequent performance year, MassHealth plans on requiring stratified performance reporting from ACOs, ACO-participating hospitals, and non-state-owned public hospitals for additional measures and/or by additional social risk factors.

MassHealth anticipates leveraging stratified performance reporting for at least two purposes:

1. To support ACO, ACO-participating hospital, and non-state-owned public hospital health equity programming and quality improvement activities
2. For public reporting of health equity performance, once technical thresholds for validity and reliability are met

MassHealth intends to set ambitious targets for stratified reporting of quality metrics by social risk factors to promote health care providers' capacity to access, analyze, and interpret social risk factor data in service of health equity goals. MassHealth also intends to use public reporting to enhance transparency around health equity performance across the system.

*Subcomponent 3: Reduce identified inequities through targeted and evidence-based interventions*

Ultimately, MassHealth expects that ACOs, ACO-participating hospitals, and non-state-owned public hospitals will demonstrate measurable and significant reductions for a subset of prioritized health inequities impacting their members and patients. MassHealth proposes selecting a subset of "target metrics" on which ACOs, ACO-participating hospitals, and non-state-owned public hospitals would be incentivized to reduce specific disparities. MassHealth intends to select target metrics using both stratified reporting data from the early years of the demonstration, as well as a predetermined set of criteria, including but not limited to:

- Relevance and importance to the MassHealth population;
- Scope of inequity and population impacted;
- Evidence base supporting relationship between a social risk factor and health or healthcare outcome;
- Conceptual and/or empirical basis for intervention; and
- Technical feasibility (including expectation that sufficient data completeness is achieved to facilitate valid baseline and annual performance).

MassHealth anticipates selecting several metrics on which inequitable outcomes have been observed between a specific socially at-risk population and a reference population. All ACOs, ACO-participating hospitals, and non-state-owned public hospitals will be accountable for reducing disparities on these metrics. In addition, MassHealth intends to work with ACOs, ACO-participating hospitals, and non-state-owned public hospitals to select a smaller number of

target metrics/dimensions of inequity for each entity, allowing for variability in that subset across entities. The agency anticipates this approach would offer an appropriate balance between incentives for targeted action on MassHealth-wide priorities and specific priorities identified by plans and providers based on the unique characteristics of their populations served.

To assess entity performance, MassHealth will establish Attainment Thresholds and Excellence Benchmarks using stratified reporting data from years 1-3 of the demonstration period. This internal benchmarking will be necessary, since national or regional benchmarks for health equity performance are not currently available; although should such benchmarks become available MassHealth will consider introduction into its program. Benchmarking will be contingent upon achievement of data completeness thresholds necessary for valid interpretation of the data. Entity performance will be determined by improvement towards and/or achievement of benchmarks.

MassHealth has begun discussing its health equity goals with stakeholders, and intends to further engage stakeholders, specifically seeking input from members and impacted communities, to inform further development and design of its proposed health equity incentive program.

#### *Non-State-Owned Public Hospital Health Equity Incentives*

Cambridge Health Alliance (CHA) is Massachusetts' sole public, non-state-owned hospital, and as a safety net hospital, disproportionately serves a greater percentage of the Medicaid and uninsured population compared to its peers. Massachusetts is committed to making bold, system-wide investments in measuring and reducing health disparities. Safety net providers are critical to achieving this goal, and CHA's work in improving care for vulnerable populations sets the foundation for closing these gaps. Additionally, CHA's dedicated demonstration payment pool, the Public Hospital Transformation and Incentive Initiatives (PHTII), will sunset at the end of the current demonstration term. Massachusetts proposes to continue critical support for CHA while shifting the focus of this support to align with the Commonwealth's health equity strategy under the demonstration.

To this end, Massachusetts proposes to implement a health equity incentive program specifically for CHA, where all measures will be aligned with the demonstration's health equity incentive program. However, CHA would be required to demonstrate performance (measuring and reducing disparities) on measures across both the Medicaid and uninsured population. This separate payment stream would create a structure of robust accountability for CHA, and advance health equity goals for the unique population that CHA services, while ensuring the sustainability of CHA's necessary services for the Medicaid and uninsured population of the Commonwealth.

MassHealth Section 1115 Demonstration Extension Request

## 3.2 Health-Related Social Needs

### A. Statement of Request

To move towards a future with robust structural integration between the Massachusetts health care system and the social services sector, MassHealth seeks waiver and expenditure authority to:

- 1) Continue the Flexible Services Program, with some adjustments to improve program accessibility; and
- 2) Expand the housing support services available in both managed care and fee for service.

### B. Background and Goals

Throughout the United States as well as in Massachusetts, health-related social needs have a significant impact on a person's health, with environmental and social factors accounting for 80-90% of the modifiable contributors to healthy outcomes of a population, and medical care accounting for the remaining 10-20%.<sup>37</sup> In 2020, 1 in 7 residents in Massachusetts experienced food insecurity, up from 1 in 11 prior to COVID-19.<sup>38</sup> Additionally, approximately 18,000 residents in the state were experiencing homelessness in 2020;<sup>39</sup> recent state efforts are helping mitigate homelessness,<sup>40</sup> though it remains a significant challenge.

Furthermore, people of color are disproportionately impacted by un-addressed health-related social needs, as compared to White and Non-Hispanic people in both Massachusetts and the United States. For example, Black and Latinx people make up 9% and 12.4% of the state population,<sup>41</sup> respectively, but account for 34.8% and 40% of people experiencing homelessness.<sup>42</sup> Twenty-six percent of Latinx individuals and 24% of Black individuals 18 years

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<sup>37</sup> Hood, Carlyn M., Keith P. Gennuso, Geoffrey R. Swain, and Bridget B. Catlin. "County Health Rankings: Relationships Between Determinant Factors and Health Outcomes." *American Journal of Preventive Medicine* 50, no. 2 (February 2016): 129–35. <https://doi.org/10.1016/j.amepre.2015.08.024>.

<sup>38</sup> "The Impact of the Coronavirus on Food Insecurity in 2020." Feeding America, October 2020. [https://www.feedingamerica.org/sites/default/files/2020-10/Brief\\_Local%20Impact\\_10.2020\\_0.pdf](https://www.feedingamerica.org/sites/default/files/2020-10/Brief_Local%20Impact_10.2020_0.pdf)

<sup>39</sup> "HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations." United States Department of Housing and Urban Development, 2020. [https://files.hudexchange.info/reports/published/CoC\\_PopSub\\_State\\_MA\\_2020.pdf](https://files.hudexchange.info/reports/published/CoC_PopSub_State_MA_2020.pdf).

<sup>40</sup> "Baker-Polito Administration Announces Over \$30 Million Investment to Support Individuals Experiencing Homelessness and Substance Use Disorders." Massachusetts Executive Office of Health and Human Services, August 2, 2021. <https://www.mass.gov/news/baker-polito-administration-announces-over-30-million-investment-to-support-individuals-experiencing-homelessness-and-substance-use-disorders>.

<sup>41</sup> "Quickfacts: Massachusetts; United States." United States Census Bureau, 2019, <https://www.census.gov/quickfacts/fact/table/MA,US/PST045219>.

<sup>42</sup> "CoC Homeless Populations and Subpopulations Reports." HUD Exchange, 2020, <https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/>.

of age and older in MA have indicated low or very low food security, as opposed to 13% of their White counterparts.<sup>43</sup>

In October 2018, CMS approved MassHealth's Flexible Services Protocol as part of the DSRIP program to test whether MassHealth ACOs can improve health outcomes and reduce total cost of care by funding targeted, evidence-based health-related social need programs in the areas of nutrition and housing support goods and services. The Flexible Services Program is not an entitlement program nor a covered service, meaning that not all MassHealth members are able to access the Flexible Services Program. Additionally, the Flexible Services Program is the payer of last resort to address unmet health-related social need. Once the Flexible Services Protocol was approved, MassHealth, ACOs, and social services organizations worked closely together to launch the Flexible Services Program in January 2020, two years later than originally planned.

The Flexible Services Program offers two categories of goods and services:

- 1) Tenancy Preservation Supports, which are housing supports that include pre-tenancy individual support, transitional assistance, tenancy sustaining support, and home modifications.
- 2) Nutrition Sustaining Supports, which include medically tailored meals and other nutritional foods, cooking supplies, transportation, and services that educate members about appropriate nutrition and help members access food needed to meet their nutritional needs.

All 17 ACOs are currently implementing Flexible Services programs, with 13 ACOs focusing on both housing and nutrition, and 4 ACOs focusing only on nutrition. As of July 2021, ACOs have partnered with 38 social service agencies to offer Flexible Services Programs, with 76 total FSPs approved by MassHealth. Collectively, ACOs successfully provided approximately 8,893 member-quarters of Flexible Services during 2020 (unique members per quarter summed across all quarters), with a member receiving four member-quarters if they received Flexible Services during all four quarters of 2020.

Despite initial implementation delays, preliminary results are promising. One ACO observed an \$11,309 reduction in total cost of care for members that received Flexible Services nutrition supports in CY2020 (n = 839), as compared to a \$345 reduction in total cost of care during the same time period for a comparison group of members who were eligible to receive Flexible Services supports but did not for various reasons (n = 162; p=0.013). Only 8% of those members

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<sup>43</sup> Mattos, Trevor, Ana Poblacion, Leran Minc, Jennifer Lemmerman, Charlotte Bruce, Luc Schuster, and Stephanie Ettinger de Cuba. "Food Insecurity Has Doubled During the Pandemic: Data, Insights and Policy Solutions." Boston Indicators, October 6, 2020. [https://www.bostonindicators.org/reports/report-website-pages/covid\\_indicators-x2/2020/october/food-insecurity](https://www.bostonindicators.org/reports/report-website-pages/covid_indicators-x2/2020/october/food-insecurity).

receiving Flexible Services nutrition supports had 4+ emergency department visits, as compared to 31% for members in the comparison group. Additionally, one ACO found that members that received both nutrition and housing supports in the first half of 2020 saw an improvement in diabetes management, resulting in an increase from 74.8% to 79.7% of members with hemoglobin A1c levels below 9%, as well as a decrease in average hemoglobin A1c levels from 7.7 to 7.3, both measures demonstrative of important improvements in diabetes control.

### C. Program Design

#### *Continue the Flexible Services Program with improvements and ongoing evaluation*

MassHealth proposes to improve the still-nascent Flexible Services Program by standardizing the design of the program while simultaneously rigorously evaluating outcomes.

MassHealth proposes to continue testing the Flexible Services Program to allow for an evaluation-driven approach towards evolution of the program. As Flexible Services Program was delayed by two years and launched at the onset of COVID-19, the program needs additional time to allow the interventions to have the intended impact as well as collect and evaluate the results. Allowing for this process would provide MassHealth with the necessary data to inform meaningful program refinement and standardization. Specific analyses may include testing to see whether programs offering grocery store vouchers to members with high emergency department utilization and food insecurity, or programs offering pre-tenancy supports with transitional assistance to members who are experiencing homelessness and have complex physical health needs, will lead to reduced total cost of care, improved health outcomes, and improved quality measures. Such data may allow MassHealth to standardize specific populations, services, and/or goods based on outcomes. MassHealth may also require certain services/supports to be bundled together (e.g., requiring pre-tenancy support to be paired with tenancy sustaining support) or offered to certain target populations if the evidence supports such changes. Ultimately, this refinement would allow for increased focus on programs that lead to improved health outcomes and reduced total cost of care as well as potentially reduced health inequities.

In the upcoming demonstration, MassHealth proposes continuing to administer the Flexible Services Program as it has during the current demonstration, which would allow ACOs to leverage the workflows, relationships, and technology they have established thus far. Specifically, before Flexible Services programs could launch under the next demonstration, ACOs would need to submit plans and budgets to MassHealth for review and approval, as they currently do. MassHealth would also contract with an Independent Assessor, which would review all ACO submissions to ensure that they are in compliance with all federal and state laws, regulations, and guidance. Once approved, MassHealth would make specific Flexible Services payments (separate from the capitation rate) to ACOs on a quarterly, prospective basis



that reflects the ACOs' approved budgets for Flexible Services supports and goods. Funding allocations would be determined using a per-member-per-month based methodology.

In addition, MassHealth is proposing several changes to the Flexible Services Program:

Change 1: Allow nutrition supports to extend to a MassHealth members' household to better meet the individual member's nutritional needs

Given that food insecurity is significantly more prevalent among households with children as compared to those without children,<sup>44</sup> it would be crucial for the next iteration of the Flexible Services Program nutrition supports to consider how an individual's household may impact the efficacy of their Flexible Services Program nutrition supports. ACOs, Social Services Organizations, and other stakeholders have strongly advocated that nutrition supports provided to eligible members should be extended to household members as appropriate, especially if there are children in the family experiencing food insecurity. Therefore, MassHealth proposes tailoring its Flexible Services nutrition programs to ensure the needs of the individual and household are considered together so that the individual would receive the full impact of the nutrition intervention. Doing so would likely improve health care outcomes and reduce costs for individual members.<sup>45</sup> This could mean, for example, an additional food box or serving of home-delivered meals.

MassHealth intends to adopt the Massachusetts Supplemental Nutrition Assistance Program (SNAP) definition for a household, which is anyone who purchases and prepares food together on a regular basis (i.e., two-thirds of the time), with some exceptions. Additionally, MassHealth intends to extend the nutrition supports to anyone who fits this definition, agnostic of the health insurance coverage status of the household members. This approach would maximize the impact of the nutritional supports for the individual member, and would also significantly simplify program implementation.

Change 2: Allow Flexible Services to be used for childcare to facilitate access to prescribed nutrition and housing support services

Recent research shows that access to childcare is a barrier to accessing and engaging in health care, affecting parents, disproportionately women, of all races and ethnicities. MassHealth proposes allowing the Flexible Services Program to provide members with intermittent childcare needed to obtain and effectively engage in the Flexible Services Program. For

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<sup>44</sup> Coleman-Jensen, Alisha, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2020. Household Food Security in the United States in 2019, ERR-275, U.S. Department of Agriculture, Economic Research Service.

<sup>45</sup> Recent studies have shown that providing nutritional supports to an individual member and members of their household led to significant improvements in the individual member's HbA1c levels and reduction in total cost of care. Feinberg, Andrea T, Allison Hess, BSN, Michelle Passaretti, Stacy Coolbaugh, and Thomas H Lee. "Prescribing Food as a Specialty Drug." NEJM Catalyst, April 18, 2018.

<https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0212>.

example, if a member attends a Section 8 housing voucher briefing in person with a patient navigator, MassHealth ACOs would be able to pay for childcare services during the time needed to do so if the member has no alternative reasonable options. Another instance may be a member eligible for cooking classes through the Flexible Services Program that needs to secure childcare for their infant. If the member is unable to find adequate childcare and needs to bring the infant, they may be less able to engage in learning important skills needed to better prepare their food to manage their diabetes. Childcare is aligned with the existing service allowing ACOs to provide members with transportation services to access the Flexible Services Program. Both of these services help to advance the goal of improving accessibility to the Flexible Services Program.

Change 3: Allow the Flexible Services Program to serve postpartum members for 12 months.

In addition to being enrolled in an ACO, members must meet at least one health needs-based criteria (e.g., behavioral health need or repeated emergency department use) and have at least one risk factor (e.g., homelessness). Currently, the Flexible Services protocol recognizes the postpartum period as a health-based need criteria for 60 days after the birth of a child. As acknowledged in the most recent amendment request to its current demonstration, MassHealth believes that this vulnerable postpartum period extends for a full 12 months. To align Flexible Services eligibility with the proposed MassHealth eligibility policy, the agency proposes that the health-based needs criteria for Flexible Services supports be extended to apply to members postpartum for 12 months, rather than the current 60 days.

*Expand Targeted Housing Support Services for members experiencing or at risk of homelessness*

MassHealth proposes expanding targeted housing support services for members that meet certain criteria offered in the MassHealth benefit during the next demonstration period. MassHealth currently provides housing support services through a managed care benefit called Community Support Program for Chronically Homeless Individuals (CSP-CHI). CSP-CHI offers pre-tenancy and tenancy sustaining support services for individuals with behavioral health conditions experiencing chronic homelessness.

Additionally, MassHealth has explored opportunities to provide tenancy sustaining support specifically for individuals that are facing eviction as a result of behavior related to a disability (e.g., mental illness or substance use disorder). Programs that provide this support have prevented homelessness for approximately 95% of individuals assisted. Analysis of these programs found that health care costs (especially inpatient costs) escalated significantly in tandem with an individual's housing crisis;<sup>46</sup> after the eviction-prevention intervention, the

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<sup>46</sup> Ash, Arlene S., Eric O. Mick, Randall P. Ellis, Catarina I. Kiefe, Jeroan J. Allison, and Melissa A. Clark. "Social Determinants of Health in Managed Care Payment Formulas." *JAMA Internal Medicine* 177, no. 10 (2017): 1424–30. <https://doi.org/10.1001/jamainternmed.2017.3317>.

individual's housing situation stabilizes, preventing homelessness, which is directly associated with decreased health care costs.<sup>47</sup>

Like the Flexible Services Program, these programs focus on assisting members to obtain and retain housing to improve health outcomes and reduce health care costs, and are robust interventions to consider including in the benefit.

- **CSP for Homeless Individuals:** MassHealth proposes to expand the eligible population for CSP-CHI services to homeless members who do not meet the U.S. Department of Housing and Urban Development's definition of "chronically homeless" but who are high utilizers of health care services (to be defined by MassHealth, e.g., multiple emergency room visits within a certain timeframe). The services for this expanded population would be the same as though provided through CSP-CHI under the current demonstration, and the newly expanded program would be called CSP for Homeless Individuals (CSP-HI).
- **CSP Tenancy Preservation Program:** CSP-TPP would support members facing eviction as a result of behavior related to a disability (e.g., mental illness, substance use disorder). CSP-TPP staff would work in partnership with Housing Court to address those issues that are jeopardizing an individual's housing situation, reconnect the individual to community-based supports, and preserve their tenancy; similar interventions have prevented homelessness for over 90% of individuals assisted. MassHealth proposes to expand CSP services to this additional target population and scope.

### 3.3 Providing MassHealth Services to Justice-Involved Individuals

#### A. Statement of Request

To address health inequities experienced by justice-involved populations, MassHealth proposes to provide uninterrupted Medicaid coverage to otherwise-eligible individuals during their incarceration. Whereas today, low-income and vulnerable populations that are eligible for MassHealth lose their Medicaid benefits if they become institutionalized in a carceral setting, even for a short period of time, this proposal would allow members to maintain their MassHealth coverage. The aim of the request is to reduce the stark disparities in health

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<sup>47</sup> Bharel, Monica, Wen-Chieh Lin, Jianying Zhang, Elizabeth O'Connell, Robert Taube, and Robin E. Clark. "Health Care Utilization Patterns of Homeless Individuals in Boston: Preparing for Medicaid Expansion Under the Affordable Care Act." *American Journal of Public Health* 103, no. S2 (October 22, 2013): 311–17. <https://doi.org/10.2105/ajph.2013.301421>.

outcomes experienced by these justice-involved populations, who are disproportionately Black and Hispanic.

Specifically, Massachusetts is requesting expenditure authority to:

1. Provide certain MassHealth covered services (including medical, behavioral health, and pharmacy services) to incarcerated individuals of all ages who otherwise meet MassHealth eligibility criteria; and
2. Provide continuous eligibility for one year after an incarcerated individual leaves a carceral setting with the goal of improving health outcomes.

Certain Title XIX requirements would not apply this expenditure authority, including:

1. Statewideness, to allow for phased implementation of this policy in different carceral settings across the state;
2. Comparability/amount, duration, and scope, to account for differences in service delivery in the carceral setting (e.g., security requirements);
3. Freedom of choice, to allow services to be delivered by designated correctional health providers;
4. Certain cost sharing requirements, to ensure incarcerated individuals do not pay more in co-payments than they are currently charged;
5. Certain eligibility requirements, to enable incarcerated individuals to maintain eligibility within the MAGI construct after age 65 and until they are released from incarceration.

Massachusetts proposes to subject this expenditure authority to a financial accountability structure that puts a portion of federal financial participation (FFP) at risk for defined outcomes related to this proposal. Massachusetts also anticipates the need for additional design, development, maintenance, and operations work related to its claims processing and information retrieval systems to implement this proposal, and intends to seek authority, as appropriate, for enhanced FFP for that purpose.

### B. Background and Goals

The federal Medicaid “Inmate Exclusion Policy” (MIEP) generally excludes any incarcerated individuals from Medicaid coverage.<sup>48</sup> For the purposes of this request, the term “incarcerated individuals” means:

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<sup>48</sup> With the exception of services for patients in medical institutions, in accordance with federal law and guidance.

- Individuals in County Correctional Facilities (CCFs), and state Department of Correction (DOC) facilities, including pre-arraignment individuals, pre-trial detainees, and sentenced individuals.
- Individuals under a civil commitment order who are currently excluded under MIEP.
- Detained and committed youth in the Department of Youth Services (DYS) juvenile justice system who are currently excluded under MIEP.

Ensuring continuity of care for this population is a high priority for Massachusetts. When looking at sentencing, Black and Hispanic individuals are disproportionately represented at higher rates than white individuals – 7.5 times and 4.3 times respectively, underscoring the health equity implications of this proposal.<sup>4</sup>

To inform the development of this proposal, Massachusetts convened an interagency Coordinating Council with representatives from the DOC, the Massachusetts’ Sheriffs Association, the thirteen Massachusetts Sheriffs’ Offices within the Commonwealth, DHS, Parole, Probation, and EOHHS.

### *Massachusetts Carceral Settings*

As a result of MIEP, incarcerated individuals are currently ineligible for most MassHealth services. Approximately 12,400 adults are incarcerated in Massachusetts correctional facilities.<sup>49</sup> At any given time, approximately half of all adults incarcerated in Massachusetts are held in County Correctional Facilities<sup>50</sup>. Adults held before sentencing, referred to as “pre-trial” detainees, represent approximately one third of incarcerated adults.

All eligible youth detained by DHS are currently covered by MassHealth, even those excluded under MIEP.<sup>51</sup> Approximately 632 youth were covered by state-only cost in calendar year 2020 because of MIEP.<sup>52</sup> These youth range in age from 14 to 21 and are committed or arraigned on all levels of criminal offenses.

### *Health concerns for individuals entering and leaving carceral settings*

Individuals entering carceral settings subject to MIEP exhibit a higher prevalence of health conditions that put them at elevated risk of mortality. As displayed in Table 2, research from across the country show that incarcerated individuals face numerous health disparities in comparison to the general public relating to hypertension, asthma, substance use disorder, oral

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<sup>49</sup> Massachusetts Department of Correction Weekly Count Sheet (7/12/2021)

<sup>50</sup> Because individuals in cycle in and out of CCFs at a faster rate than DOC facilities, over the course of a year, many more individuals will be detained or incarcerated in CCFs than “point-in-time” data suggests.

<sup>51</sup> Massachusetts does not claim FFP for DHS youth excluded under MIEP

<sup>52</sup> This number is much lower than CY 2019, when 907 youth were excluded under MIEP.

health, and particularly mental health conditions. Nationally, approximately 40% of mortality within local jails occurs within seven days of entering a carceral setting.<sup>53</sup> For individuals leaving such settings, risk to health is also elevated, including increased risk of hospitalization and mortality. Compared to the general population, incarcerated individuals in such settings have 12.7 times the chance of death within two weeks of release, and are over 120 times more likely to die of a drug overdose within two weeks of release.<sup>54</sup> While much progress has been made addressing the opioid epidemic in Massachusetts and nationwide, given the societal upheaval of the COVID-19 pandemic, rates are rising again.<sup>55,56</sup> Massachusetts trends in opioid overdose deaths are particularly stark among Black men (where the rate jumped 69% from 2019 to 2020) and Hispanic men (with the highest rate among any racial or ethnic group).<sup>56</sup>

Table 2: Individuals with justice involvement face health disparities when compared to the general public

Condition	Disparity in Health of Correctional Justice-Involved Populations
Substance Use Disorder (SUD)	Over half of incarcerated adults have SUD, and there are elevated rates of SUD among incarcerated youth. At the Middlesex Jail & House of Correction, 75% of incarcerated individuals have a substance use condition. <sup>57</sup> Individuals recently released from incarceration face 120 times higher risk of fatal overdose than the general population. Moreover, over one quarter of MassHealth members who had a fatal overdose had been recently released from incarceration. <sup>58</sup>
Mental Health	Nationally, approximately 50% to 75% of justice-involved youth meet criteria for a mental health disorder. Additionally, more than half of incarcerated male adults and three-quarters of incarcerated female adults

<sup>53</sup> Noonan, Margaret E. “Mortality in Local Jails, 2000-2014 - Statistical Tables.” United States Department of Justice Office of Justice Program, January 27, 2020. <https://bjs.ojp.gov/content/pub/pdf/mlj0014st.pdf>.

<sup>54</sup> “An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015).” The Commonwealth of Massachusetts Executive Office of Health and Human Services, August 2017. <https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-august-2017/download>.

<sup>55</sup> “Current Opioid Statistics.” Massachusetts Department of Public Health, May 2021. <https://www.mass.gov/lists/current-opioid-statistics#updated-data-%E2%80%93-as-of-may-2021>.

<sup>56</sup> “Provisional Drug Overdose Death Counts.” United States National Center for Health Statistics, 2021. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

<sup>57</sup> Middlesex County Restoration Center Commission (2019). “Year One Findings and Recommendations”. Accessible at <https://www.mamh.org/library/middlesex-county-restoration-center-commission-year-one-findings-and-recommendations>.

<sup>58</sup> Massachusetts Department of Public Health. “An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts” (2011-2015) (published August 2017).

	across the country have a mental health condition. <sup>59</sup> In Massachusetts, 36% of male and 81% of female individuals incarcerated in DOC facilities have a mental health condition, while 28% and 75% respectively have a serious mental health condition. <sup>60</sup> Between 60 and 70% of Massachusetts youth in the custody of the DYS (the juvenile justice carceral entity) have been found to have at least one mental health condition. <sup>61</sup> Nearly 50% of incarcerated individuals at the Middlesex Jail & House of Correction have a mental health condition – 80% of whom have a co-occurring substance use condition. <sup>57</sup>
Prenatal care	Justice-involved youth have higher incidence of reproductive health needs, including pregnancy. <sup>62,63</sup>
Hypertension	Incarcerated adults are approximately 1.2 times more likely to have hypertension. <sup>64</sup>
Asthma	Incarcerated adults are more than 1.3 times more likely to have asthma.

Individuals leaving carceral settings tend to experience difficulties accessing the care they need, largely due to challenges in (re-)establishing MassHealth coverage, in making appointments before coverage is established, and in planning around uncertain release dates. They are also more likely to lack health insurance.<sup>65</sup> Other barriers include trouble navigating the health care

<sup>59</sup> James, Doris J., and Lauren E. Glaze, “Mental Health Problems of Prison and Jail Inmates,” U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. September, 2006.

<sup>60</sup> Massachusetts Department of Correction Research and Planning Division (2020). “Prison Population Trends 2019”. Accessible at <https://www.mass.gov/doc/prison-population-trends-2019/download>.

<sup>61</sup> Grisso, Thomas & Davis, Maryann & Vincent, Gina. (2004). “Mental Health and Juvenile Justice Systems: Responding to the Needs of Youth with Mental Health Conditions and Delinquency”.

<sup>62</sup> Albertson, Elaine M., Christopher Scannell, Neda Ashtari, and Elizabeth Barnert. “Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration”. American Journal of Public Health, Vol. 110, No. 3 (March 2020).

<sup>63</sup> Barnert, Elizabeth S., Raymond Perry, and Robert E. Morris. “Juvenile Incarceration and Health”. Academic Pediatrics 16:2 (March 1, 2016).

<sup>64</sup> Binswanger, Ingrid A et. al. « Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population”. J Epidemiol Community Health. 63(11):912–919. (January 11, 2007).

<sup>65</sup> Winkelman, Tyler N., Edith C. Kieffer, Susan D. Goold, Jeffrey D. Morenoff, Kristen Cross, and John Z. Ayanian. “Health Insurance Trends and Access to Behavioral Healthcare Among Justice-Involved Individuals.” Journal of General Internal Medicine 31, no. 12 (December 31, 2016): 1523–29.

<https://doi.org/10.1007/s11606-016-3845-5>.

system, lack of transportation, and interruption in medication.<sup>66</sup> For individuals in County Correctional Facilities, the date of release can change. Individuals with serious mental illness are more likely to be released to face more unpredictable release times, for example through bail, release from court, or withdrawal of a bench warrant, leaving less time for re-entry planning<sup>67</sup> Uncertain release dates can cause Medicaid re-instatement and connection to community providers to be especially difficult.

*MIEP leads to challenges in maintaining continuity of care and improving population health*

The vast majority of the Massachusetts incarcerated population is eligible for MassHealth before and upon release from carceral settings,<sup>68</sup> and many individuals experiencing detention or incarceration do not stay for long. Average lengths of stay across facility types range from less than a week to several years.<sup>69</sup>

The loss of coverage upon becoming incarcerated creates health system churn, fragmentation of care during critical periods in members' lives, and undermines MassHealth's ability to provide continuity of care for its members when they return to the community. As individuals cycle in and out of carceral settings, MassHealth faces challenges in measuring and managing its populations' health. When MassHealth eligibility is suspended during adult incarceration, even for very short stays, new barriers to care are introduced. Correctional staff may not have access to outside health records helpful in assessing and treating individuals and by the time staff are able to obtain records (especially in County Correctional Facilities), a person might have already left the carceral setting. Lifting Medicaid suspension can take time. Appointments often cannot be made until the coverage is re-activated, impeding a smooth transition to outside medical care upon release.

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<sup>66</sup> Golzari, Mana, and Anda Kuo. "Healthcare Utilization and Barriers for Youth Post-Detention." *International Journal of Adolescent Medicine and Health* 25, no. 1 (2013): 65–67. <https://doi.org/10.1515/ijamh-2013-0008>.

<sup>67</sup> Draine, Jeffrey, Amy Blank Wilson, Stephen Metraux, Trevor Hadley, and Arthur C. Evans. "The Impact of Mental Illness Status on Length of Jail Detention and the Legal Mechanism of Jail Release". *Psychiatric Service* 2010 May; 61(5): 458-62

<sup>68</sup> Western, Bruce, and Jessica T. Simes. "Drug Use in the Year After Prison." *Social Science & Medicine* 235 (August 2019). <https://doi.org/10.1016/j.socscimed.2019.112357>. (Citing Massachusetts DOC's partnership with University of Massachusetts in re-entry activities and finding that of incarcerated individuals leaving Massachusetts DOC facilities found that 96% were enrolled MassHealth at the one-week mark, and 90% were enrolled in MassHealth at the one-year mark)

<sup>69</sup> Pre-trial detainees are typically held for about a month; one-third are detained for less than a week. Sentenced adults in CCFs are held an average of four to five months.



*Massachusetts has worked across agencies to address challenges caused by MIEP.*

Massachusetts has taken many steps to optimize continuity of care and promote equitable health outcomes for justice-involved populations. Massachusetts was one of the first states to suspend, rather than terminate, coverage for incarcerated adults, and effectuate coverage (reactivating or reapplying for coverage) upon release.<sup>19</sup>

Massachusetts' commitment to health care coverage for justice involved individuals started early, with extension of MassHealth coverage to youth detained by DYS, the Commonwealth's juvenile justice agency. While youth are committed to DYS custody, DYS staff work with the youth and family to connect with a community primary care provider and community mental health provider. DYS engages the youth in enrolling in and maintaining MassHealth as they discharge from state care (which, depending on the circumstances, can include a MassHealth re-enrollment process).

In addition, MassHealth and partners have:

- Engaged in re-entry planning and connections to community providers;
- Worked with facilities to process new applications for individuals who were previously uninsured prior to incarceration;
- Entered into Data Sharing Agreements with the DOC and the 13 County Sheriffs' Offices that have correctional facilities;
- Established a dedicated phone line and team to process eligibility status updates for incarcerated individuals;
- Continued to re-activate community Medicaid benefits for individuals who become eligible for release;
- Supported a number of grant- and state-funded re-entry initiatives, including the Justice Community Opioid Innovation Network;<sup>70</sup> and
- Developed the MassHealth Behavioral Health for Justice Involved<sup>71</sup> program, which is currently implemented in two counties and offers (1) in-reach activities which take place

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<sup>70</sup> The National Institutes of Health, through its HEAL Initiative (Helping End Addiction Long Term), created the Justice Community Opioid Innovation Network. The Massachusetts Justice Community Opioid Innovation Network Hub is led by investigators at Baystate Health and the University of Massachusetts Amherst in collaboration with the Massachusetts Department of Public Health, seven Sheriff's Offices, and community treatment providers.

<sup>71</sup> In 2019, MassHealth began a state-funded demonstration to provide Behavioral Health Supports for Individuals who are Justice Involved (BH-JI) in Worcester and Middlesex counties through a partnership among MassHealth and Massachusetts' Executive Office of the Trial Court, Massachusetts Parole Board, the

in correctional facilities prior to a participant’s release, and (2) community supports provided to participants after release from incarceration and for individuals on probation or parole. This program has served more than 1,000 individuals and is scheduled to expand statewide this year.

However, despite these efforts, the health disparities described above persist, leading the Commonwealth to propose waiving the exclusion and providing full Medicaid coverage to this population.

### C. Program Design

#### *Coverage and eligibility*

MassHealth proposes providing Medicaid coverage to “qualified individuals” who:

1. Are detained or incarcerated in a County Correctional Facility or Department of Correction correctional facility located in Massachusetts;
2. Are civilly committed and currently excluded under MIEP; or
3. Are detained or incarcerated through the Massachusetts Department of Youth Services and currently excluded under MIEP.

A “qualified individual” would have eligibility determined according to MassHealth requirements and would receive the benefit plan for which they are eligible (e.g., MassHealth Standard). To receive MassHealth coverage through this proposed initiative, criteria would include that a prospective member be a Massachusetts resident; be a U.S. Citizen or qualified alien (or receive MassHealth Limited under 42 CFR 435.139); and meet the income and asset standards for the applicable Medicaid program. Enrollment in MassHealth would be voluntary for the eligible individual.

Additional details on how health care would be delivered and coordinated are described below under *Proposed Processes*.

#### *Impact on Members*

Going above and beyond the applicable Community Standard of Care for correctional facilities,<sup>72</sup> Massachusetts anticipates that this expenditure authority would contribute to

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Massachusetts Department of Correction, and county Sheriff’s Offices. BH-JI supports individuals with incarceration experience via: (1) “in-reach” activities which take place in prior to a participant’s release, and (2) community supports provided to participants after release from incarceration and for individuals on probation or parole.

<sup>72</sup> The “Community Standard of Care,” as defined by the DOC, for medical, dental, and mental health Services means the scope and quality of services, including diagnostic testing, preventive services, and after care considered appropriate, in terms of type, amount, frequency, level, setting and duration which is appropriate

ongoing continuous healthcare improvement efforts for incarcerated and newly released MassHealth members by increasing continuity of care, improving transitions to and from correctional facilities, and enhancing access to healthcare services. Specifically, Massachusetts anticipates that this expenditure authority would increase engagement in primary and behavioral health care in the community, decrease avoidable hospitalizations and Emergency Department visits, improve behavioral health outcomes, reduce recidivism, and as Black and Hispanic individuals are disproportionately represented in the Massachusetts justice-involved population, decrease disparities in health outcomes.<sup>4</sup>

If approved, MassHealth anticipates the ability to further streamline eligibility processes and integrate this population more effectively into MassHealth. These enhancements would reduce burdensome workarounds, while greatly improving both the member and provider experience. Most importantly, Massachusetts anticipates an overall decrease in the disruption of benefits and diminishment of individuals “falling through the cracks” after release. Under the proposed model, while MassHealth would still rely on correctional facilities to notify MassHealth of incarceration for identification purposes, MassHealth would no longer need to “suspend” coverage through workarounds, and “reinstate” coverage upon release. Community placements and appointments needed post-release could be facilitated farther in advance and secured with better success if the individual has comprehensive coverage. There is a growing body of evidence that access to health care coverage could also bring down recidivism rates.<sup>73</sup>

MassHealth is also proposing providing 12-months continuous eligibility for individuals upon release from incarceration (see Section III.3.3) to ensure members are not disincentivized from securing employment and additional supports following release by fear of losing benefits. This continuous eligibility would also allow individuals (especially in County Correctional Facilities and the DYS juvenile justice system) to maintain a connection to their community providers with whom they may have developed long-standing relationships as well as smooth re-

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to the patient's diagnosis or condition. The care must be medically necessary and consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition, help restore or maintain the patient's health, prevent the deterioration or palliate the patient's condition, prevent the reasonably likely onset of a health problem, or detect an incipient problem. The “Community Standard” shall be interpreted in light of a prison system environment, taking into consideration the unique nature of the delivery of health care to an Inmate population within a prison system, and taking into account the Inmate’s individual history of incarceration and present circumstances. Accordingly, services should be evidence based and should incorporate best practices utilized by health care professionals in prison systems.

73 Doleac, Jennifer L. “New Evidence That Access to Health Care Reduces Crime.” Brookings, January 3, 2018. <https://www.brookings.edu/blog/up-front/2018/01/03/new-evidence-that-access-to-health-care-reduces-crime>

integration back into the community following release. As noted above, health care coverage may have a role in reducing recidivism.

Finally, Massachusetts intends to continue its BH-JI demonstration and expand it statewide. Preliminary results from Massachusetts' BH-JI demonstration indicate a decrease in inpatient and emergency room utilization, and increased connection to more appropriate outpatient behavioral health services.

### *State Accountability*

Massachusetts is committed to ensuring that the proposed demonstration authorities advance the goals of the Medicaid program by improving access to health care and outcomes for justice-involved members. Therefore, Massachusetts proposes establishing a slate of metrics for measuring and reporting on ongoing health care quality improvement efforts in correctional health settings. These metrics would be selected from the Massachusetts Aligned Measure Set for Global Budget-Based Risk Contracts<sup>74</sup>; established by EOHHS Quality Measure Alignment Taskforce, where appropriate for this population; or drawn from outside measure sets approved by the Task Force if exceptions are required for this specialized population. Massachusetts may identify one set of metrics for the longer-term sentenced population that are appropriate for a population that is continuously enrolled for a longer period of time, and a subset of metrics for the detained and short-term sentenced populations that can be used over a shorter time period. Metrics may include, for example, "Screening for Clinical Depression and Follow-Up Plan" and "Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment". Accountability will place a percentage of federal financial participation (FFP) for the expenditure authority for this initiative at risk, starting in or around Year 3 of implementation.

### *Investing in Justice-Involved Populations*

If this initiative is approved, Massachusetts plans to create a new trust fund, mirroring the existing Substance Use Disorder Trust Fund established by the Commonwealth to support initiatives approved in the current demonstration, and appropriating an amount equivalent to the net new Federal Financial Participation (FFP) received under the proposal to this fund. The fund would invest exclusively in four anticipated categories: administration of this initiative, such as process and technological enhancements to allow for data-sharing between MassHealth and correctional facilities; increased healthcare in correctional facilities, such as

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74 Massachusetts Executive Office of Health and Human Services, Quality Measure Alignment Taskforce, "Massachusetts Aligned Measure Set for Global Budget-Based Risk Contracts 2021 Measures and Implementation Parameters," October 15, 2020. <https://www.mass.gov/doc/2021-measures-and-implementation-parameters-0/download> Accessed August 2, 2021.

strengthened behavioral health services;<sup>75</sup> re-entry preparation in correctional facilities, such as skills building or educational programs; and community-based investments, including housing supports and job coaching, for individuals re-entering the community.

### *Proposed Processes*

As is the case today, when an individual is arrested, the correctional provider would conduct a health assessment and coordinate with community providers to obtain any necessary information or records.

*Pre-trial (County Correctional Facilities):* When an adult is held pre-trial, they would be screened for MassHealth eligibility. With the individual's consent, correctional staff would initiate the process for determining eligibility for MassHealth and, for managed care eligible members, enrolling into a MassHealth managed care plan. Individuals entering a correctional facility who are already enrolled in a MassHealth managed care plan would remain in their existing plan without disruption to coverage and services, subject to details described in "*Periods of Incarceration*" below.

*Period of Incarceration (County Correctional Facilities/Department of Correction):* Eligible incarcerated adults would remain enrolled in MassHealth for the duration of their incarceration. When entering into a correction facility, coverage via the individual's managed care plan (if applicable) would remain in place. After a certain period of time (e.g., 90 days) the individual would be transitioned into MassHealth fee-for-service. During this period, the correctional health providers would hold primary responsibility for a member's care and MassHealth would pay these providers for medically necessary covered services. MassHealth benefits would be available to incarcerated members, including access to medications through the MassHealth pharmacy program. The scope of covered services available to incarcerated members may be limited or modified, however, based on the unique circumstances of this population, including the security requirements of the correctional facilities. MassHealth intends to waive premiums and cost-sharing for individuals in carceral settings because incarcerated individuals generally are not currently obligated to provide premiums or cost-sharing for healthcare.

*Approaching Release (County Correctional Facilities/ Department of Corrections):* A health care navigator would initiate pre-release planning a certain period (e.g., 90 days) before scheduled release date. Prior to release, the incarcerated member would be transitioned back to their managed care plan (or other available plan of the member's choice), to facilitate planning for their care in the community. Building on current policy, pre-release planning would include

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<sup>75</sup>As previously noted, the initiatives described in this request go beyond the Community Standard of Care that applies in Massachusetts correctional facilities.

providing the incarcerated individual with a 30-day supply of necessary medications upon release to community.<sup>76</sup> The correctional facility and MassHealth managed care plan would coordinate to ensure appropriate follow-up upon release.

*12 Months Post-release:* Upon release from a carceral setting, members would receive 12 months of continuous eligibility. The primary goal would be to facilitate re-entry transition and stabilization within the community. Continuous coverage would also help to ensure individuals are able to access coordinated physical and behavioral health care to meet their unique needs.

#### *Provision of Healthcare Services*

Most care would be provided by correctional healthcare providers operating within the various state and county correctional facilities, and DYS facilities due to security considerations.

Correctional agencies and their healthcare providers would facilitate access to the full array of services covered under MassHealth Standard, with the exception of any services determined to be not viable to provide in a correctional setting. This may require access to community providers via telehealth or transport from correctional facility to community location when determined to be both clinically appropriate and safe to do so.

Responsibilities of community health care providers (e.g., PCPs) and managed care plans would be defined as supportive of and supplemental to correctional providers while incarcerated members are enrolled in managed care.

#### *Upon entry and approaching release:*

- Correctional providers would be the attending of record and would have full oversight and decision-making capacity for member-related health care. Correctional providers would consult with community providers at their discretion. Correctional facilities (or their vendors) would be responsible for providing health care services, for facilitating access to the full slate of services, and for ensuring the quality of those services.
- Community providers (e.g., primary care providers, outpatient behavioral health providers) would play an integral role in establishing a member care plan. The community provider would serve as a consultant and would be responsible for the following: virtual visits, virtual visit prior to release to establish care with member, synchronous and/or asynchronous communication with correctional provider, facilitating health information exchange, and providing an in person visit within first 14 days post-release.
- Managed care plans would be responsible for communicating accountability to their provider networks regarding eligible incarcerated members. They may be required to provide additional resources for eligibility/enrollment, transitions of care, and case

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<sup>76</sup> MassHealth anticipates that these medications will be reimbursed through MassHealth Fee-for-Service

management support for eligible members. They would also be required to establish methods of supporting high risk individuals (e.g., case management support and support for health-related social needs).

*Other time periods of incarceration:*

- Correctional providers would be the attending of record and would be the primary provider that is responsible for health-related decisions, including but not limited to, laboratory orders, prescriptions, orders for imaging and specialty evaluation, urgent evaluations, physical exams, ordering routine preventive health screenings. Correctional facilities (or their vendors) would be responsible for providing health care services, for facilitating access to the full slate of services, and for ensuring the quality of those services.<sup>77</sup>
- Community providers would be less directly involved but would be encouraged to maintain members as active in their panel. The correctional provider, who would be the attending of record, would be able to request a consultation from a member's community primary care provider or specialty provider (virtual visits with established sub-specialists would be encouraged, particularly in cases when that provider type is not available on-site).

*Organizational and partner responsibilities*

MassHealth would pay for medically necessary services provided to MassHealth Members in state correctional, county correctional, and DYS facilities, as well as include this population in agency-wide initiatives, such as program integrity, quality improvement, and member protections monitoring.

MassHealth will work with correctional partners to verify that vendors are credentialed and registered as Medicaid providers in good standing with the Medicaid program and to document MassHealth covered services that are provided to MassHealth Members who are incarcerated.

*Implementation Timeline*

Given the extensive preparation that would be required for MassHealth, state correctional, county correctional, and DYS facilities to implement MassHealth coverage for incarcerated individuals, implementation would occur in phases. The Commonwealth anticipates implementing this new initiative in three phases, with approximately one-third of correctional facilities passing readiness review and launching coverage in each phase. MassHealth would

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<sup>77</sup> Correctional facilities are legally required to rely on the expertise of medical staff in making medical care decisions. *Estelle v. Gamble* 429 U.S. 97 1976.)

support all facilities in preparing for and implementing any new activities and systems necessary for implementation.

**Goal 4: Sustainably support the Commonwealth’s safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care**

**4.1 Safety Net Care Pool (SNCP)**

**A. Statement of Request**

MassHealth requests authority for three funding streams within the Safety Net Care Pool, ranging in total funding from \$1.12 billion to \$1.13 billion from FY23 to FY27. These funding streams are:

1. Disproportionate Share Hospital (DSH) allotment pool, supporting:
  - a. Expansion of Safety Net Provider funding (described further below);
  - b. Health Safety Net payments to hospitals and community health centers;
  - c. Uncompensated care provided at Department of Public Health (DPH) and Department of Mental Health (DMH) hospitals; and
  - d. Payments to providers designated as Institutions for Mental Disease (IMDs) for otherwise unreimbursed behavioral health care provided to MassHealth members ages 21-64;
2. Uncompensated Care Pool (UCP), supporting care for uninsured patients through the Health Safety Net and at DPH and DMH hospitals, to the extent the Commonwealth’s expenditures for uninsured care exceed (1) above; and
3. ConnectorCare premium and cost sharing affordability “wrap” payments (See Section III.5.1).

**B. Background and Goals**

In 2016, under the demonstration, MassHealth restructured its SNCP to align with the goals of the ACO and CP programs, while creating a path to sustainability for Massachusetts’ safety net providers and maintaining the state’s overall safety net for the uninsured and underinsured. The restructuring enabled significant investments in MassHealth’s ACO and CP programs, ensuring safety net hospitals were engaged and held accountable by linking Safety Net Provider payments to ACO participation and performance, and continuing to fund care for the uninsured through the Health Safety Net and overall DSH Pool funding.

In the next demonstration period, MassHealth’s proposed Safety Net Care Pool design reaffirms the Commonwealth’s commitment to sustaining safety net providers while holding them accountable for population health and health equity. The proposal sunsets time-limited



payment vehicles (e.g., DSRIP), preserves core programs at current funding levels (e.g., Health Safety Net), and expands the number of hospitals eligible for Safety Net Provider Payments, from 14 to 23.

### C. Program Design

The Safety Net Provider Payments are a funding mechanism to support the operational needs of safety net hospitals that made a commitment to partner with MassHealth in its delivery system reform efforts. To receive funding, eligible hospitals must demonstrate meaningful participation in MassHealth's ACO program. A portion of each year's funding is withheld, which providers may then earn based on performance on ACO measures. MassHealth proposes to maintain the existing eligibility requirements for these payments. To be eligible, hospitals must have a Medicaid and uninsured payer mix of greater than or equal to 20% and a commercial payer mix of less than or equal to 50%. Due to changes in payer mix, nine additional hospitals will be eligible, which will increase the number of hospitals participating in the SNCP from 14 to 23. To accommodate this expansion, MassHealth requests expenditure authority to increase the total pool from \$173 million to \$193 million. The expansion of the pool of eligible providers will ensure safety net hospitals across Massachusetts remain committed to serving MassHealth members through the ACO program. Additionally, MassHealth proposes to maintain the withhold structure for each year which ties the withhold payments to outcome measures that mirror MassHealth's ACO and quality measures. While MassHealth recognizes that safety net providers need ongoing support above and beyond what other providers receive, it is critical that these same set of expectations around care delivery and value-based performance apply to these supplemental funding streams.

MassHealth also proposes to maintain the structure of the SNCP in recognition of the Commonwealth's commitment to reimburse providers for otherwise uncompensated care delivered to uninsured and underinsured residents. Massachusetts proposes to continue the Uncompensated Care Pool for the Commonwealth's expenditures for uninsured care. Currently, MassHealth's Uncompensated Care Pool allotment is \$100 million per year, and MassHealth seeks to update that level of expenditure authority to the total level of uncompensated care available as defined by CMS' requirements, less the amount accounted for by the Commonwealth's annual DSH allotment.

In addition, Massachusetts currently receives federal matching funds for state subsidies to ConnectorCare premiums and cost sharing. ConnectorCare is essential to maintaining Massachusetts' low uninsured rate, and the combination of premium and cost sharing wraps ensure affordability and therefore access to health insurance for Health Connector (state marketplace) enrollees earning at or below 300 percent of the federal poverty level.

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At the end of the current demonstration period, the state will sunset the payment streams encompassed by the Delivery System Reform pool in the SNCP – the Delivery System Reform Incentive Payment (DSRIP) program and the Public Hospital Transformation and Incentive Initiatives (PHTII).

Section VI. includes a breakdown of anticipated funding for each of the three streams listed above. However, funding levels of individual initiatives are subject to change based on ongoing negotiations between the Commonwealth and CMS.

Table 3: Safety Net Care Pool Funding

	SFY 2023	SFY 2024	SFY 2025	SFY 2026	SFY 2027
<b>Disproportionate Share Hospital (DSH) Pool</b>					
Public Service Hospital Safety Net Care Payment	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000
Health Safety Net Trust Fund Safety Net Care Payment	\$242,000,000	\$242,000,000	\$242,000,000	\$242,000,000	\$242,000,000
Institutions for Mental Disease (IMD)	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000
Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	\$40,000,000	\$40,000,000	\$40,000,000	\$40,000,000	\$40,000,000
Special Population State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	\$116,000,000	\$125,000,000	\$125,000,000	\$125,000,000	\$125,000,000
Safety Net Provider Payments	\$193,000,000	\$193,000,000	\$193,000,000	\$193,000,000	\$193,000,000
<b>DSH Pool Authority</b>	<b>\$741,000,000</b>	<b>\$750,000,000</b>	<b>\$750,000,000</b>	<b>\$750,000,000</b>	<b>\$750,000,000</b>
<b>Uncompensated Care Pool</b>					
Uncompensated Care Pool	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000

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<b>Uncompensated Care Pool Total</b>	<b>\$100,000,000</b>	<b>\$100,000,000</b>	<b>\$100,000,000</b>	<b>\$100,000,000</b>	<b>\$100,000,000</b>
<b>Connector Subsidies</b>	<b>\$280,000,000</b>	<b>\$280,000,000</b>	<b>\$280,000,000</b>	<b>\$280,000,000</b>	<b>\$280,000,000</b>
<b>SNCP Total</b>	<b>\$1,121,000,000</b>	<b>\$1,130,000,000</b>	<b>\$1,130,000,000</b>	<b>\$1,130,000,000</b>	<b>\$1,130,000,000</b>

**Goal 5: Maintain near-universal coverage including updates to eligibility policies to support coverage and equity**

**5.1 Eligibility**

**A. Statement of Request**

MassHealth seeks authority to:

- 1) Make updates to CommonHealth for disabled adults: (a) streamline the eligibility process for adults ages 21-64 by eliminating the one-time spend-down (or “deductible”) for non-working disabled adults; and (b) enable long-time CommonHealth members to retain their coverage after age 65 regardless of whether they are working;
- 2) Implement 12-month continuous eligibility for individuals upon release from incarceration;
- 3) Implement 24-month continuous eligibility for members experiencing homelessness for 6-months or more;
- 4) Extend retroactive eligibility for pregnant women and children to three months (eliminating the current waiver for these populations); and
- 5) Continue all other eligibility and coverage expansions under the current demonstration, including ConnectorCare subsidies that ensure that coverage through the state Marketplace is affordable for individuals earning up to 300% of the FPL.

## B. Background and Goals

MassHealth is committed to improving access to health coverage and health outcomes for low to moderate income individuals across the Commonwealth. As one of the largest insurers in Massachusetts, MassHealth has significantly contributed to maintaining the Commonwealth's consistent near-universal insured rate at approximately 97% (highest in the nation). MassHealth continuously seeks to streamline applicant and member experience by minimizing disruption in coverage and reducing excessive barriers to gaining or maintaining health coverage, promoting the core objectives of the Medicaid program.

The proposed strategy for the next demonstration period aims to:

- Streamline applicant and member experience and reduce eligibility system workarounds;
- Support ongoing coverage for disabled adults who are long-time CommonHealth members as they age;
- Decrease disruption in coverage for targeted populations that are particularly vulnerable to such disruptions (i.e., members who are homeless, justice-involved);
- Support MassHealth's strategic focus on coverage and care for children and youth, as well as on maternal health, by extending retroactive coverage for pregnant women and children; and
- Preserve affordability, coverage, and access to care through state-supported premium and cost sharing subsidies for lower-income Health Connector enrollees.

## C. Program Design

### *Extending CommonHealth to include non-working and working adults ages 21 – 64 and non-working adults ages 65 and over*

The CommonHealth program, which is authorized under the demonstration, provides full MassHealth coverage to disabled adults and children whose incomes are above the thresholds to qualify for MassHealth Standard (generally 138% FPL for adults and 150% FPL for kids). CommonHealth has no income limit, and members pay sliding scale premiums based on their income. MassHealth proposes to make updates to CommonHealth for disabled adults to: (a) streamline the eligibility process for adults ages 21-64 by eliminating the one-time spend-down (or "deductible") for non-working disabled adults; and (b) enable long-time CommonHealth members to retain their coverage after age 65 regardless of whether they are working.

- a) MassHealth is proposing to streamline and simplify eligibility for disabled adults by eliminating the one-time deductible for disabled adults who are not working full-time. The effect of this proposal will enable MassHealth to provide real-time eligibility determinations and eliminate complicated operational workarounds, thereby improving the overall

member experience. Streamlining access to coverage will support the Commonwealth's goal to provide comprehensive coverage for individuals with disabilities in order to meet their health care needs.

MassHealth recognizes that the original design over 20 years ago of the CommonHealth program, including the deductible for non-working adults, was intended to create work incentives for individuals with disabilities. However, it may unintendedly result in a *disincentive* because individuals with disabilities may be concerned about starting to work, gaining income above MassHealth Standard levels (138% of the Federal Poverty Level, or less than \$18,000 a year for an individual), and losing their health coverage if they are unable to maintain stable employment and meet CommonHealth criteria. Individuals with disabilities, including both physical and behavioral health disabilities, face barriers to maintaining steady employment due to their health conditions. This challenge has been exacerbated by the COVID-19 pandemic, which has had a disproportionate impact on access to employment for individuals with disabilities due to economic and health vulnerability.

Therefore, MassHealth proposes to eliminate the linkage between CommonHealth coverage and employment in order to provide a more reliable and stable source of health care coverage for individuals with disabilities. As they do today, CommonHealth members will continue to pay sliding-scale premiums based on their income.

- b) MassHealth also proposes to enable long-time CommonHealth members (those who have been enrolled in CommonHealth for ten years or longer) to retain their coverage after age 65 regardless of whether they are working. The goal is to support ongoing coverage for disabled adults as they approach retirement.

For these reasons, Massachusetts seeks expanded expenditure authority to include this population in the definition of CommonHealth Adults. Massachusetts also seeks a waiver of applicable provisions of Section 1902(a) of the Social Security Act, in order to disregard asset and income limits that otherwise apply to individuals aged 65 and over.

#### *Continuous Eligibility for Targeted Adult Populations*

MassHealth requests authority to provide 12-months continuous eligibility to individuals upon release from incarceration. Individuals would receive uninterrupted MassHealth benefits, regardless of changes in circumstance, not to exceed 12-months following release from a correctional public institution. The primary goal is to facilitate re-entry transition, to increase community tenure and to decrease the risk of recidivism. Continuous coverage will also help to ensure individuals have the ability to access coordinated physical and behavioral health care to meet their unique needs. This request is complementary the request to provide comprehensive MassHealth benefits to justice-involved individuals also being proposed (see Section III.3.3).

Additionally, MassHealth proposes to provide 24-months continuous eligibility to individuals with a confirmed status of homelessness for a specified amount of time (e.g., 6 months), as documented by the Homeless Management Information System (HMIS) Data Warehouse administered by the Massachusetts Department of Housing and Community Development. The transitory nature of many who are homeless and the intrinsic difficulty in contacting these members via regular means (e.g., mail, phone) often contributes to administrative loss of coverage. To address this, MassHealth proposes that individuals receive uninterrupted MassHealth benefits, not to exceed 24-months following a confirmed documentation of homelessness. The primary goal is to ensure uninterrupted access to physical and behavioral health care, as well as supports that promote self-sufficiency and community stabilization, for a population that is particularly medically complex and requires unique enrollment and engagement strategies.

Loss of coverage due to incomplete/missing renewal paperwork is a significant barrier to serving this vulnerable population and connecting them to the services they could benefit from, such as CSP-CHI. Recent MassHealth-Homeless Management Information System data matching exercises have demonstrated the prevalence of this issue:

- Of 11,176 members experiencing homelessness, 1,209 lost eligibility during 2018-2021, 16% due to incomplete or missing paperwork;
- Of 874 members experiencing chronic homelessness, 15% lost eligibility in 2017 due to incomplete or missing paperwork.

This issue is particularly significant since those individuals who lose coverage are unable to access MassHealth behavioral health and housing-related services specifically designed to assist them. In response, in recent years MassHealth has embarked on numerous efforts to improve coverage stability for this population including establishing a dedicated Assistance Line for homeless providers and conducting onsite eligibility reviews and determinations at shelters and related events;<sup>78</sup> however, this issue is somewhat intractable and, given the importance of reaching these members, requires a more systematic approach of continuous enrollment to have a greater impact.

#### *Retroactive Eligibility*

MassHealth proposes to eliminate its waiver of retroactive eligibility under 42 CFR 435.915 for Medicaid-eligible pregnant women and children up to age 19 described in 1902(l) and CHIP-eligible children up to age 19, including unborn children, described in 2102(b). In doing so,

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<sup>78</sup> *Boston's Housing Surges: Helping Older Adults Experiencing Chronic Homelessness Find a Permanent Place To Call Home*, US Interagency Council on Homelessness, [www.usich.gov/news/bostons-housing-surges-helping-older-adults-experiencing-chronic-homelessness-find-a-permanent-place-to-call-home/](http://www.usich.gov/news/bostons-housing-surges-helping-older-adults-experiencing-chronic-homelessness-find-a-permanent-place-to-call-home/). Downloaded 8/5/2021

MassHealth would provide retroactive coverage up to the first day of the third month prior to the date of application for individuals that meet these definitions. This request aligns with MassHealth’s strategic focus on coverage and care for children and youth, as well as on maternal health, by extending retroactive coverage for pregnant women and children. MassHealth is not requesting any changes to the demonstration of retroactive eligibility under 42 CFR 435.915 for all remaining populations described in *Table A* in the current demonstration’s Special Terms and Conditions.

### *ConnectorCare*

The Massachusetts Health Connector’s ConnectorCare program is an essential component in maintaining Massachusetts’ low uninsured rate. ConnectorCare preserves affordability, coverage, and access to care through a combination of state-supported premium and cost sharing subsidies, in addition to the federal premium and cost sharing subsidies available to lower income Health Connector enrollees. The current SNCP authorizes federal matching funds for state ConnectorCare premium and cost sharing subsidies, and the Commonwealth requests a continuation of this authority. Premium subsidies help to make it affordable for lower income residents to purchase health insurance, and cost sharing subsidies assure that they have access to care when they need it by reducing the cost of doctor’s visits, prescriptions, and other care at the point of service, to a level that is affordable and comparable to what the population was able to access through the former Commonwealth Care demonstration program.

## IV. SUMMARY OF NEW WAIVER & EXPENDITURE AUTHORITIES REQUESTED

Massachusetts is generally seeking to continue all federal expenditure and waiver authorities approved in the current Section 1115 Medicaid demonstration and proposed in pending amendments, except as described below.

Specifically, Massachusetts requests to continue all expenditure authorities approved and waivers granted under the provisions, terms, and conditions of the current demonstration, except that Massachusetts no longer needs authority to continue the Delivery System Reform Incentive Program, the Public Hospital Transformation Incentives Initiative, the Pediatric Asthma Pilot Program, Pilot ACOs, and continuous eligibility for individuals enrolled in Student Health Insurance Plans.

Massachusetts also seeks to continue the expenditure authorities and waivers sought in all pending amendments to the current demonstration, including the June 2021 amendment.

The table below lists and summarizes the new or updated waiver or expenditure authorities proposed to support the goals and policy initiatives described in the preceding sections.

Table 4. Summary of New Authorities Requested

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<b>Policy</b>	<b>Type of Authority</b>	<b>Statutory and Regulatory Citation (for waiver authorities)</b>
Implement changes to 340B payment methodologies	Waiver	Section 1902(a)(30)(A) of the Act, to the extent it incorporates  42 CFR 447.518(a)(2)
Implement a Primary Care Sub-Capitation in the ACPP and PCACO programs in order to pay participating PCPs at rates that vary from the State Plan, and to pay Primary Care ACOs to make such payments on behalf of the state	Expenditure	
Implement a Primary Care Sub-Capitation in the ACO ACPP and PCACO programs in order to pay participating PCPs at rates that vary from the State Plan, and to pay Primary Care ACOs to make such payments on behalf of the state	Waiver	Section 1902(a)(30)(A) of the Act
Student Loan Repayment	Expenditure	
Expand Diversionary Behavioral Health Services to members enrolled in Fee-For-Service	Expenditure	
Health Equity Related Payments for ACOs, ACO affiliated hospitals, and non-state-owned public hospitals	Expenditure	
Flexible Services Program: to pay ACOs for the delivery of Flexible Services in addition to the capitation or administrative payments	Expenditure	
Implement new versions of the CSP program, including CSP-HI, CSP-TPP	Expenditure	
Provide full MassHealth coverage for otherwise-eligible members during incarceration	Expenditure	



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Three streams of Safety Net Care Pool funding, for the Disproportionate Share Hospital allotment pool, Uncompensated Care Pool, and the ConnectorCare premium and cost sharing affordability subsidies	Expenditure	
Update CommonHealth eligibility to include Non-Working Adults 65 and over in CommonHealth definition, and in order to disregard asset and income limits that otherwise apply to individuals aged 65 and over	Expenditure	
	Waiver	Section 1902(a) of the Act
24-months continuous eligibility to individuals with a confirmed status of homelessness	Waiver	Section 1902(e)(14) of the Act, to the extent it incorporates 42 CFR § 435.916(a)
12-months continuous eligibility to individuals upon release from incarceration	Waiver	Section 1902(e)(14) of the Act, to the extent it incorporates 42 CFR § 435.916(a)
Retroactive eligibility under 42 CFR 435.915 for all remaining populations described in Table A of the current demonstrations STCs except for pregnant women and Medicaid and CHIP children up to age 19, including unborn children	Waiver	Section 1902(a)(34) of the Act to the extent it incorporates 42 CFR 435.915

V. QUALITY

1. MassHealth ACO Programs Quality Strategy

MassHealth’s goal in the proposed demonstration is to ensure ACOs may earn incentives for delivering high quality care to MassHealth members. Quality performance and improvement activities will be incentivized according to the following guiding principles for quality program design:

- Aligned with overarching waiver priorities of better care, better health, and lower cost, in domains including:
  - Preventive Health
  - Care Coordination and Integration

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- Care for Acute and Chronic Conditions
- Member Experience
- Reflective of demonstration priorities related to maternal and pediatric subpopulations; chronic conditions; behavioral health and substance use disorders; and integrated, whole-person care
- Prioritizing health outcomes, including measures sourced from clinical and patient-reported data
- Including topics and measures for which there are opportunities to promote health equity by social risk factors including race, ethnicity, language and/or disability status
- Striving for parsimony, aiming to minimize burden on providers and members while maximizing impact of the measure slate

MassHealth proposes to select quality measures according to the following principles:

- Aligned, where possible, with relevant local and national frameworks, including the Massachusetts Quality Alignment Task Force aligned set and the CMS Child and Adult Medicaid Core Sets
- If necessary to address critical measurement gaps, consider other nationally endorsed and/or validated measures and/or survey instruments or previously developed MassHealth measures

MassHealth seeks to implement an incentive payment arrangement in which MassHealth may pay a bonus based on the ACO's combined performance on quality and health equity indicators. The aggregate score will be comprised of quality measures both on overall plan level and measures stratified by demographic characteristics as determined by EOHHS. The measures and score calculation will be defined per EOHHS guidance. EOHHS anticipates that the ACO may be eligible to earn a bonus payment, defined as a percentage of their monthly capitation payment or total cost of care benchmark based on performance of the aggregate score.

Each ACO would be assigned a Quality Score based on the ACO's performance on a range of State-defined quality measures, organized into domains. The ACO's quality score would be a weighted average of scores in each specified domain. For quality measures based on national measure specifications, the State would use nationally available Medicaid benchmarks to establish its Attainment Thresholds and Excellence Benchmarks where feasible. For quality measures for which there are not appropriate national or regional benchmarks, MassHealth would establish benchmarks using ACO program data from years 1-2 of the next demonstration period. MassHealth proposes holding entities accountable for reporting on quality measures in year 1 (Pay for Reporting), moving quickly to accountability for performance (Pay for

Performance) as early as year 2. In cases where the measures are new or clear benchmarks are not identified, MassHealth anticipates moving to Pay for Performance no earlier than year 3.

## **2. MassHealth External Quality Review, Quality Assurance and Performance Improvement Activities**

In accordance with federal regulations at 42 CFR Part 438, MassHealth also employs a variety of additional mechanisms to monitor the quality of and access to care provided to members under this demonstration:

### **a) External Quality Review**

Since 2006 MassHealth has contracted with a qualified, independent External Quality Review Organization (EQRO), to analyze aggregated information on quality, timeliness, and access to the health care services that Managed Care Entities (MCEs) or its contractors furnish to Medicaid recipients. External Quality Review includes 3 mandatory activities:

- Annual validation of performance measures reported to or calculated by MassHealth,
- Annual validation of performance improvement projects required by EOHHS; and
- At least once every three years, review of compliance with standards mandated by 42 CFR Part 438, Subpart E, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

Additionally, at the recommendation of CMS, MassHealth added a fourth activity, Network Adequacy Validation, in 2020. While ACPPs are required to meet all 4 standards defined above, PCACOs as PCCM entities are only required to meet the first two (validation of performance measures and performance improvement projects).

### **2018-2020 Results**

*Performance Measure Validation* – The Performance Measure Validation process assesses the accuracy of performance measures either reported by Managed Care Entities or calculated by the state. The EQRO assesses 3 performance measures per MCE each year; measures for validation are selected based on: 1) the probability of an error inherent in a measure; 2) measure results deviating from those that are expected; or 3) designated as a priority for review by MassHealth.

From 2018-2020 the EQRO validated 38 measures across all managed care plans. For all 38 measures, MCEs were found to have no underlying data quality issues and were compliant with state specifications and reporting requirements. MCE-specific recommendations and performance trends in comparison to national benchmarks can be found in the 2018, 2019, and 2020 reports: <https://www.mass.gov/info-details/masshealth-quality-reports-and-resources>.

*Performance Improvement Project (PIP) Validation* – In 2018, MCEs initiated a new quality improvement cycle and selected new PIP topics on which to focus for the next 2-3 years. Most MCEs initiated projects in Q1 of 2018, while ACPPs and MCOs initiated projects in Q4 of 2018. The variation in project start-up was related to the implementation of new ACO and MCO contracts in March 2018.

PIP Topics varied across MCEs and included: Asthma, Diabetes, Hypertension, Dental, Cervical Cancer Screening, Follow-up after Mental Health Hospitalization, Substance Use Disorder, Health-Related Social Needs and Depression Screening. The EQRO scored each PIP and scores ranged from 87 to 100%. The EQRO did not discern any issues with the quality of the PIPs but did make recommendation regarding the assessment of intervention effectiveness. MCE-specific PIP findings can be found in the 2018, 2019, and 2020 reports:

<https://www.mass.gov/info-details/masshealth-quality-reports-and-resources>.

*Compliance Validation* - The triennial compliance validation determines the extent to which MCEs are compliant with the quality standards mandated in 42 CFR Part 438, Subparts D and E. Also included as part of the compliance audit is related sections of the MCE contracts with MassHealth. In 2020, the EQRO conducted a compliance audit of a subset of MCEs; Compliance validation for the ACO and MCO programs will take place in 2021.

Based on regulatory and contract requirements, compliance reviews were divided into the following 14 standards:

- Enrollee Rights and Protections
- Enrollee Information
- Availability and Accessibility of Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Practice Guidelines
- Enrollment and Disenrollment
- Grievance System
- Sub-contractual Relationships and Delegation
- Quality Assessment and Performance Improvement Program
- Credentialing
- Confidentiality of Health Information
- Health Information Systems
- Program Integrity

Specific elements under each compliance standard are reviewed and scored by the EQRO as met, partially met, or not met. For those elements not fully met MCEs were required to submit a corrective action plan for review and approval by MassHealth. Overall compliance scores for

MCEs ranged from 93-100%. Full results of the compliance validation can be found at: <https://www.mass.gov/info-details/masshealth-quality-reports-and-resources>.

### Quality Assurance and Performance Improvement Activities

All contracts with MassHealth Managed Care Entities including Managed Care organizations, Accountable Care Partnership Plans, Primary Care Accountable Care Organizations, and the behavioral health vendor, require the adherence, monitoring, and reporting of key aspects of quality, member experience, and access. These contract provisions serve as the foundation of quality management activities across the agency.

#### *Compliance Reporting:*

Through its contracts, MassHealth has established a series of reports to assess plan compliance with the various CMS programmatic and quality standards set forth in 42 CFR Part 438 Subparts D and E. In addition to identifying reports, MassHealth also establishes performance targets and timeframes for report submissions which can vary depending upon the report and may be annual, biannual, quarterly, or monthly. Reports are submitted to MassHealth contract management staff and are reviewed accordingly. If reports indicate an MCE is not meeting performance targets, the MCE is required to submit an action plan indicating corrective actions to improve performance as well as any results of those improvements. The MassHealth EQRO also provides valuable compliance review function through its triennial compliance audit – see External Quality Review section above.

#### *Quality Performance Measures:*

For each Managed Care Program, MassHealth established a quality performance slate consisting of select Healthcare Effectiveness Data and Information Set (HEDIS), CMS, and MassHealth-developed measures that are used to evaluate MCE performance. Quality indicators were focused in five priority domains:

- Maternal, Childhood, and Family Health Promotion
- Healthy Living, Chronic Disease Prevention and Control
- Reduction of Emergency Department Utilization and Hospitalizations
- Behavioral Health and Addiction Treatment
- Patient Centered Long Term Care Services and Supports

Where feasible MassHealth aligned quality measures across managed care programs; however, differences in quality measure slates do exist but are reflective of the populations each program serves.

MassHealth assessed MCE performance on quality measure slates in 2018, 2019, and 2020 (measurement periods CY 2017, CY 2018, and CY2019 respectively) and compared performance to National (MCOs and behavioral health vendor) and Regional (ACPPs and PCACOs) Medicaid

benchmarks. Quality performance results are processed internally through MassHealth’s Internal Quality Committee and MassHealth program leadership and are then publicly reported on the MassHealth Website. Regarding MassHealth performance, MassHealth MCOs and the behavioral health vendor performed between the National Medicaid 75<sup>th</sup> and 90<sup>th</sup> percentiles for most quality measures. Full results for can be accessed via the web at: <https://www.mass.gov/info-details/masshealth-quality-reports-and-resources>. ACPPs and PCACOs were assessed in a slightly different manner. Each measure in the quality slate has or will have an “attainment threshold” and a “goal benchmark” based on regional or national standards. For both the 2018 and 2019 performance years, ACPP and PCACO performance exceeded attainment thresholds on nearly all of the 12 benchmarked clinical quality measures, with variation among ACOs presenting opportunity for improvement. ACPPs and PCACOs are also accountable for performance on two member experience measures for which ACPPs and PCACOs are performing well above attainment thresholds with opportunity for improvement. Further results are included in The MassHealth Delivery System Restructuring: 2019 Update Report (<https://www.mass.gov/doc/masshealth-aco-year-2-report/download>).

*Monitoring Measures and Other Measurement:*

In addition to the quality performance measures listed above, MassHealth monitors other quality metrics to ensure continued high quality of care and high performance. Monitoring measures are indicators that MassHealth considers important and may be used to conduct longitudinal assessment over time and determine quality improvement objectives.

*CMS Adult and Child Core Measure Sets* – MassHealth calculates and reports 28 of the 33 Adult Core and 21 of the 25 Child Core Measures. When compared to other states, MassHealth performed at or near the top quartile for 19 of the 25 Adult Core and 17 of the 21 Child Core measures reported in 2019. For full details on MassHealth Core Measure performance visit: <https://www.medicaid.gov/state-overviews/stateprofile.html?state=massachusetts>.

*Healthcare Effectiveness Data and Information Set (HEDIS) Measures* – MassHealth’s experience with HEDIS measurement extends back to 1996 when it began collecting and reporting on HEDIS measures for the managed care products. Since then, MassHealth has required that all contracted MCEs calculate and submit HEDIS data to MassHealth annually for review. HEDIS measures submitted by the plans cover several domains:

- Effectiveness of Care
- Overuse and Appropriateness
- Access and Availability of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information

MassHealth also requires through its contracts that MCEs consider the results of HEDIS measures when developing quality improvement and assessment activities.

*Member Experience Surveys* – Similar to the HEDIS reporting, MassHealth requires collection and submission of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to MassHealth. MassHealth reviews performance on 5 composite measures:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making

When comparing MCE composite results to National Committee for Quality Assurance (NCQA) Quality Compass benchmarks MassHealth plans perform at or just below the 75<sup>th</sup> percentile.

*Quality Improvement (QI) Activities:*

MassHealth requires that all MCEs, except PCACOs, conduct performance improvement projects, per MassHealth and CMS specifications. MassHealth has established a QI measurement cycle that consists of a planning/baseline period and up to 2 re-measurement periods to allow for tracking of improvement gains. At the outset of each QI Goal cycle, EOHHS establishes a series of QI goal domains to focus MCE QI activity. MassHealth may designate or may allow MCEs to select measurement and quality improvement activities for each of those domains. Annually as part of the QI process, MCEs submit a progress report, focused on planning and modification to the previous year’s plans, and an annual report measuring progress from the previous year.

Table 9: MassHealth established Domains for the 2018-2020 QI measurement cycle

<b>Managed Care Entity (MCO/ACPP)</b>	<b>Prepaid Inpatient Health Plans (Behavioral Health Vendor)</b>
<ul style="list-style-type: none"> <li>• Behavioral Health</li> <li>• Population/Community Needs Assessment and Risk Stratification</li> </ul>	<ul style="list-style-type: none"> <li>• Initiation and engagement in Alcohol or other drug dependence treatment</li> <li>• Follow-up for Children Prescribed Attention Deficit Disorder medication</li> <li>• Practice Based Care Management.</li> <li>• Integrated Care Mgt. for Acute Care Episodes</li> <li>• Timely Access to Outpatient Treatment Services</li> <li>• Antidepressant Medication Management</li> </ul>

	<ul style="list-style-type: none"><li>• Availability and placement time for inpatient stays</li></ul>
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MassHealth works with its EQRO to review and assess PIP performance. Specific MCE projects and the results of the 2018-2020 Quality Improvement Projects can be found in the EQR technical reports accessed at: <https://www.mass.gov/info-details/masshealth-quality-reports-and-resources>. In January 2021, MCEs initiated the 2021-2023 Quality Improvement Cycle with all focusing on the domains of Telehealth and Flu vaccination.

## VI. Financial Data and Budget Neutrality

### Budget Neutrality

The federal government requires states to demonstrate that federal Medicaid spending for the demonstration does not exceed what the federal government would have spent in the absence of the demonstration. Since the inception of the demonstration, Massachusetts has met this budget neutrality test and has used program savings (budget neutrality "room") to invest in significant advances, such as premium subsidies in the ConnectorCare program (and its predecessor Commonwealth Care) to promote coverage expansion, and provider payments to support safety net hospitals. The changes proposed in this demonstration request continue to meet budget neutrality requirements during the proposed period. The details of the budget neutrality calculation projections are presented in the Budget Neutrality Attachment.

### Budget Neutrality Methodology

Massachusetts' budget neutrality calculation is detailed in Section XIV and Attachment D of the current demonstration's STCs. The calculation demonstrates that gross spending under the demonstration ("with waiver") is less than what gross spending would have been in the absence of a waiver (the "without waiver" limit). Prior to the 6<sup>th</sup> extension period, Massachusetts was permitted to roll-over budget neutrality savings over the lifetime of the demonstration, however, aligned with CMS' guidance, Massachusetts limited the roll-over of accumulated budget neutrality savings to savings realized during the previous five years and no savings is carried over from years prior to SFY 2018. Accordingly, the budget neutrality demonstration includes "with waiver" expenditures and "without waiver" expenditure limit calculations beginning in SFY 2018. In addition, savings are phased down rather than carried forward in full. Beginning in SFY 2018 the share of savings recognized each year is phased down to 25 percent. The budget neutrality calculation for this demonstration request builds upon what was established in previous extensions and adds new services and populations. Projected actual expenditures build on prior experience and changes detailed in this request. As detailed in Section III.4.1, Massachusetts requests adding to the base expenditures the following new services and populations:



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1. *MassHealth services provided to CommonHealth enrollees over age 65 and who are no longer working:* The waiver requests expanding the CommonHealth eligibility group to include these individuals. Expenditures and member months for the CommonHealth eligibility group include these individuals.
2. *MassHealth services provided to enrollees upon release from incarceration:* The waiver requests expanding MassHealth eligibility to include these individuals. Expenditures and member months for these individuals to reported under the appropriate waiver MEGs.
3. *MassHealth services provided to enrollees with confirmed status of homelessness:* The waiver requests expanding MassHealth eligibility to include these individuals. Expenditures and member months for the New Adult eligibility group include these individuals.

Additionally, Massachusetts is requesting expenditure authority for health equity related payments. The health equity related payments include four programs that will come directly out of budget neutrality savings: 1) a health equity initiative for acute hospitals participating in an ACO, to address and reduce health disparities; 2) a health equity incentive for non-state owned public hospitals to address and reduce health disparities; 3) student loan repayment to increase the number of diverse and culturally competent behavioral health clinicians who commit to serving MassHealth members; and 4) Flexible Services to help reduce health the disparities between people with and without HRSNs

In addition, Massachusetts is requesting authority to enroll certain justice-involved populations, including incarcerated individuals, in MassHealth. MassHealth proposes to treat the Justice Involved population as a hypothetical population. This population would be eligible to receive MassHealth benefits if it were not for their incarcerated status, and providing Medicaid benefits to this population will avert costs to Medicaid incurred by members upon release from a correctional facility.

“Without waiver” expenditures for populations and services included in the previous demonstration period are calculated by multiplying historical pre-waiver per member, per month costs, trended forward to the extension period (based on the President’s Budget trend rates defined in the current waiver for each existing population) by actual caseload member months for the base (non-expansion) populations.

### Budget Neutrality Impact

As noted above, the changes proposed in this extension request continue to meet budget neutrality requirements during the extension period. The attached budget neutrality calculation shows that projected expenditures over the life of the demonstration from SFY 2018 through SFY 2027, the end of the demonstration extension request, will be approximately \$85 billion less than projected expenditures in the absence of the demonstration. After phasing down the

share of savings recognized, Massachusetts' budget neutrality cushion is projected to be \$16.5 billion for the period SFY 2018 – SFY 2027. Massachusetts is proud of the extent to which this budget neutrality room represents ongoing and anticipated efforts to control health care costs in Massachusetts. Massachusetts also recognizes that the extension period may include a time when Massachusetts' economic environment will support investment in the demonstration programs beyond current projections, and is pleased that the budget neutrality calculation provides the potential to make such changes.

## VII. EVALUATION

Interim Evaluation results of the current demonstration are attached in Attachment 3.

### **Evaluation of the Proposed Demonstration Extension**

For the requested 5-year extension of the demonstration starting July 1, 2022, the Commonwealth will develop and implement an evaluation plan to study the success of the following goals:

1. Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model
2. Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care
3. Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals
4. Sustainably support the Commonwealth's safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care
5. Maintain near-universal coverage including updates to eligibility policies to support coverage and equity

MassHealth proposes to set specific and measurable evaluation goals in the domains listed below that will factor into providers' financial accountability to the state and the Commonwealth's financial accountability to CMS. State and provider performance against these measures will form the foundation of the quantitative evaluation of these goals and sub-goals under the demonstration. As a complement to the quantitative evaluation, the Commonwealth will use qualitative evaluation methods to give context to and illuminate the quantitative data and to investigate specific patterns or other findings in this data.

In addition to using an independent evaluator to evaluate the demonstration as required, MassHealth may also utilize the services of an independent evaluator to measure the successes through a midpoint and final assessment of the listed goals. Massachusetts may also implement additional evaluation techniques, such as rapid cycle evaluation.

**Evaluation of Goal 1:** Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model.

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- ACO quality results (clinical quality measures and member experience data)
- ACO spending results
- MassHealth ACO adoption rate
- Reduction in avoidable utilization
- Reduction in state spending growth

**Evaluation of Goal 2:** Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care.

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- Primary care sub-capitation model uptake
- Primary care quality outcomes
- Pediatric-specific quality outcomes
- Member experience surveys
- Behavioral health quality outcomes

**Evaluation of Goal 3:** Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals.

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- Quality outcomes stratified by race, ethnicity, language, disability status, sexual orientation, and gender identity
- Maternal health outcomes
- Member experience surveys
- For the evaluation of the provision of MassHealth services to justice-involved populations, metrics may include:

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- Avoidable hospitalization and ED visits within first 30 days of release
- Drug overdoses within first 30 days of release
- Suicide attempts within first 30 days of release
- In-office visit with PCP and behavioral health (if warranted) within first 30 days of release
- The ability for individuals who initiate Hepatitis C while incarcerated to complete Hepatitis C treatment after release
- Individuals with substance use disorder maintaining medication-assisted treatment after incarceration
- Community tenure after incarceration

**Evaluation of Goal 4:** Sustainably support the Commonwealth's safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- Uncompensated care
- ACO participation of safety net providers
- Health quality outcomes, stratified by race, ethnicity, language, disability, sexual orientation, and gender identity, in the safety net

**Evaluation of Goal 5:** Maintain near-universal coverage including updates to eligibility policies to support coverage and equity

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- Massachusetts insurance coverage rates, including comparisons to other states
- Rates of members with a gap in coverage
- Impact of enrollment in new and select ongoing programs under the Demonstration on insurance coverage rates
  - CommonHealth members 65+, including those continuing on CommonHealth due to removal of work requirement
  - 12-month continuous eligibility for individual released from incarceration or are experiencing homelessness
  - Elimination of the waiver of retroactive eligibility for pregnant women and children
  - ESI premium assistance

- Health Connector premium and cost sharing subsidies

## VIII. PUBLIC NOTICE

The public process for submitting this Extension Request conforms with the requirements of STC 15, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), 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 as outlined in the Commonwealth's approved State Plan. In addition, the Commonwealth has implemented the transparency and public notice requirements outlined in 42 CFR § 431.408. The Commonwealth is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

### Public Notice

The Commonwealth released the Extension Request for public comment on August 18, 2021. The public notice, the Request, which included the Budget Neutrality Impact section, and a Summary of the Extension (including the instructions for submitting comments) were also posted on the MassHealth website at: <https://www.mass.gov/info-details/proposed-1115-demonstration-extension-2022-2027-documents>

The public notice with a link to the MassHealth website was published in the Boston Globe, Worcester Telegram & Gazette, and the Springfield Republican.

### Public Meetings

The Commonwealth will host 2 virtual listening sessions to seek input regarding this Extension Request. The sessions will include a conference line, as well as Communication Access Realtime Translation (CART) services.

The first listening session will be held on Thursday, September 9, 2021, at 11am and will be available at this link and phone number:

- Meeting Link: Join from PC, Mac, Linux, iOS or Android <https://umassmed.zoom.us/j/98201482334?pwd=Qi9JRWx1MlVlVWVURhYXA5VnhEZkFrdz09>. Password: 948301
- Or dial by Telephone: +1 312 626 6799 (US Toll)

The second listening session will be a meeting of the Medical Care Advisory Committee and Payment Policy Advisory Board, and will be held on Wednesday, September 15, 2021, at 2pm, and will be available at this link and phone number:

- Meeting Link: Join from PC, Mac, Linux, iOS or Android <https://umassmed.zoom.us/j/95670890113?pwd=SE9VMDcyM2JkOHFiV3FGa1ZhT1NnZz09>. Password: 067626

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- Or dial by Telephone: +1 646 876 9923 (US Toll)

## IX. List of Acronyms

ACO: Accountable Care Organization  
ACPP: Accountable Care Partnership Plan, also known as ACO Model A  
BH: Behavioral Health  
CBHI: Children’s Behavioral Health Initiative  
CCF: County Correctional Facility  
CHI: Chronically Homeless Individuals  
CHIP: Children’s Health Insurance Program  
CP: Community Partner  
CSP: Community Support Program  
CSPECH: Community Support Program for People Experiencing Chronic Homelessness  
DMH: Department of Mental Health  
DOC: Department of Corrections  
DPH: Department of Public Health  
DSRIP: Delivery System Reform Incentive Program  
DYS: Department of Youth Services  
EOHHS: Executive Office of Health and Human Services  
EQRO: External Quality Review Organization  
FPL: Federal Poverty Level  
FSP: Flexible Services Program  
FFS: Fee-for-service  
HEDIS: Healthcare Effectiveness Data and Information Set  
HRSN: Health-Related Social Needs  
IMD: Institutions for Mental Disease  
JI: Justice Involvement  
LTSS: Long Term Services and Supports  
MCE: Managed Care Entity  
MIEP: Medicaid “Inmate Exclusion Policy”  
MCO: Managed Care Organization  
NCQA: National Committee for Quality Assurance  
PACE: Program of All-inclusive Care for the Elderly  
PCACO: Primary Care ACO, also known as ACO Model B  
PCC: Primary Care Clinician  
PCCM: Primary Care Case Management  
PCP: Primary Care Provider  
PIP: Performance Improvement Project  
QI: Quality Improvement  
SMI: Serious Mental Illness  
SNCP: Safety Net Care Pool  
SUD: Substance Use Disorder  
TCOC: Total Cost of Care  
TPP: Tenancy Preservation Program  
UCP: Uncompensated Care Pool

## Attachments

### Attachment 1: Quality Performance Measures by MassHealth Priority and Program Measure

Table 1: Domain 1- Maternal, Childhood, and Family Health Promotion

Measure	Steward	NQF #	ACO	MCO	PCC P	SCO	One Care	BH PIHP
Childhood Immunization Status	NCQA	0038	X	X	X	blank	blank	blank
Timeliness of Prenatal Care	NCQA	1517	X	X	X	blank	X	blank
Immunization for Adolescents	NCQA	1407	X	X	X	blank	blank	blank
Oral Health Evaluation	ADA	2517	X	X		blank	blank	blank
Health-Related Social Needs Screening	EOHHS	N/A	X	blank	blank	blank	blank	blank

Table 2: Domain 2 - Healthy living, Chronic Disease Prevention and Control

Measure	Steward	NQF #	ACO	MCO	PCC P	SCO	One Care	BH PIHP
Controlling High Blood Pressure	NCQA	0018	X	X	X	X	X	blank
Asthma Medication Ratio	NCQA	1800	X	X	X			blank
Use of Appropriate Medications for Asthma	NCQA	0036	blank	blank	blank	blank	X	blank
Comprehensive Diabetes Care: Poor Control	NCQA	0059	X	X	X	blank	X	blank
Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	blank	blank	blank	blank	blank	X
Colorectal Cancer Screening	NCQA	0034	blank	blank	blank	X	X	blank
Persistence of Beta Blocker Treatment After Heart Attack	NCQA	0074	blank	blank	blank	X	X	blank
Pharmacotherapy Management of COPD Exacerbation	NCQA	0549	blank	blank	blank	X	blank	blank
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA	0577	blank	blank	blank	X	X	blank
Medication Reconciliation Post Discharge	NCQA	0097	blank	blank	blank	X	X	blank
Osteoporosis Management in Women Who Had a Fracture	NCQA	0053	blank	blank	blank	X	X	blank
Influenza Immunization	NCQA	0041	blank	blank	blank	X	blank	blank
Pneumococcal Immunization	CMS	1653	blank	blank	blank	X	blank	blank



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Measure	Steward	NQF #	ACO	MCO	PCC P	SCO	One Care	BH PIHP
Potentially Harmful Drug Disease Interactions in the Elderly	NCQA	2993	blank	blank	blank	X	blank	blank
Screening for alcohol abuse: percentage of Enrollees reporting alcohol utilization in the CAGE risk areas, and percentage of those referred for counseling.	blank	blank	blank	blank	blank	X	blank	blank
Use of High-Risk Medications in the Elderly	NCQA	0022	blank	blank	blank	X	blank	blank
Eye examination every two years: percentage of Enrollees who received vision screening in the past two years	CMS/EOHHS requirement	blank	blank	blank	blank	X	blank	blank
Hearing examination every two years: percentage of Enrollees who received a hearing screening in the past two years.	CMS/EOHHS requirement	blank	blank	blank	blank	X	blank	blank
Annual Monitoring for Patients on Persistent Medication	NCQA	2371	blank	blank	blank	X	X	

Table 3: Domain 3 - Reducing Emergency Department Utilization and Hospitalization

Measure	Steward	NQF #	ACO	MC O	PCC P	SCO	One Care	BH PIHP
Plan All-Cause Readmission	NCQA	1768	X	X	X	X	blank	blank
Emergency Department Visits for Adults with Mental Illness, Addiction, or Co-occurring Conditions	EOHHS	N/A	X	X	blank	blank	blank	blank
Acute Unplanned Admissions for Individuals with Diabetes (Adult)	EOHHS	blank	X	X	blank	blank	blank	blank

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Table 4: Domain 4 - Promoting Mental Health and Reduce Addiction through Prevention, Treatment and Care Integration

Measure	Steward	NQF #	ACO	MC O	PCC P	SCO	One Care	BH PIHP
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	NCQA	0004	X	X	X	blank	X	X
Follow-Up After Hospitalization for Mental Illness (7 days)	NCQA	0576	X	X	X	X	X	X
Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence*	NCQA	2605	X	X	X	blank	X	X
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	2800	X	X	X	blank	blank	X
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	NCQA	1932	blank	blank	blank	blank	blank	X
Antidepressant Medication Management	NCQA	0105	blank	blank	blank	X	X	X
Screening for Depression and Follow-Up	NCQA	0418	X	blank	blank	blank	blank	blank
Depression Remission or Response	NCQA	N/A	X	blank	blank	blank	blank	blank

Table 5: Domain 5 - Person-Centered Long-Term Services and Supports

Measure	Steward	NQF #	ACO	MC O	PCC P	SCO	One Care	BH PIHP
Advance Care Plan	NCQA	0326	blank			X	X	blank
LTSS Community Partner Engagement	EOHHS	N/A	X	X	blank	blank	blank	blank
Community Tenure	EOHHS	N/A	X	X	blank	blank	blank	blank
Behavioral Health Community Partner Engagement	EOHHS	blank	X	X	blank	blank	blank	blank

**Attachment 2: Budget Neutrality Worksheet**

**Attachment 3: Interim Evaluation**