ATTACHMENT A
Reserved

ATTACHMENT B
COST SHARING

Cost-sharing currently in effect unless changed by a state plan amendment.

Cost-sharing imposed upon individuals enrolled in the demonstration may vary across delivery systems, coverage types and by FPL. However, no co-payments are charged for any benefits rendered to individuals under age 21, pregnant women, individuals living in an institution or receiving hospice, and American Indian/Alaska Natives who receive services through an IHS, tribal 638 or the IHS/tribal Purchased and Referred Care program. Additionally, no premiums are charged to any individual enrolled in the demonstration whose gross income is less than 150 percent of the FPL, or to any American Indian/Alaska Natives who receive services through an IHS, tribal 638 or the IHS/tribal Purchased and Referred Care program. In the event a family group contains at least two members who are eligible for different coverage types and who would otherwise be assessed two different premiums, the family shall be assessed only the highest applicable premium. Family group will be determined using MassHealth rules for the purposes of assessing premiums as described in STC 20.

Demonstration Program	Premiums (only for persons with family income above 150 percent of the FPL)	Co-payments
MassHealth Standard/Standard ABP	$0	All co-payments and co-payment caps are specified in the Medicaid state plan.
MassHealth CarePlus	$0	MassHealth Standard co-payments apply.
MassHealth Breast and Cervical Cancer Treatment Program	$15-$72 depending on income	MassHealth Standard co-payments apply.
MassHealth CommonHealth	$15 and above depending on income and family group size	MassHealth Standard co-payments apply.
CommonHealth Children through 300% FPL Children with income above 300% FPL adhere to the regular CommonHealth schedule	$12-$84 depending on income and family group size	MassHealth Standard co-payments apply.

MassHealth Family Assistance: HIV/AIDS	$15-$35 depending on income	MassHealth Standard co-payments apply.
MassHealth Family Assistance: Premium Assistance	$12 per child, $36 max per family group	Member is responsible for all co-payments required under private insurance with a cost sharing limit of 5 percent of family income
MassHealth Family Assistance: Direct Coverage	$12 per child, $36 max per family group	Children only-no copayments.

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

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

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

ATTACHMENT B
COST SHARING

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

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

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

ATTACHMENT C
QUARTERLY MONITORING REPORT CONTENT AND FORMAT

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

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

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

NARRATIVE REPORT FORMAT:

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

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 21 (7/1/2017 – 6/30/2018) Quarter 1: (7/17 – 09/17)

Introduction

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

Enrollment Information

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

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

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

BCCTP	

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

Enrollment in Managed Care Organizations and Primary Care Clinician Plan

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

Delivery System for MassHealth-Administered Demonstration Populations

Plan Type			Difference
MCO			
PCC			
MBHP			
FFS			
PA			
ACO			

Enrollment in Premium Assistance and Small Business Employee Premium Assistance

Outreach/Innovative Activities

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

Safety Net Care Pool

Provide updates on any activities or planning related to payment reform initiatives or delivery system reforms affecting demonstration population and/or undertaken in relation to the SNCP. As per Section X, include

projected or actual changes in SNCP payments and expenditures within the quarterly report. Please note that the annual report must also include SNCP reporting as required by Section X and XIII.

Operational/Issues

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

Policy Developments/Issues

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

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

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

B. For Informational Purposes Only

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

Consumer Issues

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

Quality Assurance/Monitoring Activity

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

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS

ATTACHMENT D
MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS

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

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

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

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

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2)		BCCTP	
		PMPM	Trend	PMPM	Trend	PMPM	Trend	PMPM	Trend	PMPM	Trend
6	SFY 2003	$288.58	7.71%	$677.56	10.0%	$236.9	7.71%	$645.1	10.0%	$1,891.62	10.0%
7	SFY 2004	$310.83	7.71%	$745.32	10.0%	$255.2	7.71%	$709.6	10.0%	$2,080.78	10.0%
8	SFY 2005	$334.79	7.71%	$819.85	10.0%	$274.9	7.71%	$780.6	10.0%	$2,288.86	10.0%
9	SFY 2006	$359.23	7.30%	$824.79	7.00%	$295.0	7.30%	$718.1	7.00%	$2,449.08	7.00%
10	SFY 2007	$385.46	7.30%	$834.71	7.00%	$316.5	7.30%	$660.6	7.00%	$2,620.52	7.00%
11	SFY 2008	$413.60	7.30%	$901.39	7.00%	$339.6	7.30%	$724.3	7.00%	$2,803.95	7.00%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCTP	
		PMPM	Trend	PMPM	Trend	PMPM	Trend	PMP	Trend	PMPM	Trend
12	SFY 2009	$466.84	6.95%	$1,011.95	6.86%	$382.45	6.95%	$791.4	6.86%	$3,052.78	6.86%

13	SFY 2010	$499.05	6.95%	$1,081.37	6.86%	$407.87	6.95%	$846.6	6.86%	$3,265.69	6.86%
14	SFY 2011	$533.73	6.95%	$1,1155.55	6.86%	$436.22	6.95%	$904.7	6.86%	$3,489.72	6.86%

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

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53 (projected and rounded in millions).

#	Payment Type	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per SFY					Total SFY 2018-2022	Applicable footnotes
					SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
	System Transformation Incentive Based Pools										
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC57-71	$425.0	$425.0	$400.0	$325.0	$225.0	$1,800.0	(1)
2	Public Hospital Transformation and Incentive Initiatives (PHTII)	n/a		Cambridge Health Alliance	$309.0	$243.0	$100.0	$100.0	$100.0	$852.0	
	System Transformation Incentive Based Pools Subtotal				***$734.0***	***$668.0***	***$500.0***	***$425.0***	***$325.0***	***$2,652.0***	
	Disproportionate Share Hospital (DSH) Pool										
3	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$20.0	$20.0	$20.0	$20.0	$20.0	$100.0	(2)
4	Health Safety Net Trust Fund Safety Net Care	DSH	101CMR 613.00, 614.00	All acute hospitals and CHCs	$287.0	$287.0	$288.0	$288.0	$290.0	$1,440.0	(3)
5	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$32.0	$32.0	$32.0	$32.0	$32.0	$160.0	(4)

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (projected and rounded in millions).

6	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$51.0	$52.0	$52.0	$52.0	$52.0	$259.0	(5)
7	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$105.0	$107.0	$107.0	$107.0	$107.0	$533.0	(5)
8	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$180.0	$177.0	$176.0	$176.0	$174.0	$883.0	
	Disproportionate Share Hospital (DSH) Pool Subtotal:				***$675.0***	***$675.0***	***$675.0***	***$675.0***	***$675.0***	***$3,375.0***	
	Uncompensated Care (UCC) Pool										

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53 (projected and rounded in millions).

9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals and CHCs	$0.0	$10.0	$10.0	$10.0	$10.0	$40.0	(3)
10	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$65.0	$15.0	$15.0	$0150	$150	$125.0	(5)
11	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$147.0	$75.0	$75.0	$75.0	$75.0	$447.0	(5)
	Uncompensated Care (UCC) Pool Subtotal:				***$212.0***	***$100.0***	***$100.0***	***$100.0***	***$100.0***	***$612.0***	
	ConnectorCare Subsidies										

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (projected and rounded in millions).

12	DSHP – Health Connector Subsidies	n/a		n/a	$250.0	$250.0	$250.0	$250.0	$250.0	$1,250.0	(6)
	DSHP – Health Connector Subtotal				*$250.0*	*$250.0*	*$250.0*	*$250.0*	*$250.0*	*$1,250.0*	
	Total				**$1,871.0**	**$1,693.0**	**$1,525.0**	**$1,450.0**	**$1,350.0**	**$7,889.0**	
*Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.											

The following notes are incorporated by reference into Chart A

(1) The Delivery System Reform Incentive Payments will be distributed to participating ACOs, CPs and for other approved uses pursuant to STC57 through STC 71 and the DSRIP Protocol

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

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

(4) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD

category: inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 52 and 53 (projected and rounded in millions).

centers.

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

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

(7) Expenditures for State-Owned Non-Acute Hospitals Operated by the Department of Mental Health are inclusive of amounts included in capitation payments to One Care enrollees ages 21 and over for payments to the facilities listed in item #5.

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022. unless otherwise specified in STCs 52 and 53 (projected and rounded)

#	Payment Type	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per SFY					Total SFY 2018-2022	Source of non-federal share
					SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
	System Transformation Incentive Based Pools										
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC 57 and STC 6o.	$425.0	$425.0	$400.0	$325.0	$225.0	$1,800.0	General Fund, including provider assessment funding in the DSRIP Trust Fund
2	Public Hospital Transformation and Incentive Initiatives (PHTII)	n/a		Cambridge Health Alliance	$309.0	$243.0	$100.0	$100.0	$100.0	$852.0	Inter-Governmental Transfer
	System Transformation Incentive Based Pools Subtotal				***$734.0***	***$668.0***	***$500.0***	***$425.0***	***$325.0***	***$2,652.0***	
	Disproportionate Share Hospital (DSH) Pool										

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022. unless otherwise specified in STCs 52 and 53 (projected and rounded)

3	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$20.0	$20.0	$20.0	$20.0	$20.0	$100.0	General Fund
4	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101CMR 613.00, 614.00	All acute hospitals and CHCs	$287.0	$287.0	$288.0	$288.0	$290.0	$1,440.0	General Fund, including provider assessment funding in the Health Safety Net Trust Fund
5	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$32.0	$32.0	$32.0	$32.0	$32.0	$160.0	Certified Public Expenditure and General Fund
6	Special Population State-Owned Non-Acute Hospitals	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts	$51.0	$52.0	$52.0	$52.0	$52.0	$259.0	Certified Public Expenditure

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022. unless otherwise specified in STCs 52 and 53 (projected and rounded)

	Operated by the Department of Public Health			Hospital School Western Massachusetts Hospital							
7	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital	$105.0	$107.0	$107.0	$107.0	$107.0	$533.0	Certified Public Expenditure

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022. unless otherwise specified in STCs 52 and 53 (projected and rounded)

				Worcester Recovery Center and Hospital							
8	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$180.0	$177.0	$176.0	$176.0	$174.0	$883.0	General Fund
	Disproportionate Share Hospital (DSH) Pool Subtotal:				***$675.0***	***$675.0***	***$675.0***	***$675.0***	***$675.0***	***$3,375.0***	
	Uncompensated Care (UCC) Pool										
9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals and CHCs	$0.0	$10.0	$10.0	$10.0	$10.0	$40.0	General Fund, including provider assessment funding transferred to the HSN Trust Fund
10	Special Population State-Owned Non-Acute Hospitals Operated by the Departmen	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western	$65.0	$15.0	$15.0	$15.0	$15.0	$125.0	Certified Public Expenditure

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022. unless otherwise specified in STCs 52 and 53 (projected and rounded)

	t of Public Health			Massachusetts Hospital							
11	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$147.0	$75.0	$75.0	$75.0	$75.0	$447.0	Certified Public Expenditure

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 52 and 53, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 74.

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022. unless otherwise specified in STCs 52 and 53 (projected and rounded)

	Uncompensated Care (UCC) Pool Subtotal:				***$212.0***	***$100.0***	***$100.0***	***$100.0***	***$100.0***	***$612.0***	
	ConnectorCare Subsidies										
12	DSHP – Health Connector Premium and Cost Sharing Subsidies	n/a		n/a	$250.0	$250.0	$250.0	$250.0	$250.0	$1,250.0	Certified Public Expenditure and General Fund, including provider assessment funding in the Health Safety Net Trust Fund
	DSHP – Health Connector Subtotal				***$250.0***	***$250.0***	***$250.0***	***$250.0***	***$250.0***	***$1250.0***	
	Total				**$1,871.0**	**$1,693.0**	**$1,525.0**	**$1,450.0**	**$1,350.0**	**$7,889.0**	

*Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.

Designated State Health Programs (DSHP). The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit. No demonstration amendment is required for CMS approval of updates to Chart C of Attachment E to include additional DSHP programs. This chart shall be updated pursuant to the process described in STC 74.

Chart C: Approved Designated State Health Programs (DSHP)

These DSHPs are not subject to the overall SNCP cap.

Agency	Program Name
Health Connector	Health Connector Premium Assistance and Cost Sharing Subsidies, and HSN- Health Connector Gap Coverage Subsidies

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol
Approved: July 24, 2014

INTRODUCTION

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

This protocol describes Phase 1 of the Pediatric Asthma Pilot Program. In accordance with STC 39(e), the Commonwealth will not expand the pilot program or implement a Phase 2 until after Phase 1 has been implemented, evaluated, and CMS has issued its approval of an expansion or Phase 2. The Commonwealth must operate Phase 1 of the demonstration for at least one (1) full year before beginning to evaluate the pilot program (see STC Protocol Requirements 8 below for additional information regarding the timing of the evaluation of Phase 1). Phase 1 may last for up to three years to ensure a seamless transition to Phase 2, if approved by CMS.

In accordance with STC 39(g) "Required Protocols Prior to Claiming Federal Financial Participation (FFP)", this protocol describes how the Commonwealth plans to meet the milestones required before enrolling beneficiaries and claiming FFP under this pilot program.

To develop these protocols, the Commonwealth established an internal program design team, which includes three physicians, a nurse, a pharmacist, several policy experts, data analysts, and a legal counsel. MassHealth also convened an external Advisory Committee with 20 members, each of whom has expertise in treating high-risk pediatric asthma patients, designing and implementing clinical programs to prevent and manage high-risk pediatric asthma, and/or designing and implementing global or bundled payment structures. Advisory Committee members include physicians, nurses, pharmacists, researchers, representatives of professional organizations, and health care administrators.

This section sets forth the Commonwealth's proposal for establishing eligibility criteria for member participation in the pilot and the process for enrolling members in the pilot. Because the proposed intervention is intensive, it can only be implemented in a cost neutral way if it is targeted to the patients who are most likely to require hospital treatment for asthma in the absence of intervention. In order to target these children, the advisory committee recommended restricting eligibility to members with poorly controlled asthma, as described in section A.6. below.

The advisory committee also recommended enabling Participating Practices to enroll eligible members into the pilot through the process described in section B below, in order to enroll eligible members at the time that they most need the intervention. Participating practices may have documentation supporting a member's eligibility that is not available or not yet available through MassHealth claims data. For example, a member may have been hospitalized for asthma prior to his or her enrollment in MassHealth.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol
Approved: July 24, 2014

A. **Eligibility.** Patients who meet the criteria in section A1 through 6 below may be enrolled in the Children's High-Risk Asthma Bundled Payment Pilot (CHABP) as CHABP Enrollees:

1. Are between the ages of 2 and 18 years at the time of CHABP enrollment;

2. Are a MassHealth member;

3. Are enrolled in the MassHealth Primary Care Clinician (PCC) plan , as described in STC 41a, and on the PCC panel of the participating practice, as identified by its provider identification and service location number (PID/SL);

4. Have a clinical diagnosis of asthma;

5. Meet the clinical criteria for high-risk asthma, as demonstrated by meeting at least one of the following criteria within the 12 months prior to the date of CHABP enrollment:

   a. Inpatient hospital admission for asthma;

   b. Hospital observation stay for asthma;

   c. Hospital emergency department visit for asthma; or

   d. Oral systemic corticosteroid prescription for asthma; and,

6. Have poorly controlled asthma, as evidenced by a score of 19 or lower on Quality Metric's asthma control test (ACT) (see attachment A) at least twice within any 2 month period in the 12 months prior to the date of enrollment, based on responses by the patient if the patient is at least 12 years old or else by the patient's caregiver. The ACT may be completed in person or by telephone.

B. **Enrollment Process.** Patients who meet the eligibility criteria described in section A will be enrolled in the CHAPB through one of the following two pathways.

1. Members identified by MassHealth:
   a. The Executive Office of Health and Human Services (EOHHS) will, within 10 working days of the contract start-date and every 90 calendar days thereafter, give the participating practice a list of the members on the participating practice's PCC panel who, based on MassHealth claims data, meet the clinical criteria for high-risk asthma set forth in section A.1 through A.5 above.

   b. The participating practice must make and document its best efforts to schedule each eligible member in its practice for an office visit within 90 days of the date of the list described in paragraph 1.

c. At the office visit described in paragraph 2, the participating practice must assess each member on the list described in paragraph 1 above for poorly controlled asthma in accordance with section A.6 above and list members who meet all eligibility criteria specified in section A on the patient enrollment report (see attachment B). The practice must report to the state on the patient enrollment report the reason for not enrolling any member on the list.

2. Members identified by the participating practice.
The participating practice may also enroll on its panel PCC plan members who meet all eligibility criteria (listed in section A), but were not included on the list described in paragraph 1 above, by documenting their eligibility for the CHABP using the patient enrollment report. EOHHS will verify Member eligibility using MassHealth eligibility and claims data, to the extent it is available.

3. The participating practice must submit an initial patient enrollment report within 75 days of the contract start-date. The participating practice may submit changes to this enrollment report by the second Friday of each month for enrollment in the CHABP for the following month. Enrollment is effective as of the first of the month following submission of the enrollment report.

4. The participating practice must send a letter, approved by EOHHS, notifying each PCC plan member enrolled in the CHABP of the CHABP and the services available through the CHABP.

C. Disenrollment

1. A parent or guardian who does not wish their child to receive services through the CHABP may notify the Participating Practice in writing and request to be disenrolled from the CHABP. If the Participating Practice receives such a request, it will report the Member as “disenrolled” on the next Patient Enrollment Report it files.

2. Members who, according to the monthly enrollment roster available through the MassHealth provider online service center (POSC), (1) lose MassHealth coverage, (2) are disenrolled from the PCC plan, or (3) are enrolled with a different PCC site location, will be simultaneously disenrolled from the CHABP. If a member is disenrolled for one of these reasons and the member subsequently is (1) re-enrolled in MassHealth, and (2) re-enrolled in the PCC plan, and (3) reenrolled with the previous participating practice PCC site location, then the participating practice must re-enroll the member in the CHABP; in this case prior eligibility for the CHABP will serve as sufficient documentation of eligibility on the patient enrollment report.

3. Members will be not be disenrolled during Phase 1 of the CHABP, as further described below, for turning age 18 after being enrolled in the CHABP, nor for failing to continue to meet the clinical criteria for high-risk asthma described in section A.1 through A.5, nor for having an ACT test that fails to meet the criterion in section A.6 above, nor for any reason other than those listed in C.1 and C.2 above.

STC PROTOCOL REQUIREMENTS

1. A description and listing of the program specific asthma-related benefit package that will be provided to the pilot participants.

A. **Traditional MassHealth Covered Services**

The Participating Practice will continue to provide or arrange for all medically necessary services for the effective treatment and management of pediatric asthma for Children's High-risk Asthma Bundled Payment Demonstration Program (CHABP) enrollees, in addition to providing required CHABP services (listed in section B) and contingent CHABP services (listed in section C). The participating practice must monitor and manage high-risk asthma services for CHABP enrollees according to their needs and based on national asthma guidelines contained in expert panel report 3 (EPR 3): "Guidelines for the diagnosis and management of asthma" (see http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm[1], as those guidelines may be periodically updated). The participating practice may bill MassHealth for any such medically necessary traditional MassHealth covered services it provides on a fee-for-service basis. Payment for traditional MassHealth covered services is *not* included in the Phase 1 bundled payment.

In particular, the participating practice must:

1. Assess the member's PCC plan enrollment status at each visit.

2. Assess and monitor asthma control, impairment, and risk, and classify asthma as described in EPR 3, as part of a physician office visit;

3. Administer the asthma control test (ACT) at every well-child and asthma-related visit;

4. Provide or arrange for all medically necessary MassHealth-covered services for the effective treatment and management of pediatric asthma;

5. Ensure that the CHABP Enrollee has a written asthma action plan, in a patient-friendly format, listing the enrollee's primary care provider's and parents' contact information, triggers that exacerbate the CHABP enrollee's symptoms, symptoms to watch for, the names and doses of medications the CHABP Enrollee needs and when to use them, and instructions on when to call the primary care provider and when to see a doctor immediately. The primary care provider must review the asthma action plan at least annually and update it as necessary;

6. Provide asthma self-management education to the CHABP Enrollee and family in the office, including education on the asthma action plan;

[1] Accessed as of February 1, 2012

7. Provide or arrange for the CHABP enrollee to receive an inactivated flu vaccine when seasonally appropriate;

8. Provide care coordination by a case manager or clinician, to help CHABP enrollees access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma; and,

9. Provide clinical care management of multiple co-morbidities by a licensed clinician, including communication with all clinicians treating the patient, as well as medication review, reconciliation and adjustment.

B. **Required CHABP Services**

For each CHABP enrollee, the participating practice must:

1. At least once per month, review available data for each CHABP Enrollee to identify the need for follow-up. This review shall include:

    a. Identifying Enrollees who are due for an office visit, phone call, or other service; and

    b. Identifying cases for review and discussion by the Interdisciplinary Care Team. The ICT shall at minimum review cases for Enrollees:

        i. who had an unscheduled office visit, emergency department visit, observation stay and/or inpatient admission for asthma;

        ii. whose most recent ACT score was 19 or lower; or

    c. who were recommended for review by a clinician or a member of the ICT.

2. Contact families of CHABP enrollees within three months of enrollment and at least once every six months thereafter:

    a. To schedule office visits. The participating practice must make every effort to ensure each CHABP enrollee has an office visit within three months of enrollment into the CHABP and at least once every six months thereafter. The participating practice must help families, as needed, to arrange transportation and to avoid missing appointments and document this assistance in the CHABP enrollee's record; and,

    b. To administer the Asthma Control Test (ACT), as well as the following two additional questions:

1) During the past 4 weeks, how many days of school/daycare/summer program did the CHABP Enrollee miss because of his/her asthma?

2) During the past 4 weeks, how many days was a CHABP Enrollee's caregiver unable to work or carry out usual activities because of the Enrollee's asthma?

3. Offer and encourage families of CHABP enrollees to accept a home visit by a community health worker (CHW) or nurse to provide supplemental family education and conduct an initial environmental assessment to identify potential asthma triggers in the home; if a family declines a home visit, then the participating practice must offer supplemental family education and care coordination in the office or by telephone and document this in the CHABP enrollee's record;

4. Request permission from the CHABP enrollee's parent or guardian to contact the CHABP enrollee's school and any childcare provider. With written permission, the Participating Practice must share the CHABP Enrollee's Asthma Action Plan with the school and childcare provider and offer to explain the plan; and,

5. Contact families of CHABP Enrollees each August, either by phone or during an pre-scheduled office visit as needed, in order to:

   a. Review medications that the CHABP Enrollee currently takes or may need to re-start after the summer; and,

   b. Request updated school and childcare contact information and, with permission, share the CHABP Enrollee's Asthma Action Plan with new school and childcare personnel.

C. **CHABP Services to be provided on an as needed basis**

The participating practice must effectively manage their use of CHABP funds to meet individual CHABP enrollees' and families' needs in addition to the minimum requirements listed in section B above. The participating practice must provide additional services and supplies, based on the enrollee's assessed needs, which include, but are not limited to the following:

1. Additional home visits by a CHW or nurse to provide supplemental family education and a full home environmental assessment to identify and document the presence of environmental asthma triggers in the home;

2. Supplies to mitigate environmental triggers, such as hypoallergenic mattress and pillow covers, vacuums, HEPA filters, air conditioner units, and pest management supplies and services, as well as training by a CHW to use these supplies correctly;

3. Support by CHWs for families' advocacy with landlords and property managers to promote healthy environmental conditions in the home;

4. Care coordination, provided by a CHW, as a supplement to traditional care coordination provided by a case manager or clinician, to help CHABP enrollees and their caregivers access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma; and,

6. Contacting families of CHABP Enrollees each May, either by phone or during an office visit, in order to:

    a. Review medications that the CHABP enrollee currently takes and adjust as necessary for the summer; and,

    b. Request contact information for any summer programs that the CHABP enrollee may be enrolled in and, with permission, share the CHABP enrollee's asthma action plan with new school and childcare personnel. Clinical data indicates that many patients experience improvement in asthma symptoms during the summer; Participating Practices should focus their efforts to coordinate with summer programs on CHABP enrollees who have not demonstrated such improvement.

7. Delivering an Enrollee's prescribed medications to a school or childcare, along with the Enrollee's Asthma Action Plan, with written consent from a parent or guardian.

2. Rationale for the inclusion of each benefit in the asthma-related benefit package that will be provided to the pilot participants

The CHABP is intended to allow primary care practitioners to use a variety of evidence-based innovations in care delivery and decision-making to control asthma in children and adolescents at high risk of serious complications or death in a culturally competent and clinically relevant manner.

The recommendations of this benefit package are based on the structure provided in the latest report of the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (2007)[i], but with evidence-based content designed to accommodate new and emerging best practices in the field.

The NAEPP Guidelines structures asthma management into four components:

(1) Measures of Asthma Assessment and Monitoring;

(2) Education for a Partnership in Asthma Care;

(3) Control of Environmental Factors and Co-morbid Conditions That Affect Asthma; and,

(4) Medications.

Traditional care for asthma generally focuses on medication and education in the office setting. Phase 1 of the pilot covers currently unreimbursed services, allowing flexible use of funds to support community-based interventions. According to the NAEPP guideline, individual interventions alone are often ineffective unless they are part of a comprehensive and holistic approach to medical care. Transportation, money, and time limit traditional asthma education programs set in clinic or school settings and often cause difficulty attracting and retaining participants[ii]. The benefit package review will thus largely focus on home and community-based interventions for improved asthma outcomes.

Healthy People 2020 outlines select goals and objectives related to home interventions with an environmental focus to reduce asthma morbidity.[iii]

Table 1: Select HealthyPeople 2020 Objectives relating to environmental strategies to reduce asthma morbidity	
	Objective Description
EH-13	Reduce indoor allergen levels
RD-1	Reduce asthma deaths
RD-2	Reduce hospitalizations for asthma
RD-3	Reduce hospital emergency department visits for asthma
RD-4	Reduce activity limitations among persons with current asthma
RD-5	Reduce the proportion of persons with asthma who miss school or work days
RD-6	Increase the proportion of persons with current asthma who receive formal patient education
RD-7	Increase the proportion of persons with current asthma who receive appropriate asthma care according to National Asthma Education and Prevention Program (NAEPP) guidelines

Potential CHABP Evidence-based Interventions

Recommendations from numerous advisory groups concur that a comprehensive, multi-faceted approach to asthma management is necessary.

Table 2: Advisory group recommendations regarding a comprehensive approach to asthma management	
Publication & Advisory Group	Findings
Guidelines for the Diagnosis and Management of Asthma The National Asthma Education and Prevention Program (NAEPP) Expert Panel Report *2007*	This report states that patients who have asthma at any level of severity should reduce, if possible, exposure to allergens to which the patient is sensitized and exposed, and that effective allergen avoidance requires a multifaceted, comprehensive approach; individual steps alone are generally ineffective.
Characteristics of successful asthma programs: Asthma Health Outcomes Project[iv] *(AHOP)* U.S. Environmental Protection Agency	Presents quantitative and qualitative data on 223 asthma programs throughout the world that include at least one environmental component. The report findings indicated that programs were more likely to report a positive impact on health outcomes if they (1) were community based, (2) engaged the participation of community-based organizations, (3) provided program components in a clinical

2009	setting, (4) provided asthma training to health-care providers, (5) collaborated with other organizations and institutions and with government agencies, (6) designed a program for a specific racial/ethnic group, (7) tailored content or delivery based on individual health or educational needs, and (8) conducted environmental assessments and tailored interventions based on these assessments.
Global Strategy for Asthma Management and Prevention[v] Global Initiative for Asthma (GINA) *Updated 2011*	GINA works with health care professionals and public health officials around the world to reduce asthma prevalence, morbidity, and mortality. The organization published asthma guidelines that state ". . . among inner-city children with atopic asthma, an individualized home-based, comprehensive environmental intervention decreased exposure to indoor allergens and resulted in reduced asthma-associated morbidity."
Housing Interventions and Health: a Review of the Evidence National Center for Healthy Housing & CDC *2007*	Published the conclusions of an expert panel convened by the National Center for Healthy Housing and the CDC in December 2007 to weigh the strength of a variety of housing interventions. Home-based environmental interventions to reduce asthma triggers were among the interventions discussed. After reviewing the evidence, the panel found that interventions such as multifaceted, tailored, home-based environmental interventions and integrated pest management for asthma were effective and appropriate for implementation.
Effectiveness of Home-Based, Multi-Trigger, Multi-component Interventions with an Environmental Focus for Reducing Asthma Morbidity: A Community Guide Systematic Review Taskforce on Community Preventive Services: A collaboration between USDHHS and CDC with public and private partners *2011*	The Task Force recommends the use of home-based, multi-trigger, multi-component interventions with an environmental focus for children and adolescents with asthma, on the basis of strong evidence of effectiveness in reducing symptom-days, improving quality of life scores or symptom scores, and reducing the number of school days missed. The evidence was considered strong on the basis of findings from 23 studies in the effectiveness review.

Home Environment Strategy: Decrease Triggers & Housing Resources

Exposure to allergens and irritants within the home can trigger or exacerbate episodes of asthma. The most common asthma triggers within the home include allergens from house dust mites, pets, cockroaches, rodents, and mold as well as irritants such as environmental tobacco smoke (ETS) and indoor air pollutants. Targeting these triggers can decrease the number and severity of asthma exacerbations. Poor housing quality has been shown to be strongly associated with poor asthma control even after controlling for potentially confounding factors such as income, smoking, overcrowding, and unemployment[vi]. Moisture from leaky plumbing, high humidity, and cracks in floors and walls can contribute to mold growth; provide water for cockroaches, mice, and dust mites; and provide avenues through which cockroaches and mice can enter the home.

INTERVENTION: CHABP will address the environmental asthma triggers through an environmental assessment of the home by a specially trained community health worker (CHW). Based on the results of the home assessment, a determination of an appropriate mitigation plan would be developed. Supplies that could contribute to asthma control include HEPA vacuums, air conditioning units, allergenic covers would be available to qualifying households based on specific triggers, patient sensitization, and need. CHWs will also be trained to support families' advocacy with landlords and property managers to promote healthy environmental conditions in the home; CHWs can educate families as to landlords' legal responsibilities for maintaining their property and help families to articulate requests for corrective action.

Home-based Education Strategy:

The NAEPP recommends asthma self-management education at multiple points of care. There is evidence that using multiple approaches to address environmental triggers, specifically approaches that use both education and remediation, could be more effective than interventions that use either alone[vii].

INTERVENTION: The CHABP pilot would provide funding for CHWs who have specialized training in asthma and environmental mitigation to the high risk asthma patients and their families. The cost effectiveness of CHWs for asthma education has been established in numerous settings.[viii,ix,x,xi] The CHW training will result from a collaboration with DPH and community partners and includes a core competency training as well as additional asthma environmental mitigation training.

The education that could be supplemented by the CHW assessment and follow-up include the following:

- asthma education for caregivers
- self-management skills to promote control
- allergen control interventions
- tobacco cessation and/or avoidance for household members
- asthma action plan review
- advocacy training around housing rights

Importantly, the education is to be tailored to patient and caregiver level of literacy, will test understanding, and will be provided in a culturally and linguistically competent manner.

Office-based Strategy

In addition to the normal standard of care provided in the office setting, the CHABP is designed to allow practices the flexibility to enhance a care coordination strategy for the high risk patients identified by training CHWs to provide care coordination services for both CHABP enrollees and their caregivers. CHABP establishes a mechanism for linking office and home-based strategies for valuable information regarding the home environment, reinforcement of asthma management education concepts, and feedback to the practices regarding the patient's control. The office would also be able to offer other significant benefits to appropriate families including supplies to mitigate environmental triggers (as mentioned above) to households that qualify. The goal is to decrease asthma exacerbations and improve function by providing enhanced services that yield more timely and actionable information to prevent costly asthma exacerbations and best serve the needs of the child.

3. Eligibility, qualifications and selection criteria for participating providers, including the RFP for preapproval;

The following eligibility, qualification, and selection criteria will be used to assess provider applications for the CHABP program, and will be reflected in procurement documents. EOHHS may also consider any relevant information about the practice known to EOHHS.

A. Minimum Qualifications

To be considered for selection as a participating provider, applicants, in addition to all other requirements specified herein, must:

1. Participate as a PCC in the MassHealth PCC plan;

2. Have a MassHealth PCC plan provider identification and service location number (PID/SL) for the applicant site;

3. Have high-risk asthma patients ages 2-18 enrolled in the PCC panel, as evidenced by MassHealth claims data;

4. Possess secure broadband Internet access; and,

5. Not participate in the MDPH Reducing Ethnic/Racial Asthma Disparities in Youth (READY) study or another initiative that pays for similar services for pediatric patients with high-risk asthma at this practice site location identified by its PID/SL.

B. Participating Practice Evaluation Criteria

1. In order to be considered for participation in the CHABP, an applicant must:

   i. Demonstrate that it meets the minimum practice qualifications identified in section A;

   ii. Not receive payment or funding from any other source for services, activities, or expenses that will be funded through the CHABP; and,

   iii. Submit a complete and timely application**.**

2. The quality of the responses to the questions in the application will be evaluated in accordance with the following criteria: comprehensiveness, feasibility, appropriateness, clarity, effectiveness, innovation, and responsiveness to the needs of EOHHS and the goals of the CHABP;

3. EOHHS will also evaluate responses from each applicant based on the following criteria:

i. The extent to which the practice demonstrates commitment to participate in the CHABP for at least contingent on CMS approval:

ii. The number of high-risk asthma patients ages 2 through 18 enrolled in the applicant's PCC plan panel based on MassHealth claims data;

iii. The extent to which the applicant demonstrates its ability to manage high-risk asthma in a coordinated fashion as demonstrated by the applicant's responses to the questions in the application;

iv. The extent to which EOHHS determines that the applicant satisfies EOHHS' goals of selecting a group of pediatric primary care practices which, taken together, are diverse in terms of:

- Practice structure (e.g., solo, group, community health center);
- Practice affiliation (e.g., independent, hospital-owned);
- Geographic location;
- Bilingual and multilingual capability; and,
- Patient mix, as defined by racial and ethnic composition.

EOHHS may consider any relevant information about the practice known to EOHHS.

C. Contract Requirements for Participating Practice Staffing

The Participating Practice must:

1. Designate a financial/operational project leader. The financial/operational project leader must manage the financial resources required to manage and treat CHAPB Enrollees. During Phase 1, the financial/operational project leader will participate in monthly meetings, in person or by phone, with EOHHS-designated staff to discuss development of the Phase 2 Bundled Payment;

2. Designate a clinical project leader for the CHABP demonstration program. The clinical project leader must ensure that each Interdisciplinary Care Team (ICT), as described below, manages CHABP Enrollees' asthma according to their needs, with a goal of preventing asthma-related hospital admissions and emergency department utilization and improving health outcomes. The clinical project leader must be a licensed clinician on staff at the Participating Practice and will act as the clinical director for the CHABP within the Participating Practice;

3. Designate a group of health care professionals within the Participating Practice that must comprise an ICT for each CHABP Enrollee which must collectively provide, coordinate and supervise the provision of asthma care, services and supplies in a continuous, accessible, comprehensive and coordinated manner. The ICT must

include, at a minimum, the member's primary care provider, a Community Health Worker (CHW), and the clinical supervisor for the CHW. The ICT must include CHABP Enrollees' specialty providers who offer treatment for asthma, if any, and establish a standard procedure for communicating with specialists;

4. Employ or contract for the services of at least one full-time or part-time Community Health Worker (CHW) or train an existing staff member to become a CHW (if training an existing staff member, training must be completed prior to the provision of CHABP services). CHWs must be culturally competent in the cultures, and preferably languages, of a Participating Practice's CHABP Enrollees and must:

    a) Demonstrate their knowledge, skill and ability in the following core competencies:
        i. Knowledge and identification of environmental asthma triggers;
        ii. Environmental intervention and treatment;
        iii. Ability to counsel caregivers and pediatric asthma patients on the reduction of environmental asthma triggers and self-management; and
        iv. Effective communication and patient follow-up skills;

    b) Complete a seven (7) day CHW core competency training, sponsored by the Massachusetts Department of Public Health (DPH), an Area Health Education Center (AHEC), or a Massachusetts Community College. The core competency curriculum includes leadership skills, assessment techniques, public health, outreach, cross cultural communication, community organizing, special focus on specific diseases groups and health issues, techniques for connecting families with community services, and techniques for talking about smoking cessation. If the Participating Practice is unable to access the DPH training free of charge, the cost of training will be the responsibility of the Participating Practice;

    c) Complete a four (4) day asthma mitigation training, sponsored by DPH or provided by the Participating Practice using a curriculum approved by DPH. The asthma mitigation curriculum includes recognizing uncontrolled asthma, how to read an action plan, how to reinforce messages, environmental assessment and mitigation, and a discussion of housing law and tenants rights. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for training the CHW;

    d) Complete a two day refresher asthma mitigation and core competency training, sponsored by DPH, each year the practice is participating in the CHABP. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for the cost of the training for the CHW;

    e) Participate in quarterly CHW trainings or collaborative learning sessions organized by DPH. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for the cost of the training for the CHW; and

f) Obtain CHW certification through DPH within one year of the date that such certification becomes available.

5. Assign a clinical supervisor for the CHW. The clinical supervisor may be any clinical member of the Participating Practice who participates in the ICT(s). The clinical supervisor must participate in a half-day training, sponsored by DPH, on how best to utilize the CHW and how to integrate the CHW into the care team.

6. Designate or contract for the services of at least one individual to provide care coordination to help CHABP Enrollees and caregivers access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma. Care coordination may be provided by a CHW, case manager, or clinician.

7. Designate or contract for the services of at least one licensed clinician to provide clinical care management of multiple co-morbidities, including communication with all clinicians treating the patient, as well as medication review, reconciliation and adjustment.

D. Preapproval of RFP

The Commonwealth must submit the Request for Proposals (RFP) to the CMS Regional and Central Offices for review and preapproval prior to public release. The RFP must be submitted to CMS for review and preapproval at least 45 business days prior to the expected release date.

4. A plan outlining how this pilot may interact with other federal grants, such as for related research (e.g. NIH, HUD, etc.) and programmatic work (e.g. CHIPRA grant related to pediatric health care practices in multi-payer medical homes, etc.). This plan should ensure no duplication of federal funds and outline the state's coordination activities across the various federal support for related programmatic activities to address potential overlap in practice site selection, patient population, etc.

If a practice participates in the Patient Centered Medical Home Initiative (PCMHI) as a Technical Assistance Plus Practice and participates in the CHABP, the Commonwealth will reduce the CHABP payment by the amount of the PCMHI payment. The PCMHI Medical Home Activity Fee and the PCMHI Clinical Care Management Fee will be deducted from the PMPM CHABP Phase 1 bundled payment amount.

If a Practice participates, either on its own or as part of a PCC, in the Primary Care Payment Reform (PCPR) initiative, the PCPR participants' PMPM payment for medical home services will be deducted from the $50.00 PMPM CHABP Phase 1 Bundled Payment Amount. The PCPR PMPM payment for medical home services will be calculated by multiplying the PCPR medical home load by the risk score by the expected external service provision adjustment.

Applicants to participate in the CHABP must certify that they do not receive payment or funding from any other source for services, activities, or expenses that will be funded through the CHABP at this practice site. The application form requires applicants to respond to a number of questions regarding other related programmatic activities which may be federally funded.

In evaluating the CHABP, the Commonwealth will attempt to match Participating Practices with other practices that are participating in the same set of related programmatic activities in order to discern interactions among these activities.

Application to Participate in the Massachusetts Children's High-risk Asthma Bundled Payment (CHABP) Demonstration Program Sample Questions

a. Indicate whether the practice is participating in any of these initiatives. (Participation in these initiatives is not a prerequisite to participation in the CHABP. The Practice may participate in both the CHABP and one or more of these initiatives as long as they do not provide payment or funding for services, activities, or expenses that will be funded through the CHABP at this practice site.) Check all that apply.

(1) ___ Massachusetts CHIPRA Medical Home Demonstration Project
(2) ___ Safety Net Medical Home Initiative
(3) ___ Medicare Care Management for High-cost Beneficiaries Demonstration
(4) ___ Medicare Federally Qualified Health Center Advanced Primary Care Practice (FQHC APCP) Demonstration
(5) ___ State Demonstration to Integrate Care for Dual Eligible Individuals
(6) ___ Patient Centered Medical Home Initiative (PCMHI)
(7) ___ Other medical home initiative (describe)
(8) ___ None of the above

b. If the practice is participating in one or more of the initiatives listed above, are the staff committed to providing time and effort to the other initiative(s)? Explain the practice's plan to complete all initiatives successfully.
c. Is the PCC plan provider participating in the MDPH Reducing Ethnic/Racial Asthma Disparities in Youth (READY) study or another initiative that pays for similar services for pediatric patients with high-risk asthma at a different practice site? ____ Yes ____No If yes, please provide the name of the initiative and the participating practice site.

5. A plan for the purchase and dissemination of supplies within the pilot specific benefit package, including procurement methods, by the state and/or providers including volume discounts;

During Phase 1, CHABP providers will be responsible for the purchase and dissemination of the environmental mitigation supplies provided as necessary to CHABP beneficiaries. Providers are required to submit a plan to procure, store and disseminate environmental mitigation supplies under this pilot during the application process; this plan must also address the delivery, installation, and ease of consumer use for each supply. This plan should also address how the provider will utilize volume discounts (either its own or the Commonwealth's) in its procurement of mitigation supplies, and how the practice will instruct the CHABP parent/guardian in the use of the supplies.

The Commonwealth is responsible for the oversight of providers' environmental mitigation supply purchasing and dissemination procedures to ensure that supplies are comparable in the areas of patient outcome, safety and relative costs. The Commonwealth must also assure standardized equipment pricing, the availability of items to all CHABP enrollees, and must provide any beneficiary supports necessary to access provider-distributed environmental mitigation supplies.

Participating providers will be required to report the type, make, model, cost and quantity for each supply procured and disseminated to CHABP members on the CHABP Expenditure Report. The Commonwealth will evaluate this information on a quarterly basis to ensure consistency and quality of purchased supplies for each practice. The state will ensure there is a process to disseminate supplies as needed to best meet individual CHABP enrollees' needs. If the Commonwealth finds that a provider(s) is unable to purchase or disseminate mitigation environmental supplies where medically necessary to support the goals of the pilot, the Commonwealth must immediately notify CMS and provide a mitigation strategy that begins with the Commonwealth intervening in order to ensure needs are met.

As part of the evaluation of Phase 1 and as a condition of approval for Phase 2, the Commonwealth will conduct a value analysis to assess the environmental mitigation supplies purchased and disseminated in terms of patient outcome, safety, and relative costs to develop product selection and standardization guidelines to be used during Phase 2 of the Pilot. The purpose of this analysis will be to determine how the bundled payment model and products provided under this contingent service correlate with costs, outcomes, and safety.

6. Payment rate setting methodology outlining the per member per month (PMPM) payment for the pilot services and supplies, consideration of risk adjustment and the estimated/expected cost of the pilot.

Providers who contract with the MassHealth PCC Plan will be reimbursed on fee for service (FFS) basis. Under Phase 1 of CHABP, participating PCCs will receive a prospective, monthly PMPM payment to cover the CHABP asthma mitigation services not currently reimbursed by MassHealth for members with high risk asthma (services include home visits by CHW, supplies and services to mitigate environmental asthma triggers). The data used to develop the Phase 1 PMPM is included in the tables below.

The PMPM payment is built up from an estimated cost of the covered benefits and an estimate of how many members will receive each supply or service. Supply costs were estimated based on actual costs incurred by Massachusetts health care providers who are currently distributing these supplies through their practices.

The budget table below includes an estimate of the percent of CHABP Enrollees that will receive a specific supply or service during a given year. Not all Enrollees will require each supply on an annual basis (for example, a family may already own a vacuum cleaner with a HEPA filter). Participating providers may distribute supplies to CHABP members in subsequent years of Phase 1 for a number of reasons, including for example:

- The member was newly eligible for CHABP because the member recently turned 2 years of age, enrolled in MassHealth, enrolled in the PCC Plan, was assigned to the Participating Practice's PCC Panel, met the clinical criteria for high-risk asthma, and/or met the criteria for poorly controlled asthma.

- The family had previously declined a home visit, but accepted a home visit in the second year. The environmental assessment identified the need for supplies that had not been identified previously through conversations with the family in the office and by telephone.

- The supply is no longer operational and required replacement.

- The family moved to a new housing situation and was unable to bring the supply with them.

The estimated percentage of members that will receive a supply during a year takes these contingencies into account. The estimates were based on the experience of existing programs, where for example, 30% of members declined a home visit where supplies were provided, as well as a consensus of the pilot advisors.

Estimated cost of Community Health Worker Visits and Phone Calls

	Visit	Phone Calls
CHW salary/hour	$ 15.00	$ 15.00
Hours per visit, including prep	4	0.25
Salary cost/visit	$ 60.00	$ 3.75
Supervision cost (10%)	$ 6.00	$ 0.38
Fringe, travel, indirect (45%)	$ 29.70	$ 1.86
Cost/visit	$ 95.70	$ 5.98

Budget for an average panel of high-risk asthma Members

Supply	Average Cost Each	Number	Price per Member	% of Members Receiving Supply	Cost per Member
Vacuum	$200.00	1	$200.00	70%	$140.00
Filters	$40.00	1	$40.00	70%	$28.00
Bedding	$90.00	1	$90.00	70%	$63.00
Pillows	$14.00	2	$28.00	70%	$19.60
Environmental Kits	$55.00	1	$55.00	45%	$24.75
Educational Materials	$20.00	1	$20.00	100%	$20.00
A/C Units	$115.00	1	$115.00	10%	$11.50
Pest Management	$135.00	1	$135.00	50%	$67.50
Total Supplies Cost					**$374.35**
CHW initial visit/education	$95.70	1	$95.70	70%	$66.99
CHW 2nd & 3rd visit, environmental mitigation	$95.70	2	$191.40	50%	$95.70
CHW 4th & 5th visit follow-up education	$95.70	2	$191.40	30%	$57.42
Total home visit cost					**$220.11**
Phone calls	**$5.98**	**9**	**$53.83**	100%	**$53.83**
Total cost per member per year					$648.29
Cost per member per month					**$54.02**

Supply Item	Required Features
Vacuum	High Efficiency Particulate Air (HEPA) filter that removes 99.97% of particles at least 0.3 microns in size; double bag
Vacuum bags	Fits vacuum
Mattress cover	Allergen-impermeable, allergen-proof, zippered, waterproof
Pillow	Allergen-impermeable, allergen-proof
Air conditioner	High Efficiency Particulate Air (HEPA) filter that removes 99.97% of particles at least 0.3 microns in size

7. Payment methodology outlining cost and reconciliation for the infrastructure payments to participating provider sites, and the eligibility and reporting requirements associated with the infrastructure payments.

The Commonwealth will not make infrastructure payments as part of the CHABP initiative to participating provider sites during Phase 1 of the pilot. The Commonwealth must request CMS approval in order to implement infrastructure payments during Phase 2. During Phase I, the Commonwealth must work with stakeholders, including providers and an advisory committee, to develop the cost and reconciliation methodology for infrastructure payments, which will be submitted as a condition for approval Phase 2.

During Phase 1, the financial/operational project leader will participate in monthly meetings, in person or by phone, with EOHHS-designated staff and/or with the project Advisory Committee to discuss development of the Phase 2 Infrastructure Payment and Reconciliation Methodology.

During Phase 1, the Participating Practice will develop, or contract with another entity to provide, any additional infrastructure necessary to meet the specifications that EOHHS ultimately establishes for managing the Phase 2 Bundled Payment. This infrastructure may include, but is not limited to:

a. Systems to coordinate ambulatory services provided by other health care providers, including specialists;

b. Contracts and other documentation necessary to make payments to these other providers;

c. Financial systems to accept Bundled Payments from EOHHS and to use them to pay for services provided by these other health care providers; and

d. Information technology systems to track Bundled Payments received from EOHHS and payments made to these other providers.

During Phase 2, Participating Provider sites may be eligible for up to $10,000 per practice site for infrastructure changes. The amount of infrastructure support is variable up to this maximum; actual awards will varydepending on the provider's readiness, EOHHS's review and finding of such readiness, and CMS' concurrence on the use of the proposed funding for the Participating Practice. A description of the award, distribution, and reconciliation process for these funds must receive CMS approval prior to implementation during Phase 2. Infrastructure payments are subject to the spending limitation of the infrastructure and capacity-building (ICB) component of the Safety Net Care Pool (SNCP), and are further contingent on continued CMS approval of the SNCP and the ICB.

8. Evaluation Design

The Commonwealth must develop an evaluation design for the CHABP pilot program which will be incorporated into the evaluation design required per STC 84 following CMS review and approval. The Commonwealth must submit the evaluation design to CMS no later than 60 calendar days after the approval of this Pediatric Asthma Pilot Program Protocol.

The objective of the evaluation is to determine the benefits and savings of the pilot as well as design viability and inform broader implementation of the design. The evaluation design must include an evaluation of programmatic outcomes for purposes of supporting any future expansion of the pilot project, including Phase 2. As part of the evaluation, the state at a minimum must include the following requirements:

i. Collect both baseline and post-intervention data on the service utilization and cost savings achieved through reduction in hospital services and related provider services for the population enrolled in the pilot. This data collection should include the quality measure on annual asthma-related emergency room visits outlined in the initial core set of children's health care quality measures authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA) beginning with a baseline set at the onset of the pilot, adjusted for the age range enrolled in the pilot program;

ii. A detailed analysis of how the pilot program affects the utilization of acute health services, such as asthma-related emergency department visits and hospitalizations by high risk pediatric asthma patients, and how the pilot program reduces or shifts Medicaid costs associated with treatment and management of pediatric asthma;

iii. A detailed analysis of the provision of mandatory and optional CHABP services provided to enrollees, which must include an analysis of purchasing strategies, supply costs, and stratification of distribution and provision of CHABP services by enrollee age, as well as an analysis of any optional services provided to enrollees that differ from those specified in this protocol;

iv. An assessment of whether the cost projections for the provider payment were appropriate given the actual cost of rendering the benefits through the pilot program; and,

v. A detailed analysis of how the effects of the pilot interact with other related initiatives occurring in the state.

The goal of the evaluation is to assess the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation as demonstrated by changed practices in asthma care and improved health outcomes at the same or lower cost. The Phase 1 hypotheses are that:

1. There will be a lower rate of asthma-related hospitalization and emergency department visits among enrollees compared to the comparison group.

2. Enrollees will attain better asthma control as measured by lower numbers of days absent from school/work/summer program as compared to the comparison group.

3. Total expenditures for the pilot including bundles payments for optional services for enrollees will be equal to or less than overall expenditures for the comparison group.

Specifically, the Commonwealth will examine changes in: 1) the way providers deliver services to CHABP Enrollees; 2) CHABP Enrollees' self-management of asthma; 3) CHABP Enrollees' health service use (i.e. emergency department use); 4) CHABP Enrollees' healthcare expenditures; and 5) CHABP Enrollees' quality of asthma care. This will include a cost-effectiveness analysis to examine the relative value between the pilot and the usual care.

Additionally, the Commonwealth will conduct a value analysis to assess the impact of environmental mitigation supplies purchased and disseminated in terms of patient outcome, safety, and relative costs. The purpose is to determine how the bundled payment model and products provided under this optional service correlate with costs, outcomes and safety.

The evaluation will use a mix of qualitative and quantitative methods. Data will be collected from Participating Practices and CHABP Enrollees, and extracted from Medicaid claims data and the MassHealth program office. Individuals with characteristics comparable to participating members will be identified for comparisons. The Commonwealth must submit its evaluation of the first full year of Phase 1 to CMS within 180 days of the end of the pilot year. To the extent that Phase 1 remains in place while the Commonwealth is conducting the evaluation and awaiting approval of its Phase 2 proposal, it will conduct an evaluation of each subsequent full pilot year on an annual and cumulative basis. Year one Phase 1 evaluation data will be a component of CMS' review of the Commonwealth's Phase 2 proposal. If CMS' review of the Commonwealth's Phase 2 proposal begins after the end of a subsequent full pilot year of Phase 1, then CMS may also include data from the Commonwealth's evaluation of that subsequent year in its review of the Commonwealth's Phase 2 proposal.

Data Sources

Data will be collected from Participating Practices to evaluate changes in the practice at 1 year intervals following implementation of Phase 1 of the pilot. The Commonwealth will also collect data from CHABP Enrollees at the pilot enrollment and 1 year after the enrollment to assess changes in asthma control and the number of days absent from school/work. Medicaid claims data will be used to evaluate changes in service use and healthcare expenditures. Additionally, data collected from participating members, healthcare expenditures paid by Medicaid, and program operation costs from the pilot management office will be used for the cost-effectiveness analysis.

Comparison Group

To mitigate the potential bias that any observed changes in outcomes are resulting from high service utilization or poor asthma control prior to the pilot participation or from concurrent changes in healthcare environment, the Commonwealth will identify a matched comparison group. To the extent available and comparable, the Commonwealth will include practices that applied for the pilot but were not chosen for the 1st phase in this comparison group. Both practice and member characteristics will be considered in the matching algorithm. Exact matching on important characteristics and propensity score matching techniques will be used to ensure the comparability of characteristics between Participating Practices/members and the comparison group. Considering these practice characteristics in the matching algorithm and subsequent statistical analysis are intended to isolate the effect of the pilot from other initiatives. This approach also addresses requirements set forth by STC 84.

Measures

Measures used in this evaluation are organized into three groups: changes in provider practice, changes in self-management of asthma, changes in service use (i.e. emergency department use), number of days missed from school/work/summer program due to asthma, healthcare expenditures, and quality of care. The initial core set of children's healthcare quality measured authorized by the Children's Health Insurance program Reauthorization Act (CHIPRA) will serve as the guide for service use and quality of care measures (see Measures: changes in service use, healthcare expenditures, and quality of care). Also, healthcare expenditures and program operation costs will be included in the analysis to assess the viability of the pilot and to develop a payment rate for the program (see Measures: measures for the cost-effectiveness analysis).

Changes in provider practice

Qualitative semi-structured key informant interviews with members of the interdisciplinary care team in each Participating Practice will be conducted at 1 year intervals after implementation of Phase 1 of the pilot. These interviews will assess changes in the way providers deliver services by identifying key components of changes in the practice and potential barriers in implementing the pilot.

Changes in self-management on asthma

Telephone and/or mail surveys will be used to evaluate changes in asthma management and the effect of the pilot. The survey instrument includes the asthma control test (ACT) measure and questions on the number of days absent from school for children/teens and from work for parents. These measures will also represent the effects in the cost-effectiveness analysis. The Commonwealth will conduct the surveys on all participating members and individuals in the comparison group at the baseline and at 12 month after baseline as budget permits.

Changes in service use, healthcare expenditures, and quality of care

MassHealth claims data will be used to derive healthcare service utilization, healthcare expenditures, and quality of care measures before the pilot enrollment and through the first year of the pilot participation. Key healthcare service utilization measures include asthma-related emergency department (ED) visits and asthma-related hospitalizations. Other types of service use also will be analyzed to examine possible shifting in services. Quality of care will be evaluated based on Healthcare Effectiveness Data and Information Set (HEDIS) specifications for asthma care and on the use of asthma-control medications following NQF 1799 Medication Management for People with Asthma.

Measures for cost-effectiveness analysis

In addition to healthcare expenditures from claims data, cost data will include program operation costs. Healthcare expenditures are MassHealth payment amounts for providers which are reported in claims. Program operation costs include the per-capita bundled payments for participating members and program-related administrative costs; and costs of environmental mitigation supplies purchased by providers. The MassHealth PCC plan staff will provide information on program operation costs. These cost data will represent the cost to Medicaid in the cost-effectiveness analysis.

Data Analysis

Qualitative data collected from staff in Participating Practices will be analyzed to identify common themes of changes in service delivery across Participating Practices. Innovative approaches and barriers for service delivery related to the pilot implementation will be summarized by the practice.

A difference-in-differences analytical framework will be used to analyze outcomes from claims data and data collected from Participating Members. The Commonwealth will compare changes in services use, healthcare expenditures, asthma control, and number of days absent from school/work for participating members to those for individuals in the matched comparison group. Outcome measures will be available for each individual for two or more times before and during the first year of the pilot. Measures for an individual at different time points are likely to be correlated. The Commonwealth will apply generalized estimating equations to account for the within-subject correlations. Given the usual time lag of claims data and the seasonal nature of acute events associated with asthma, quantitative analysis using claims data will begin at 1 year after the pilot implementation.

The Commonwealth will develop a measure of total cost based on health care expenditures, adjusted for case mix, plus program operations costs. The Commonwealth will conduct cost-effectiveness analysis to estimate the relative value between the pilot and the usual care. The ACT score and the number of days being absent from school/work measures the effect of the pilot, which is independent from the costs included in the analysis. Results will show the incremental costs associated with each day not absent from school or work.

Notice of Opportunity to Participate in Pediatric Asthma Advisory Committee

Published on the Commonwealth Procurement Access and Solicitation Site (Comm-PASS) April 6, 2011.

The Executive Office of Health and Human Services (EOHHS), Office of Medicaid seeks individuals to serve on the Pediatric Asthma Bundled Payment Pilot Advisory Committee.

St.2011, C.131, S.154 directs EOHHS to "develop a global or bundled payment system for high-risk pediatric asthma patients enrolled in the MassHealth program, designed to prevent unnecessary hospital admissions and emergency room utilization." This legislation also provides for EOHHS to consult with relevant providers in designing and implementing the pediatric asthma project. The University of Massachusetts Medical School (UMMS) is working with EOHHS to help develop this initiative.

EOHHS wishes to establish and consult an Advisory Committee on designing and implementing the high-risk pediatric asthma global or bundled payment demonstration program. The Advisory Committee may make recommendations on issues such as specifying the target patient population to be included in the initial demonstration, the basket of services to be included in the bundled payment, the risk adjustment methodology, the infrastructure required to manage the bundled payment, the evaluation metrics, and potential strategies for sharing savings between the MassHealth program and participating providers. EOHHS anticipates that this Advisory Committee will meet approximately once or twice per month or as EOHHS determines necessary beginning in or around April, 2011 through approximately December, 2012.

EOHHS seeks individuals, including representatives of providers who wish to participate in the high-risk pediatric asthma global or bundled payment demonstration program, to serve on this Advisory Committee. To be eligible to participate in the Advisory Committee, such individuals must have expertise (1) treating high-risk pediatric asthma patients, and/or (2) designing and implementing clinical programs to prevent and manage high-risk pediatric asthma, and/or (3) designing and implementing global or bundled payment structures. EOHHS will not compensate individuals for serving on this Advisory Committee. Participation in this Advisory Committee is not a pre-requisite for participation in the global or bundled payment demonstration program.

Interested individuals should submit an up-to-date resume or Curriculum Vitae and a letter of interest highlighting their relevant experience and expertise by April 13, 2011.

EOHHS and UMMS will review the responses and select individuals who bring the greatest breadth and depth of relevant knowledge and expertise to serve on the Advisory Committee. EOHHS reserves the right to request additional information from potential participants, solicit additional individuals for participation, and reject applicants for participation as it determines appropriate to assure that the Advisory Committee meets the agency's needs.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol
Approved: July 24, 2014

Advisory Committee Members

Name	Title	Institution/ Employer	Qualifications
Gary Adamkiewicz, PhD, MPH	Research Scientist	Harvard School of Public Health	• Research on the studies of indoor environmental conditions • Member of the Healthy Public Housing initiative – a community-centered asthma intervention project • Member of the Asthma Regional Council • Provide training on healthy homes issues • Several publications and research on asthma
Stacey Chacker	Director of Environmental Health and Asthma Regional Council	Health Resources in Action, Inc.	• Member Steering Committee Massachusetts Asthma Action Partnership • ARC and UMass developed tools – Investing in Best Practices for Asthma and Insurance Coverage for Asthma: A Value and Quality Checklist • November 2010 – Symposium leader for Improving Asthma Management in a Changing Healthcare System
May Chin, RN, MS, MBA	Project Director Asthma Prevention and Management Initiative	Floating Hospital for Children at Tufts Medical Center	• Registered Nurse for over 40 years • Designed and implemented the Asthma Prevention and Management Initiative at Tufts • Cardiac Care demonstration project which resulted in full implementation as a reimbursable standard of care
Patricia Edraos, JD	Health Resources Policy Director	Massachusetts League of Community Health Center	• Assisted Medicaid agency in CHIP expansion • Educational programs for global payment
Jim Glauber, MD, MPH	Senior Medical Director	Neighborhood Health Plan	• Pediatrician in practice for 19 years • Management of children with special healthcare needs i.e. asthma, prenatal diabetes • Developed asthma disease management program • Received grant for Implementation of an Enhanced Asthma Home Environmental Program
Polly Hoppin, ScD	Research Professor and Program Director	School of Health and Environment University of Massachusetts, Lowell	• Senior advisor to the Regional Director of DHHS • Principal Investigator on project to better understand how health insurance plans make decisions to cover preventive measures • Designing a coordinated asthma home visit system for the city of Boston • Several publications on the subject of Asthma • Secretary's Award for Distinguished Service in 1998 for developing five-year strategic plan to combat Asthma

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Name	Title	Institution/ Employer	Qualifications
Lara Khouri, MBA, MPH	Director, Integrated Care	Children's Hospital	• Business Perspective – Accounting & Management • Managed Care Contracting on behalf of large academic medical centers • Developed innovative payment structures – pay for performance
Ted Kremer, MD	Director, Pediatric Sleep Medicine	UMass Memorial Medical Center	• Pediatrician in practice for over 12 years • Board certified in Pediatric Pulmonology • Member of the Division of the Pediatric Pulmonary, Asthma, Sleep and Cystic Fibrosis Center at UMass Memorial
Kimberly Lenz, Pharm.D.	Clinical Consultant Pharmacist	UMass Medical School – Commonwealth Medicine	• Registered pharmacist 8 years • Participated in an asthma outreach program while a student at St. Louis Children's Hospital • Member of the Pediatric Pharmacy Advocate Group
William Minkle, MS	Executive Director	ESAC (Ecumenical Social Action Committee, Inc.)	• Supervise ESAC's Boston Asthma Initiative (BAI) for 4 years • 30 years non-profit experience with community programs • Member Boston Community Asthma Initiative Steering Committee
Neil Minkoff, MD	Chief Medical Officer	1776 Healthcare	• Has been practicing medicine for 15 years • Currently clinical lead for creating bundled payment • Extensive medical management experience
Shari Nethersole, MD	Medical Director for Community Health	Children's Hospital, Boston	• Pediatrician in practice for over 25 years • Drafted the MA Provider Consensus Statement in conjunction with the Asthma Regional Council • Oversaw the design and establishment of the Community Asthma Initiative at Children's.
Dorothy Page, MSN, FNP	Pediatric Nurse Practitioner	UMass Memorial Medical Center	• Registered Nurse for 40 years • Member of the Pediatric Pulmonary, Asthma, Sleep and Cystic Fibrosis Center – Umass Memorial • Developed the clinical asthma program working with school nurses for the high risk and poorly controlled asthmatics
Margaret Reid, RN, BA	Director, Division of Healthy Homes and Community Supports	Boston Public Health Commission	• Registered Nurse for 17 years – currently working on Master's • Convened the Boston Asthma Home Visit Stakeholders Group • 2009 –EPA National Environment Leadership Award in Asthma Management • Member Massachusetts Asthma Action Partnership

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Name	Title	Institution/ Employer	Qualifications
Elaine Erenrich Rosenburg, MS	Executive Director	Asthma & Allergy Foundation of America/New England Chapter, Inc.	• Member of the Steering Committees for the Boston Urban Asthma Coalition and the Massachusetts Asthma Action Program and the Health Access Resource Network • Work closely with parents of asthma patients • Help to manage children's asthma to reduce asthma incidents especially those requiring ER visits
Matthew Sadof, MD, FAAP	Director, Medical Home and Primary Care Asthma Intervention Programs	Baystate Medical Center	• Pediatrician in practice for 25 years • Received numerous grants for Asthma research • Directs a program that utilizes CHW's to extend care to children with asthma • Cares for a high-risk pediatric population with asthma at a local clinic
Megan Sandel MD, MPH, FAAP	Director & Co-Founder	Doc4kids project	• Pediatrician in practice for 15 years focused solely on care for low income children • Member Asthma Regional Coordinating Council • Ongoing research on How Much is Too Much to Wheeze: Asthma • Co-authored with **Jean Zotter** a publication on How substandard Housing affects children's health
Winthrop Whitcomb, MD, MHM	Medical Director, Healthcare Quality	Baystate Medical Center	• Physician for over 20 years • Chair of the total hip replacement bundled payment program pilot at Baystate
Elizabeth Woods, MD, MPH	Director of the Children's Hospital Boston's Community Asthma Initiative	Children's Hospital, Boston	• Pediatrician in practice for over 25 years • April 12, 2007 Elizabeth Woods Day in Boston for community asthma efforts • Principal investigator on a grant providing coordination of asthma care at home • Principal investigator on a grant addressing health disparities for children living in Jamaica Plain, Roxbury and Dorchester dealing with asthma

References

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[viii] Described in more detail in the Massachusetts DPH Community Health Worker Advisory Council Report, *Community Health Workers in Massachusetts: Improving Health Care and Public Health* (Boston, MA: Massachusetts Department of Public Health, 2010).
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[xi] Krieger, JW et al. The Seattle-King County Healthy Homes Project: a randomized, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. *Am J of Pub Hlth.* 2005;95 (4):652- 659.

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

Introduction

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

1) The cost limit must be calculated on a provider-specific basis.
2) Only the providers receiving SNCP payments for uncompensated care pursuant to STC 49(c) will be subject to the protocol.
    a. All Medicaid Fee-for-Service payments for services and managed care payments, including any supplemental or enhanced Medicaid payments made under the State plan [1], SNCP payments subject to the Provider Cap pursuant to STC 50(c), and any other revenue received by the providers by or on behalf of Medicaid-eligible individuals or uninsured patients are offset against the eligible cost. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance- and incentive-based payments and grants and awards both currently in existence and those that may be implemented during future demonstration renewal periods, such as those listed below.

    b. Performance- and incentive-based payments, including but not limited to:
        i. Pay-for-performance payments made under the Medicaid state plan;
        ii. Quality incentive payments associated with an alternative payment arrangement authorized under the Medicaid state plan or the section 1115 demonstration;
        iii. Delivery System Transformation Initiative payments made under the 1115 demonstration;
        iv. Patient Centered Medical Home Initiative payments, including care management and coordination payments, made under the 1115 demonstration;
        v. Shared savings and other risk-based payments under an alternative payment arrangement (e.g., Primary Care Payment Reform, subject to CMS approval), authorized under the Medicaid state plan or the section 1115 demonstration;

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

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

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

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

Determination of Allowable Medicaid and Uninsured Costs

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

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

1. Inpatient acute hospital services: Medical services provided to a member admitted to an acute inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
2. Outpatient acute hospital services: Outpatient Hospital Services include medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services. Outpatient Services include medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, hospital-based physicians' offices, hospital-based nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.

c. 1115 Demonstration Allowable Costs
   i. 1115 Demonstration Expenditures: Costs incurred by acute hospitals for providing Medicaid state plan services to members eligible for Medicaid through the 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the Medicaid state plan and are provided by acute hospitals under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
      1. The Commonwealth must not claim costs for the Pediatric Asthma Pilot Program until receiving CMS approval of the Pediatric Asthma Program payment protocol as described in Special Term and Condition 40(h).
      2. Intensive Early Intervention Services for Children with Autism Spectrum Disorder. The Commonwealth must not claim costs for the Intensive Early Intervention Services for Children with Autism Spectrum disorder until CMS approves the Intensive

Early Intervention Services for Children with Autism Spectrum Disorder the Pediatric Asthma Pilot Program payment protocol as specified in STC 40(h).

3. Diversionary Behavioral Health Services.

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

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

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

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

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

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

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

Worksheet C

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

Worksheet D

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

Worksheet D consists of the following five parts:

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

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

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

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

2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

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

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

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

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

NOTES:

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

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

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

The Commonwealth will use the CMS 2552[2] and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the CMS 2552 cost report, hospitals subject to the cost limit protocol will file the UCCR to allocate allowable 2552 costs to Medicaid

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

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

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

Overview

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

NOTES:

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

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

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

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

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

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

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

UCCR Instructions

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

Column 1 – Reported Costs

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

Column 2 – Reclassification of Observation Costs and inclusion of Post-Stepdown Costs
Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

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

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

Column 3 – Total Costs

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

Column 4 – Charges

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

Column 5 – Hospital Cost-to-Charge Ratios

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

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

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

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

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

Column 7 – MassHealth FFS Inpatient Costs

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

Column 8 – MassHealth Fee-for-Service Outpatient Charges

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

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

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

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

Column 9 – MassHealth Fee-for-Service Outpatient Costs

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

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

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

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

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

Column 1 – Total Routine Cost Center Inpatient Costs

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

Column 2 – Total Inpatient Days

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

Column 3 – Per Diem

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

Column 4 – MassHealth Fee-for-Service Inpatient Days

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

Column 5 – Total MassHealth FFS Inpatient Costs

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

Column 6 – Medicaid Managed Care Inpatient Days

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

Column 7 – Total Medicaid Managed Care Inpatient Costs

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

Column 8 – HSN and Uninsured Care Inpatient Days

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

Column 9 – Total HSN and Uninsured Care Inpatient Costs

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

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

For the purposes of completing Schedule C:

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

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

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

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

- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:

  - Professional component of physician charges;

- Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

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

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

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

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

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

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

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

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

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

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

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

Column 7 – HSN and Uninsured Care Inpatient Charges

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

Column 8 – HSN and Uninsured Care Inpatient Costs

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

Column 9 – HSN and Uninsured Care Outpatient Charges

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

Column 10 – HSN and Uninsured Care Outpatient Costs

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

Column 11 – Total HSN and Uninsured Care Costs

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

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

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

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

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

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

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

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

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

Column 1 – Professional Component of Physicians' Costs

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

Column 2 – Overhead Costs Related to Physicians' Services

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

Column 3 – Total Physicians' Costs

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

Column 4 – Total Physician Inpatient and Outpatient Charges

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

Column 5 – Cost-to-Charge Ratios

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

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

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

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

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

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

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

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

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

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

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

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

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

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

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

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

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

Column 1 – Total System Expenditures

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

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

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

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures
Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

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

Line Instructions:

Hospital and Clinic Revenue:

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

Line 1 – Payer Medical Claims Revenue

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

Column 5 - Health Safety Net and Uninsured

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

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

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

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

Line 3-5 – Supplemental Payments

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

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

Line 6 – Medicare Revenue

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

Line 7 – Third Party and Self Pay Revenue

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

Line 8 – Other Revenue

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

Line 9 – Subtotal Hospital and Clinic

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

Lines 10-15 Physician Revenue

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

Line 16 – Subtotal Physician Revenue

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

Line 17 – Total Revenue.

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

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

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

Column 2 – Medicaid FFS Outpatient Revenue

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

Column 3 – Medicaid Managed Care Inpatient Revenue

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

Column 4 – Medicaid Managed Care Outpatient Revenue

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

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

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

Column 6 – Total Revenue

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

<u>Schedule G: Notes</u>

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

III. Reconciliation

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552[3] cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

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

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

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

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

Final Reconciliation

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

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

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

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

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

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

Determination of Allowable Medicaid and Uninsured Costs

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

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

2. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
3. Outpatient chronic disease and rehabilitation hospital services: Rehabilitative and medical services provided to a member in a chronic disease or rehabilitation outpatient setting including but not limited to chronic disease or rehabilitation hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services include, but are not limited to, radiology, laboratory, diagnostic testing, therapy services (i.e., physical, speech, occupational and respiratory) and Day surgery services. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
4. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.

c. 1115 Demonstration Allowable Costs
    i. 1115 Demonstration Expenditures: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members eligible for Medicaid through the section 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
        1. Diversionary Behavioral Health Services.
d. Medicaid Managed Care Costs: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.

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

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

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

General Description of Methodology

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

II. Summary of 2552-10 Cost Report

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

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

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

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

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

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

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

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

Worksheet D consists of the following five parts:

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

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

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

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

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

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

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

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

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

NOTES:

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

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

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

The Commonwealth will use the CMS 2552[4] and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

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

Overview

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

NOTES:

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

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

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

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

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

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

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

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

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

UCCR Instructions

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

Column 1 – Reported Costs

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

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

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

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

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

Column 3 – Total Costs

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

Column 4 – Charges

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

Column 5 – Hospital Cost-to-Charge Ratios

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

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

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

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

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

Column 7 – MassHealth FFS Inpatient Costs

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

Column 8 – MassHealth Fee-for-Service Outpatient Charges

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

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

  - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

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

Column 9 – MassHealth Fee-for-Service Outpatient Costs

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

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

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

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

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

Column 1 – Total Routine Cost Center Inpatient Costs

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

Column 2 – Total Inpatient Days

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

Column 3 – Per Diem

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

Column 4 – MassHealth Fee-for-Service Inpatient Days

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

Column 5 – Total MassHealth FFS Inpatient Costs

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

Column 6 – Medicaid Managed Care Inpatient Days

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

Column 7 – Total Medicaid Managed Care Inpatient Costs

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

Column 8 – HSN and Uninsured Care Inpatient Days

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

Column 9 – Total HSN and Uninsured Care Inpatient Costs

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

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

For the purposes of completing Schedule C:

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

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

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

  - Individuals with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
    - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:

    - Professional component of physician charges;
    - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

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

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

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

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

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

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

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

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

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

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

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

Column 7 – HSN and Uninsured Care Inpatient Charges

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

Column 8 – HSN and Uninsured Care Inpatient Costs

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

Column 9 – HSN and Uninsured Care Outpatient Charges

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

Column 10 – HSN and Uninsured Care Outpatient Costs

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

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

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

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

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

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

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

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

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

  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).

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

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

Column 1 – Professional Component of Physicians' Costs

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

Column 2 – Overhead Costs Related to Physicians' Services

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

Column 3 – Total Physicians' Costs

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

Column 4 – Total Physician Inpatient and Outpatient Charges

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

Column 5 – Cost-to-Charge Ratios

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

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

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

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

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

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

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

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

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

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

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

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

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

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

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

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

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

Column 1 – Total SNHCS Expenditures

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

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

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients

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

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

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

Schedule F: Medicaid and Uninsured Revenue

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

Line Instructions:

Hospital and Clinic Revenue:

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

Line 1 – Payer Medical Claims Revenue

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

Column 5 - Health Safety Net and Uninsured

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

Line 2 – Pay for Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since following payments are not payments for the provision of medical care,

they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance- based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

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

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

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

Line 7 – Third Party and Self Pay Revenue

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

Line 8 – Other Revenue

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

Line 9 – Subtotal Hospital and Clinic

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

Lines 10-15 Physician Revenue

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

Line 16 – Subtotal Physician Revenue

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

Line 17 – Total Revenue.

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

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

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

Column 2 – Medicaid FFS Outpatient Revenue

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

Column 3 – Medicaid Managed Care Inpatient Revenue

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

Column 4 – Medicaid Managed Care Outpatient Revenue

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

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

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

Column 6 – Total Revenue

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

Schedule G: Notes

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

IV. Reconciliation

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552[5] cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

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

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

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

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

the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

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

Final Reconciliation

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

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

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

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

Institutions for Mental Diseases – Psychiatric Hospitals and Community Based Detoxification Centers (CBDCs) Protocol for Medicaid and Uncompensated Care Cost

The Commonwealth will use the reports described below to collect data from these providers.

Psychiatric hospitals will fill out the CMS 2552 and UCCR, as required of other hospitals in the cost limit protocol. CBDCs are non-hospital human and social services contractors that do not file a CMS 2552 cost report; therefore, for the purposes of the protocol, the Commonwealth will use only the Massachusetts **Uniform Financial Statements and Independent Auditor's Report (UFR)** to determine costs and revenues. The UFR is the set of financial statements and schedules required of human and social service contracting with state departments. For the calculation of provider-specific cost limits, psychiatric hospitals and CBDCs will fill out the necessary reports with the information that is relevant to the services they provide to the Medicaid-eligible and HSN and uninsured populations.

Determination of Allowable Medicaid and Uninsured Costs

a. DSH Allowable Costs
    i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable psychiatric hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
    ii. Pharmacy service costs are separately identified on the CMS 2552 10 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
    iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of "hospital services" for medical assistance. "Medical assistance" is defined as the cost of care and services "for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals [who are eligible]…" Section 1905 of the Act.

b. Medicaid State Plan Allowable Costs
    i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by institutions for mental disease. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
        1. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
        2. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
        3. Community Based Detoxification Center (CBDC): CBDCs are eligible to receive Safety Net Care Pool payments as Institutions for Mental Diseases (IMDs) under the section 1115 demonstration. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
            a. Acute Inpatient Substance Abuse Treatment Services: Short-term medical treatment for substance withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling, and post detoxification referrals provided by an inpatient unit, either freestanding or hospital-based, licensed as an acute inpatient substance abuse treatment service by the Massachusetts Department of Public Health under its regulations at 105 CMR 160.000 and 161.000. These services are delivered in a three-tiered system consisting of Levels III-A through III-C that must conform with the standards and patient placement criteria issued and enforced by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services.
            b. Substance Abuse Outpatient Counseling Service: An outpatient counseling service that is a

rehabilitative treatment service for individuals and their families experiencing the dysfunctional effects of the use of substances.

ii. 1115 Demonstration Population Expenditures: Costs incurred by psychiatric hospitals and CBDCs for providing IMD services to members eligible for Medicaid through the State plan and section 1115 demonstration will be counted as allowable costs. Allowable costs for psychiatric hospital services and CBDC services provided under the 1115 demonstration include service-related expenditures (please note that all services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs). The list of allowable services is contained in the Cost Element table.

1. Diversionary Behavioral Health Services

c. Medicaid Managed Care Costs: Costs incurred by IMDs for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
d. Other Allowable Costs, Approved 1915(c) Waivers. The list of allowable services in contained in the Cost Element table.
e. Additional Allowable Costs – The list of allowable services is contained in the Cost Element table.

I. Summary of 2552-10 Cost Report (Psychiatric Hospitals Only)

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

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

1) General service cost centers
2) Inpatient routine service cost centers
3) Ancillary service cost centers
4) Outpatient service cost centers
5) Other reimbursable cost centers
6) Special purpose cost centers
7) Other special purpose cost centers not previously identified

8) Costs applicable to nonreimbursable cost centers to which general service costs apply
9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

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

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

Worksheet C

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

Worksheet D

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

Worksheet D consists of the following five parts:

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

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

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

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

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

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

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

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

NOTES:

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

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

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and

uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth must use the CMS 2552[6] and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

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

Overview

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

NOTES:

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

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

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

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

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

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

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

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Medicare cost principles								
Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day		X				X		

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Treatment Program Services								
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

UCCR Instructions

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

Column 1 – Reported Costs

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

Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs
Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

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

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

Column 3 – Total Costs

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

Column 4 – Charges

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

Column 5 – Hospital Cost-to-Charge Ratios
Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

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

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

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

- MassHealth FFS Charges may not include:

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

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

Column 7 – MassHealth FFS Inpatient Costs

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

Column 8 – MassHealth Fee-for-Service Outpatient Charges

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

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

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

Column 9 – MassHealth Fee-for-Service Outpatient Costs

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

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

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

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

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

Column 1 – Total Routine Cost Center Inpatient Costs

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

Column 2 – Total Inpatient Days

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

Column 3 – Per Diem

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

Column 4 – MassHealth Fee-for-Service Inpatient Days

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

Column 5 – Total MassHealth FFS Inpatient Costs

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

Column 6 – Medicaid Managed Care Inpatient Days

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

Column 7 – Total Medicaid Managed Care Inpatient Costs

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

Column 8 – HSN and Uninsured Care Inpatient Days

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

Column 9 – Total HSN and Uninsured Care Inpatient Costs

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

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

For the purposes of completing Schedule C:

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

- Medicaid Managed Care Charges may not include:

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

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

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

- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:

  - Professional component of physician charges;
  - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

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

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

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

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

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

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

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

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

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

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

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

Column 7 – HSN and Uninsured Care Inpatient Charges

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

Column 8 – HSN and Uninsured Care Inpatient Costs

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

Column 9 – HSN and Uninsured Care Outpatient Charges

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

Column 10 – HSN and Uninsured Care Outpatient Costs

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

Column 11 – Total HSN and Uninsured Care Costs

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

Schedule D: Computation of Uncompensated Care Physician Costs

For purposes of completing Schedule D:

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

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

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

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

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

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

    - Individuals with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or

- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians' Costs

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

Column 2 – Overhead Costs Related to Physicians' Services

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

Column 3 – Total Physicians' Costs

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

Column 4 – Total Physician Inpatient and Outpatient Charges

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

Column 5 – Cost-to-Charge Ratios

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

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

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

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

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

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

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

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

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

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

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

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

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

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

Total Massachusetts Medicaid Fee-For-Service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 9 and column 11.

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

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

Column 1 – Total System Expenditures

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

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

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

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

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

Schedule F: Medicaid and Uninsured Revenue

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

Line Instructions:

Hospital and Clinic Revenue:

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

Line 1 – Payer Medical Claims Revenue

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

Column 5 - Health Safety Net and Uninsured

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

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

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

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

Line 3-5 – Supplemental Payments

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

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

Line 6 – Medicare Revenue

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

Line 7 – Third Party and Self Pay Revenue

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

Line 8 – Other Revenue

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

Line 9 – Subtotal Hospital and Clinic

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

Lines 10-15 Physician Revenue

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

Line 16 – Subtotal Physician Revenue

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

Line 17 – Total Revenue.

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

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

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

Column 2 – Medicaid FFS Outpatient Revenue

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

Column 3 – Medicaid Managed Care Inpatient Revenue

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

Column 4 – Medicaid Managed Care Outpatient Revenue

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

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

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

Column 6 – Total Revenue

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

<u>Schedule G: Notes</u>

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

III. Uniform Financial Report (UFR)

CBDCs are entities that provide health care services for substance abuse that contract with the MassHealth agency, Medicaid Managed Care Entities and the Bureau of Substance Abuse Services, the latter providing services to the uninsured. Each CBDC is licensed by the Bureau of Substance Abuse Services under the requirements set forth in 105 CMR 164.000. Because CBDCs are not a hospital, they do not fill out the Medicare CMS-2552 cost report and instead fill out the Uniform Financial Report (UFR).

UFR reports are filed with the Massachusetts Operational Services Division (OSD) on an annual basis. This report captures administration and support costs, as defined in 808 CMR 1.00, which includes expenditures for the overall direction of the organization, e.g., general record keeping, budgeting, etc., but also the salaries and expenses of the organization's staff. The report will also capture expenditures for health care services, as defined in M.G.L. c. 118 § 2 (b), the pricing of which is set by the Center for Health Information and Analysis

The CBDCs are required to keep necessary data on file to satisfy the UFR reporting requirements, and books and records must be maintained in accordance with generally accepted accounting principles set forth by the American Institute of Certified Public Accountants (AICPA).

The UFR must be submitted on or before the 15th day of the fifth month after the end of the contractor's fiscal year.

The UFR reports the following data elements:

1. Net Assets
2. Total Current Assets
3. Total Assets
4. Total Current Liabilities
5. Total Liabilities
6. Total Liabilities and Net Assets
7. Total Revenue, Gains, and Other Support
8. Total Expenses and Losses
9. Indirect / Direct Method
10. Cash from Operating Activities
11. Cash from Investing Activities
12. Cash from Financing Activities
13. Total Expenses – Programs
14. Total Expenses – Supporting Services
15. Surplus Percentage
16. Surplus Retention Liability

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

The CBDC's program expense is broken down by provider type for Psychiatric Day Treatment and Substance Abuse Class Rate Services, including:

1. Psychiatrist
2. N.P., Psych N., N.A., R.N.-Masters
3. R.N.-Non Masters
4. L.P.N.
5. Occupational Therapist
6. Psychologist – Doctorate
7. Clinician (formerly Psych. Masters)
8. Social Worker – L.I.C.S.W.
9. Social Worker – L.C.S.W., L.S.W.
10. Licensed Counselor
11. Cert. Voc. Rehab. Counselor
12. Counselor
13. Case Worker/Manager – Masters
14. Case Worker/Manager
15. Direct Care/Program Staff Supervisor
16. Direct Care/Program Staff

Per unit cost from UFR. The provider will calculate a per unit cost from the UFR for inpatient detoxification programs, who do not submit the Medicare 2552 cost report, by dividing the total reimbursable program expense (Schedule B line 53E) by line 6SS (number of service units delivered). The per diem cost will be reported by the CBDC on the CBDC Protocol Form.

Allowable Costs

i. From the MMIS paid claims database, the State will obtain the number of units of care, including administrative units, provided to all Medicaid patients.
ii. Providers will be required to file a supplemental schedule with EOHHS that reports the number of units, days of care, including administrative days, for services provided to Medicaid MCO and other uninsured patients.[7]
iii. The state will calculate costs by multiplying the per unit cost with the number of MassHealth, Medicaid MCO, and uninsured units described above.

[7] This is not currently available on the UFR report.

Payments

i. From the MMIS paid claims database, the state will obtain payments made to programs for services, including administrative days, provided to MassHealth patients.
ii. Providers will be required to file a supplemental schedule with EOHHS reporting payments received from all sources for services provided to Medicaid MCO and uninsured patients.

Determination of Provider-Specific SNCP Limit for CBDCs

The State will calculate a provider-specific SNCP limit for each CBDC as by subtracting all applicable payments from the allowable costs

IV. Reconciliation

Interim Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552[8] cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three after months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

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

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

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of

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

overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

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

Final Reconciliation for CMS 2552 and UCCR Methods

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

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

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

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

Interim Reconciliation for UFR Method

Each provider's uncompensated care costs must be computed based on the provider's as-filed Uniform Financial Report (UFR) and for the actual service period. The UFR is filed five months after the close of the cost reporting period. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service period. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The interim reconciliation described above will be performed and completed within twelve months after the filing of the provider's UFR.

Final Reconciliation for the UFR Method

Each provider's uncompensated care costs must be recomputed based on the provider's audited UFR for the actual service period. The UFR is audited and settled by the Commonwealth to determine final allowable costs and reimbursement amounts as recognized by the Commonwealth based on this cost limit protocol. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service

period. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government. Settlement of any over- or underpayment to a provider will be treated as a separate transaction rather an adjustment to the following year's interim payment.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The final reconciliation described above will be performed and completed within twelve months after the audited provider UFR is made available.

ATTACHMENT K
PUBLIC HOSPITAL TRANSFORMATION AND INCENTIVE INITIATIVE PROTOCOL

I. PREFACE

1. MassHealth Medicaid Section 1115 Demonstration Waiver

This Attachment K, Public Hospital Transformation and Incentive Initiatives (PHTII) Protocol, applies to the extension period of the Centers for Medicare & Medicaid Services (CMS) approved section 1115 demonstration waiver, entitled MassHealth (11-W-00030/1) (demonstration) from July 1, 2017 through June 30, 2022 (DY 21 through DY 25), as set forth in Attachment E and STC 56.

2. Public Hospital Transformation and Incentive Initiatives (PHTII)

STC 56 of the demonstration authorizes the Commonwealth to implement the Public Hospital Transformation and Incentive Initiatives (PHTII) funded through the Safety Net Care Pool (SNCP).

PHTII payments are intended to support the public hospital system for improvements in delivery systems and payment models that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

The Public Hospital will be required to develop and implement initiatives and activities, and to achieve performance metrics, as described and approved in this PHTII Protocol in order to receive the incentive payments.

In concert with the Commonwealth of Massachusetts' MassHealth transition from fee-for-service models into integrated accountable, total cost of care models in this demonstration, a defined portion of PHTII funding will be aligned with accountability for Medicaid Accountable Care Organization (ACO) performance accountability for the public hospital's MassHealth patient panel utilizing the Delivery System Reform Incentive Program (DSRIP) measures.

In addition, PHTII transformation initiatives will include a focus on behavioral health integration initiatives as well as other approved initiatives that support the public hospital's ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations it serves. These initiatives may include:

a) Integration of Behavioral Health and Primary Care;
b) Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions;
c) Referral Management and Integrated Care Management;
d) Evidence-Based Practices for Medical Management of Chronic Conditions; and/or
e) Community Empowered Population Health Initiative (Not Selected).

These initiatives may complement or enhance other federal initiatives in which a hospital may be participating, but they must not duplicate the exact same activities for which the public hospital receives specific funding by the U.S Department of Health and Human Services or any other state or federal funding source.

Pursuant to STC 56, PHTII payments are not direct reimbursement or payment for services, should not be considered patient care revenue, will not be offset against other Medicaid reimbursements to a hospital system, and will not be counted as payments when calculating hospital-specific cost limits under the Safety Net Care Pool Uncompensated Care Cost Limit Protocol.

3. PHTII Eligibility

STC 56 describes the eligibility for PHTII. Cambridge Public Health Commission d/b/a Cambridge Health Alliance (CHA) (hereby referred to as Public Hospital) is the only acute-care, non-federal, non-state Public Hospital in the Commonwealth and is eligible to earn PHTII payments outlined in Attachment E.

4. PHTII Protocol

In accordance with STC 56, Attachment K governs PHTII initiatives, guidelines, structure, and evaluation processes for reporting for payment, as outlined in Section V.

Following approval of the PHTII protocol by CMS and throughout the demonstration renewal period, the Massachusetts Executive Office of Health and Human Services (EOHHS) may propose revisions to the PHTII protocol, in collaboration with the Public Hospital, to reflect modifications to any component of the final approved protocol, including but not limited to initiatives, measures, metrics, and data sources or to account for other unforeseen circumstances in the implementation of the PHTII program. CMS must render a decision on proposed PHTII protocol revisions within 30 business days of submission by EOHHS. Such revisions must not require a waiver amendment, provided that they comport with all applicable STC requirements.

II. DESCRIPTION OF PHTII TRANSFORMATION FOCUS AREAS

5. PHTII Focus Areas

A defined portion of PHTII funding will be aligned with accountability for Medicaid Accountable Care Organization (ACO) performance accountability for the Public Hospital's MassHealth patient panel utilizing the DSRIP measures. Because the Public Hospital relies on PHTII as an important component of its overall MassHealth funding structure, linking a portion of PHTII funding with these DSRIP performance measures will ensure full alignment across payment streams and focus on improving these outcomes.

Other PHTII transformation initiatives will include a focus on behavioral health integration initiatives as well as other approved initiatives that support the Public Hospital system's ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations it serves.

Additional PHTII initiatives may include the following:

a) Integration of Behavioral Health and Primary Care;
b) Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions;
c) Referral Management and Integrated Care Management;
d) Evidence-Based Practices for Medical Management of Chronic Conditions; and/or
e) Community Empowered Population Health Initiative (Not Selected).

Integration of Behavioral Health and Primary Care

To continue the advancement in integrated medical and behavioral health care in the context of population health management and alternative payment models, this initiative will leverage evidence-based practices to advance screening, treatment and improved access to behavioral health care based in the primary care setting for adults, children and adolescents. This suite of initiatives will include a focus on population health, quality outcomes, patient engagement and experience of care improvements, coordinated, cross continuum care, and effective care management and follow-up on targeted conditions including depression, anxiety, and substance use disorders. This will be enabled through the optimization of screening and follow-up workflows, expansion of evidence-

based treatment options, provider and staff training and engagement, building relationships among staff and providers across the system, and building community connections to support patient care.

Collaborative care, an evidence based delivery model involving a greater role of non-medical specialists to augment primary care and provide care management, has been shown to support the Triple Aim among patients with depression, the most prevalent mental disorder.[1,2] The key elements of collaborative care models include: the use of a mental health registry, stepped care approach to depression management (i.e. intensifying treatments when needed), use of validated instruments (such as the Patient Health Questionnaire (PHQ-2 or PHQ-9) for depression, Generalized Anxiety Disorder scale (GAD-7) for anxiety, National Institute on Alcohol Abuse and Alcoholism single item screening tool (NIAAA-1), Alcohol Use Disorders Test (AUDIT), National Institute on Drug Abuse quick screen test (NIDA-1) and the Drug Abuse Screening Test (DAST), and regular caseload consultations by the psychiatrist and the behavioral care manager. Additional elements of integration include the co-location of behavioral health staff (such as therapists and psychiatrists) into primary care, meetings held by primary care and behavioral health team members to discuss cases, training of primary care and behavioral health staff on effective screening and collaborative care, and strategies to address substance use disorder (such as SBIRT) in primary care.[3]

Findings from more than 80 studies demonstrated that collaborative care increased adherence to evidence-based depression treatment by twofold and improved outcomes, including in low-income populations.[4] Studies have also revealed value in terms of cost-effectiveness, cost-benefit analysis, and improved patient satisfaction with care.[5] Substance use and addiction are significant challenges for society and for public payer populations. Unidentified mental health and substance use treatment needs contribute to higher costs and poor health outcomes. A recent publication released by the Substance Abuse and Mental Health Services Administration reported that in Massachusetts, only 53.8 % of adults with any mental illness (approximately 522,000 individuals per year in 2010-2014) actually received mental health treatment within the prior year, and only 7.5% of those with alcohol abuse or dependence received treatment in the prior year.[6] Furthermore, the national problem of opioid use disorder and overdose is increasing year by year in Massachusetts.[7]

According to the American Academy of Pediatrics (AAP), behavioral and emotional problems during childhood are common, often undetected, and frequently untreated despite. Approximately 11% to 20% of children in the United States have a behavioral or emotional disorder at any given time.[8,9] Developmental and behavioral health disorders are now the top 5 chronic pediatric conditions causing functional impairment.[10,11,12] The AAP urges clinicians to screen for

[1] Institute for Clinical and Economic Review. March, 2015. Integrating Behavioral Health into Primary Care.

[2] Unützer J, Katon WJ, Williams JW, Callahan CM, Harpole L, Hunkeler EM, Hoffing M, Areán PA, Hegel MT, Schoenbaum M, Oishi SM, Langston CA. Improving primary care for depression in late life: the design of a multi-center randomized trial. Medical Care. 2001; 39:785-799.

[3] The Diamond Model is based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT Study by Jurgen Unutzer, MD as well as numerous other controlled trials from Institute for Clinical Systems Improvement and Minnesota Family Health Services presentation to the Institute for HealthCare Improvement Annual Forum, Dec 2010.

[4] Archer, Janine, et al. "Collaborative care for depression and anxiety problems." *The Cochrane Library* (2012).

[5] Katon WJ. “Collaborative Depression Care Models: From Development to Dissemination.” American Journal of Preventive Medicine, 012;42(5):550–552.

[6] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Massachusetts, 2015*. HHS Publication No. SMA-16-BARO-2015-MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[7] http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf

[8] Costello EJ, Mustillo S, Erkanli A, Keeler G, Angold A. Prevalence and development of psychiatric disorders in childhood and adolescence. *Arch Gen Psychiatry*. 2003;60(8):837–844

[9] *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

[10] Slomski**,** A. Chronic Mental Health Issues in Children Now Loom Larger Than Physical Problems *JAMA. 2012;308(3):223-225.*

developmental and behavioral problems at all health supervision visits using quality tools.[13] There is an opportunity to update routine, comprehensive screening for behavioral and developmental conditions in the child and adolescent population, using validated screening instruments such as the Survey of Wellbeing of Young Children (SWYC) for developmental screening, the Pediatric Symptom Checklist (PSC) and PHQ-9 for depression, and CRAFFT, a short clinical assessment tool for substance related risks and problems, and to develop the associated registries, analyze utilization patterns and service gaps, and optimize follow-up care according to the evidence base.[14]

Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions
Poor access to appropriate levels of care is a leading barrier to recovery for individuals with mental health and substance use (MHSU) conditions.[15] A comprehensive system for MHSU treatment – offering the right care to the right people at the right time – requires a wide range of services and delivery methods to meet the unique needs of individuals and families. Among others, these services include outpatient counseling (including primary care integration), intermediate care (intensive outpatient, partial hospital), residential and inpatient facilities, support for care transitions, and triage and emergency services. A robust continuum of care helps people access services when they need and want them, improving patient experience and the value of care (quality/cost). A comprehensive treatment system allows individuals and their providers to develop an optimal care plan most likely to help them stay connected to their communities, succeed in daily activities, such as work or school, and engage in family and community supports toward recovery. Individuals who do receive appropriate treatment early in their onset of illness may require less intensive care, experience fewer relapses,[16] and have better long-term health outcomes.[17] New programs offering integrated, person-centered MHSU care show promising results – greater use of community-based outpatient care, fewer hospital and emergency department (ED) admissions, and better health outcomes.[18-19]

However, left untreated, behavioral health disorders and co-occurring health conditions have harmful economic, interpersonal, and social impacts for the population as a whole.[20] This troubling impact is most evident in the 20 to 30 year gap in life expectancy among people living with serious

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[11]Halfon N, Houtrow A, Larson K, Newacheck PW. The changing landscape of disability in childhood. *Future Child.* 2012;22(1):13–42

[12]Promoting Optimal Development: Screening for Behavioral and Emotional Problems. Carol Weitzman, Lynn Wegner, the Section on Developmental and Behavioral Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, Council on Early Childhood and Society for Develop Mental and Behavioral Pediatrics. *Pediatrics* Feb 2015, 135 (2) 384-395.

[13]Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, Medical Home Initiatives for Children With Special Needs Project Advisory Committee *Pediatrics* Jul 2006, 118 (1) 405-420.

[14]Massachusetts Department of Public Health Bureau of Substance Abuse Services. Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment Using the CRAFFT Screening Tool. Boston, MA. Massachusetts Department of Public Health, 2009.

[15]American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf.

[16]Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. Managing Managed Care: Quality Improvement in Behavioral Health. Washington (DC): National Academies Press (US); 1997. Available from: http://www.ncbi.nlm.nih.gov/books/NBK233235/

[17]Kane JM, Robinson DG, Schooler NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. Am J Psychiatry 2016; 173:362–372.

[18]Krupski A, West II, Scharf DM, et al. Integrating primary care into community mental health centers: Impact on utilization and costs of health care. Psychiatric Services in Advance. 2016:1-7. doi: 10.1176/appi.ps.201500424.

[19]Gilmer TP, Henwood BF, Goode M, et al. Implementation of integrated health homes and health outcomes for persons with serious mental illness in Los Angeles County. Psychiatric Services in Advance. 2016:1-6. doi: 10.1176/appi.ps.201500092.

[20]American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf.

mental illnesses (SMI).[21-22] This disparity is driven by higher rates of chronic disease (e.g. diabetes, hypertension, hyperlipidemia, and obesity), delayed diagnosis and treatment of medical conditions,[23] fragmented delivery of care, medication side effects,[24] and higher rates of modifiable risk factors.[25] On average, 4.2 percent of Massachusetts residents are living with SMI and 10 percent have a SUD.[26] Among adults who access mental health care, 30 percent still report unmet needs, and more than one-third of those treated in the state's public mental health system say it has not improved their functioning.[27]

Massachusetts' MHSU service gaps are due in part to shortages across the entire care continuum, from outpatient care to emergency services, inpatient beds, partial hospital programs, crisis stabilization units, detoxification, residential programs, and so on. This can result in sub-optimal wait times for outpatient therapy; extended hospitalizations due to lack of community-based services; and "boarding" in emergency departments (ED) as people await transfer to intermediate or acute care. Massachusetts faces an opioid use epidemic that has doubled the rate of overdose deaths from 2012 to 2015[28], and the need is growing exponentially for expanded Medication-Assisted Treatment (MAT) and evidence-based outpatient care for SUD. Expansion of services in areas that are most lacking, particularly in the intermediate care levels that provide step-down and diversionary services, will assist in shifting care away from more intensive levels and providing care at the appropriate level. Enhancement of treatment modalities will be explored that promote greater efficiency and create capacity within existing services, such as shorter term evidence-based treatments and technology-based services such as telemedicine consultations. Patient care teams may be redefined to include clinicians, paraprofessionals, peer specialists/coaches, community-based providers, social support providers, etc., with the patient at the center of the team.

A substantial portion of the public care system for individuals with the most disabling conditions extends beyond health care services to rehabilitative and support services, including housing, job counseling, literacy, and other programs. Poor linkage and fractured funding impedes the ability to provide access to these services in a coordinated and integrated way.[29] One strategy is the formalization of agreements between healthcare providers and community-based providers who offer complementary services, and providing integrated population case management. A focus on health promotion is essential to impact health outcomes for this population, as a national study estimated 85 percent of the life expectancy gap for people living with schizophrenia was attributable to "natural" causes, such as cardiovascular disease, cancers, pneumonia, and diabetes.[30]

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[21]Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med. Care. Jun 2011;49(6):599-604.

[22]Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Preventing Chronic Disease. 2006;3(2):1-14.

[23]Nasrallah HA, Meyer JM, Goff DC, et al. Low reates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: Data from the CATIE schizophrenia trial sample at baseline. Schizophrenia Research. 2006;86(1-3):15-2.

[24]Meyer JM, Davis VG, Goff DC, et al. Change in Metabolic Syndrome Parameters with Antipsychotic Treatment in the CATIE Schizophrenia Trial: Prospective Data from Phase 1. Schizophr. Res. 2008;101(1-3):273-286.

[25]SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010.

[26]Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral Health Barometer: Massachusetts, 2015. HHS Publication No. SMA–16–Baro–2015–MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[27]Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Preventing Chronic Disease. 2006;3(2):1-14.

[28]Massachusetts Department of Public Health. Data Brief: Opioid-related Overdose Deaths Among Massachusetts Residents. May 2016. Available at: http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf.

[29]Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. Managing Managed Care: Quality Improvement in Behavioral Health. Washington (DC): National Academies Press (US); 1997. Available from: http://www.ncbi.nlm.nih.gov/books/NBK233235/

[30]Kane JM, Robinson DG, Schooler NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. Am J Psychiatry 2016; 173:362–372.

Early screening and intervention for medical conditions is essential, particularly for patients taking antipsychotic medications that increase the risk for certain medical conditions, most notably metabolic syndrome. Modifiable factors such as smoking, diet, physical activity, substance use, and social needs are key drivers that can be addressed through promoting healthy living through education, skills training, and behavioral therapy.[31-32]

Referral Management and Integrated Care Management

Toward the goals of better health and optimal, more coordinated and cost-effective care, this suite of initiatives is aimed at increasing patient access to high-quality care, promote appropriate referrals and access (i.e. the right provider in the right setting) based on the complexity of the patient's needs. Providing integrated care across the continuum of care through effective referral management and care coordination is foundational to the accountable care model and alternative payment arrangements with quality, cost and health care utilization accountability. This is particularly important for Medicaid and other vulnerable patient populations that often face barriers to care and care fragmentation. This initiative builds and supports systems to maintain a preferred, high value network and simultaneously provide highly coordinated and quality care in four ways: focus on public hospital system access and effective operational improvements in primary care and medical, surgical and behavioral health specialties, encourage public hospital referrals and the use of care within the public hospital system and with clearly defined high value preferred provider networks enabled to coordinate care and redirect referrals from higher cost, lower-value external referrals, build relationships with key community-based partners such as visiting nurse associations (VNAs), skilled nursing facilities (SNFs), and detoxification facilities, and leverage proven technology to improve access and convenience for the patient panel to specialty opinions and care. The Massachusetts Office of the Attorney General's report published in September 2015 found wide variation in the prices health insurance companies pay providers for similar services, unexplained by differences in quality, complexity of services, or other common measures of consumer value. The report found that higher priced providers are drawing patient volume from lower priced providers, which increases costs as care is shifted from less expensive settings to more expensive settings. Referral networks comprised of high value providers are an opportunity to address this.

In addition, this initiative will refine emergency department (ED) and inpatient case management capabilities to offer alternative treatment modalities and community-based care to patients. This initiative will expand e-consults beyond tele-dermatology in order to increase access to consultations with specialists, reducing cost and enabling more capacity for face-to-face visits when appropriate. This initiative may focus on facilitating transportation to in-network care providers for patients who lack transportation by utilizing a non-medical transportation support service. Convenience and effectiveness also drives efforts to examine text-messaging in care management.

Evidence-Based Practices for Medical Management of Chronic Conditions

Evidence based medicine (EBM) is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The goal is to improve outcomes, quality, and cost by reducing the variation of care for key conditions and integrate EBM into the health care delivery system across the continuum. Variation of care was outlined in the 2010 Dartmouth Institute's reflections on geographic variations; however, similar variations in care may also be observed within health care systems and practices, acknowledging natural differences between patients. Safer, higher-quality care, redesigned systems of care that integrate the use of

[31]Bartels S, Desilets R. Health Promotion Programs for People with Serious Mental Illness (Prepared by the Dartmouth Health Promotion Research Team). Washington, DC. SAMHSA-HRSA Center for Integrated Health Solutions. Jan 2012.

[32]Bruins J, Jorg F, Bruggeman R, Slooff C, Corpeleijn E, et al. (2014) The Effects of Lifestyle Interventions on (Long-Term) Weight Management, Cardiometabolic Risk and Depressive Symptoms in People with Psychotic Disorders: A MetaAnalysis. PLoS ONE, 2014; 9(12); 1-20.

information technology can best support clinical and administrative processes to adopt EBM and improve patient outcomes.

Efforts to change the culture of medical practice to adopt EBM include education on recommendations from peer-reviewed groups such as Cochrane or the U.S. Preventive Services Task Force (USPTF), integration of EBM into clinical activities via clinical decision support (CDS) for chronic conditions and prevention, and the application of population health data to prioritize and subsequently develop systems to close quality gaps. Planned future initiatives build on capabilities to develop and use population health databases, risk stratify patients, and help connect the most costly and vulnerable patients with complex care management, transitional facilitators, and palliative care services. Medical management programs aim to develop and implement evidence-based clinical guidelines for populations of patients with particular conditions to ensure the right care at the right time in the right context and produce optimal outcomes for quality, safety, cost, and experience. Efforts may focus on improving care and reducing cost for populations of patients with five conditions: chronic obstructive pulmonary disease; congestive heart failure; hypertension; diabetes; and pediatric asthma.

Evidence-based patient engagement strategies may include those such as motivational interviewing in chronic health conditions and for substance use disorders, expansion of nursing, pharmacist, and other care team member roles in chronic disease management, and mental health team integration within primary care. Initiatives may include refining tools, frameworks, analytics, and clinical workforce development in the use of evidence-based guidelines across the care continuum.

Community Empowered Population Health Initiative

In recognition that social, behavioral, and environmental factors account for 70% of what it takes to stay healthy while only 10% are attributable to direct medical care, this initiative will build and support systems to address social determinants of health (SDH) and address health disparities in patients with chronic conditions.[33] According to the Institute of Medicine, "an aligned system with a strong interface among public health, health care, and the community and non-health sectors could produce better prevention and treatment outcomes for populations living with chronic illness."[34] Healthy People 2020 highlights the importance of addressing the social determinants of health by including "create social and physical environments that promote good health for all" as one of the four overarching goals for the decade.[35] Based on emerging evidence that addressing social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs, CMS has prioritized addressing SDH through the Accountable Health Communities model to address critical gaps between clinical care and community services.[36] The initiative also recognizes that health disparities have persisted for families and communities that have systematically experienced social and economic disadvantage and consequently face greater obstacles to optimal health.[37,38]

Improving SDH and health disparities requires supporting communities in addressing their health needs, implementing screening and referral processes to social service agencies and building programs that identify and address health disparities. Community health improvement teams will work with community based organizations and governmental entities to support their efforts to

[33]McGinnis et al. The Case for More Active Policy Attention to Health Promotion. Health Affairs 2002: 21(2); 78-93
[34]IOM. Living well with chronic illness: a call for public health action. Washington, DC: The National Academies Press; 2012
[35]Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[36]Alley DE, et al. Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid. N Engl J Med 2016; 374:8-11.
[37]CMS. CMS Equity Plan for Improving Quality in Medicare. Sept 2015. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf
[38]CMS. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-health-disparities.html

improve community health. Clinical and community health improvement teams will work together to screen for SDH, refer patients with social needs to existing community services, and rescreen patients with social needs. Clinical and community health improvement teams will also work closely to identify populations with disproportionately higher rates of poor control of chronic health conditions, monitor and improve their care through ensuring they receive interventions such as education, outreach, and linkage to primary, specialty and other ambulatory care services.

III. PROPOSED PUBLIC HOSPITAL TRANSFORMATION AND INCENTIVE INITIATIVES

6. Public Hospital Transformation and Incentive Initiatives

The Public Hospital must implement PHTII initiatives approved by EOHHS and CMS that are outlined within this protocol and that meet all requirements pursuant to STC 56, and all requirements set forth in Section III.

7. Minimum Number of Initiatives

The Public Hospital must select a minimum of four initiatives and no more than five initiatives in total for PHTII, in addition to the portion of PHTII funding linked to DSRIP performance accountability for the Public Hospital's attributed primary care panel within an ACO. Cambridge Health Alliance has selected four initiative areas 1 – 4 and corresponding Measure Slates 1 – 4 and 6.

8. Public Hospital PHTII Initiative Toolkit

Section VIII, paragraph 23 includes the menu of PHTII Initiatives and corresponding outcomes and improvement Measure Slates from which an eligible public hospital may select. Each initiative description includes:

a. Rationale for the proposed initiative (evidence base and reasoning behind initiative idea);
b. Goals and objectives for the initiative (initiative-specific Triple Aim goals and expected initiative outcomes);
c. Core components or key activities to guide initiative development and implementation;
    i. The core components for the initiatives are not required. However, most will be necessary to achieve the required results. The core components provide a guide for how the initiatives are implemented by the public hospital.
d. Measure Slates required for the initiative, including clinical event outcomes and other specified outcomes and improvement measures.
    i. The PHTII funding at risk for improved performance on outcomes and improvement indicators will be spread among four (4) Measure Slates associated with ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations. Each Measure Slate is a list of outcomes and improvement indicators for which the Public Hospital must successfully achieve defined metrics for a specified number of the indicators on the list within each specified demonstration year.
    ii. Each Measure Slate is designed specifically for a PHTII initiative. For the purposes of the at-risk funding for improved performance on outcomes and improvement indicators, the Measure Slates for PHTII initiatives are as follows:

        (a) Measure Slate 1 – Integration of Behavioral Health (BH) and Primary Care Initiatives
        (b) Measure Slate 2 – Comprehensive Systems for Treating Mental Health and Substance Use Conditions
        (c) Measure Slate 3 – Referral Management Initiatives and Integrated Care Management
        (d) Measure Slate 4 – Evidence-Based Practices for Medical Management of Chronic Conditions
        (e) Measure Slate 5 – Community Empowered Population Health Initiative (Not Selected).

iii. A specified number of outcomes and improvement indicators will need to be achieved in each DY, according to the table below.

The Public Hospital receives payment when a measure is individually achieved and reported, up to the established number of outcomes and improvement indicators assigned funding in a given demonstration year. For example in Measure Slate 2 in DY 22, if the Public Hospital achieves 4 indicators (out of the defined number for that year which is set at 5 indicators), the public hospital will be paid for those 4 indicators during that demonstration year. However, if the Public Hospital achieves a greater number than the defined number of improvement indicators established for a given year (for example, 6 indicators compared to the defined number established at 5 indicators), the Public Hospital will only be paid for the first 5 indicators that it achieves on that Measure Slate during that demonstration year.

	DY21	**DY22**	**DY23**	**DY24**	**DY25**
Measure Slate 1	Achieve 2 of 4 Indicator Goals	Achieve 4 of 11 Indicator Goals	Achieve 5 of 11 Indicator Goals	Achieve 6 of 11 Indicator Goals	Achieve 7 of 11 Indicator Goals
Measure Slate 2	Achieve 2 of 5 Indicator Goals	Achieve 5 of 13 Indicator Goals	Achieve 7 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals
Measure Slate 3	Achieve 2 of 5 Indicator Goals	Achieve 4 of 10 Indicator Goals	Achieve 7 of 13 Indicator Goals	Achieve 6 of 10 Indicator Goals	Achieve 8 of 13 Indicator Goals
Measure Slate 4	Achieve 2 of 3 Indicator Goals	Achieve 4 of 13 Indicator Goals	Achieve 7 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals
Measure Slate 5	N/A (Not Selected)	Achieve 3 of 9 Indicator Goals (Not Selected)	Achieve 5 of 9 Indicator Goals (Not Selected)	Achieve 5 of 9 Indicator Goals (Not Selected)	Achieve 6 of 9 Indicator Goals (Not Selected)

iv. The Public Hospital is not required to pre-determine which outcomes and improvement indicators will be achieved in terms of performance goals in each year; instead, the Public Hospital must achieve the established performance goals for the specified number of outcomes and improvement indicators applicable to a demonstration year, which are individually payable when an indicator is individually achieved and reported up to the established number of outcomes and improvement indicators assigned funding in that demonstration year. Beginning in DY23, for each of the Measure Slates 1 – 5, at least 2 measures are required to continue achievement from the year immediately previous. A description of the funding allocation for the at-risk outcomes and improvement indicators can be found in Section VI, paragraph 18. Updates to technical specifications of outcomes and improvement measures in Measures Slates 1 – 5 shall not require a protocol modification and can be implemented by the Commonwealth without further approval.

e. <u>Pay-for-Reporting Measure Slate</u>

Measure Slate 6 reflects Population-Wide Public Health Measures. Measure Slate 6 will be Pay-for-Reporting for DYs 21 – 25.

	DY21	**DY22**	**DY23**	**DY24**	**DY25**

Measure Slate 6	Pay-for-Reporting	Pay-for-Reporting	Pay-for-Reporting	Pay-for-Reporting	Pay-for-Reporting

A description of the funding allocation for the pay-for-reporting measure slate can be found in Section VI, paragraph 18.

9. Medicaid ACO Performance Accountability for Public Hospital's MassHealth Panel

The public hospital will report on measures associated with Medicaid Accountable Care Organization (ACO) performance accountability for the Public Hospital's MassHealth patient panel utilizing the DSRIP measures.

IV. NON-FEDERAL SHARE OF PHTII PAYMENTS AND ALIGNED MASSHEALTH ACO PERFORMANCE ACCOUNTABILITY FUNDS INCORPORATED INTO PHTII FUNDING STREAM

11. Identification of Allowable Funding Sources

a. Allowable Funding Sources

Allowable funding sources for the non-federal share of PHTII payments must include all sources authorized under Title XIX and federal regulations promulgated thereunder.

i. The source of non-federal share of DYs 21 – 25 PHTII payments to the Public Hospital will be an intergovernmental funds transfer. The Executive Office of Health and Human Services (EOHHS) will issue a request to the Public Hospital for an intergovernmental transfer in the amount of the non-federal share of the applicable incentive payment amounts at least 15 days prior to the scheduled date of payment. The Public Hospital will make an intergovernmental transfer of its funds to EOHHS in the amount specified by a mutually agreed timeline determined by EOHHS in consultation with the Public Hospital, and in accordance with the terms of an executed payment and funding agreement, and all applicable laws. Upon receipt of the intergovernmental transfer, EOHHS will draw the federal funding and pay both the nonfederal and federal shares of the applicable DYs 21 – 25 payment(s) to the Public Hospital according to a mutually agreed upon timeline determined by EOHHS in the consultation with the Public Hospital, and subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals.

b. Change in Funding Source

If the source of non-federal share of PHTII payments changes during the renewal period, EOHHS must notify CMS and seek CMS' approval of such change prior to claiming FFP for any payment utilizing such funding source. No waiver amendment is required.

V. PHTII REPORTING AND PAYMENT IN DYs 21 – 25

12. PHTII Initiatives and Measure Slate 1 – 6

Three times per year, the Public Hospital seeking payment under PHTII must submit reports to the Commonwealth demonstrating progress on PHTII initiatives that the Public Hospital has selected pursuant to paragraph 7. The Commonwealth must provide such reports to the assigned independent assessor. The reports must be submitted using the standardized reporting form approved by EOHHS. The reports must include the incentive payment amount being requested for the progress achieved on PHTII initiative activities in accordance with payment mechanics (see Section VI). The report must include data on the progress with the initiative and must provide a

narrative description of the progress made. The reports must contain sufficient data and documentation to allow CMS, the state, and the independent assessor to determine if the hospital is achieving progress with the initiative. The hospital system must have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

a. Reporting period of July 1 through October 31: the report and request for payment is due November 30.
b. Reporting period of November 1 through February 28/29: the report and request for payment is due March 31.
c. Reporting period of March 1 to June 30: the report and request for payment is due July 31. The Commonwealth may permit the reporting for payment of specified outcomes measures subsequent to the July 31 reports for each demonstration year in recognition that additional time may be needed for necessary data to be available.

These reports will serve as the basis for authorizing incentive payments to the Public Hospital. The actual payment amounts will be determined by EOHHS in accordance with the provisions of Section VI. EOHHS will schedule the payment transaction for the hospital within 30 days following EOHHS approval of the hospital report, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals. The state must inform CMS of the funding of PHTII payments to the provider through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter.

An independent assessor will review each report, to ensure accurate reporting of the hospital's achievement, and make recommendations to the state regarding approvals, denials or recommended changes in order to approve payment. EOHHS will provide final approval of all PHTII payments. The hospital must be allowed an opportunity to respond to, and correct, any recommendation for denial of payment, for a metric that the hospital believes it achieved, through the resubmission of required clarifications and/or data.

13. MassHealth DSRIP Performance Accountability for Public Hospital's MassHealth Panel

The public hospital will also follow the reporting process as defined by EOHHS for the Medicaid DSRIP performance accountability measures for the Public Hospital's MassHealth panel.

Generally, EOHHS will make payments to the Public Hospital for the DSRIP performance measures at the same time as it makes payments associated with the Public Hospital's third annual reporting cycle, as described in paragraph 12c above. However, if any DSRIP performance measures or domains are completed and approved by EOHHS pursuant to the DSRIP process at another time during the year, EOHHS shall make payments to the Public Hospital in the most proximate report for payment. For DSRIP performance measures that may rely on claims and/or other lagged sources of data administered by MassHealth, EOHHS shall make estimated payments to the Public Hospital, which shall be subject to final reconciliation outlined in this paragraph and paragraph 14 below. If it is determined that the progress by the Public Hospital had not been achieved as calculated in the estimated payment and that such progress would have resulted in a lower payment amount, the Public Hospital will be required to re-pay the federal portion of the overpayment amount. If the review determines that actual progress exceeded the estimate and the estimated payment amount, then the Public Hospital will be able to receive the appropriate additional payment in conjunction with the intergovernmental transfer process outlined in Section IV, paragraph 11.

14. Year-end Payment Reconciliation

Based on its review and verification of the Public Hospital's third annual report for payment, EOHHS will perform reconciliation as an additional check to verify that all PHTII payments made to the hospital were correct. If, after the reconciliation process EOHHS determines that the hospital was overpaid, the overpayment will be properly credited to the Commonwealth and the federal government or will be withheld from the next PHTII payment for the hospital, as determined by EOHHS. If, after the reconciliation process EOHHS determines that the hospital was underpaid, then subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals, EOHHS will schedule necessary payment transaction(s), or will add the additional amount to the next PHTII payment for the hospital, as determined by EOHHS.

15. Commonwealth Reporting to CMS in DYs 21 – 25

PHTII will be a component of the Commonwealth's quarterly operational reports and annual reports related to the demonstration. These reports will include:

a. All PHTII payments made to the specific hospital that occurred in the quarter;
b. Expenditure projections reflecting the expected pace of future disbursements for the participating hospital;
c. An assessment by summarizing the hospital's PHTII activities during the given period; and
d. Evaluation activities and interim findings of the evaluation design.

16. Claiming Federal Financial Participation

The Commonwealth will claim federal financial participation (FFP) for PHTII incentive payments on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set up exclusively for PHTII payments. FFP will be available only for PHTII payments made in accordance with all pertinent STCs and the stipulations of this master PHTII plan, including Section VI. The Commonwealth and the hospital system receiving PHTII payment must have available for review by CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in the approved PHTII protocol.

VI. DISBURSEMENT OF PHTII FUNDS

17. PHTII Incentive Payments

a. <u>Eligibility for PHTII Incentive Payments</u>
PHTII payments for the Public Hospital are contingent on that provider reporting progress on the PHTII initiatives and achieving performance for at risk outcomes and improvement measures as defined in the approved protocol. As outlined in Sections V and VI of the PHTII protocol, the hospital will be able to receive PHTII incentive payments related to approval of the required reports for payment. PHTII incentive payments may equal but not exceed the allotment outlined in Attachment E.

b. <u>DYs 21 – 25 PHTII Payments</u>
In DYs 21 – 25, PHTII funds will be available as incentive payments to the Public Hospital based on successfully executing and reporting on approved PHTII initiatives. The Public Hospital shall be eligible to receive the full amount of PHTII Initiatives Progress Reporting and Measure Slate 6 Reporting funding for successful completion of the progress reporting requirements during the first and second reports for payment, as specified in paragraph 12.

c. <u>Funding At Risk for Outcomes and Improvement</u>
Inclusive of the funding allotted to PHTII Outcomes and Improvement Measure Slates and MassHealth DSRIP performance accountability measures, the percentage of PHTII funding at

risk for improved performance on outcomes and improvement indicators will gradually increase from 15 percent in DY 21 to 30 percent in DY 25.

18. PHTII Funding Allocation Formula

The following chart depicts the percentage and dollar amount of total PHTII funds available per demonstration year for PHTII initiatives and the at-risk amounts for performance on the outcome and quality indicators.

	MassHealth DSRIP Performance Accountability for Public Hospital's MassHealth Panel		**PHTII At-Risk Measure Slates 1 – 4 Outcomes and Improvement Indicators**		**PHTII Initiatives Progress Reporting and Measure Slate 6 Reporting**		**Total**
DY 21	5%	$15.45M	10%	$30.9M	85%	$262.65M	$309M
DY 22	5%	$12.15M	10%	$24.3M	85%	$206.55M	$243M
DY 23	10%	$10M	10%	$10M	80%	$80M	$100M
DY 24	15%	$15M	10%	$10M	75%	$75M	$100M
DY 25	20%	$20M	10%	$10M	70%	$70M	$100M

a. Funding for MassHealth DSRIP Performance Accountability for Public Hospital's MassHealth Panel

In DY 21, 5% of total PHTII funds are available as incentive payments for meeting all qualification criteria for and participating in one of MassHealth's ACO models for the Public Hospital's MassHealth primary care patient panel. The funding allocation available for successful performance on MassHealth DSRIP performance accountability measures for the Public Hospital's MassHealth primary care patient panel members is 5% in DY 22, 10% in DY 23, 15% in DY 24, and 20% in DY 25.

b. Funding Allocation for PHTII At Risk Outcomes and Improvement Indicators

The amount of funding at risk for performance on the outcome and improvement indicators will be 10% of the total annual PHTII funding in DYs 21 – 25. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement using a valid, standardized method, outlined in Section VI, paragraph 19. The defined number of outcome and improvement indicators targeted for achievement in a given demonstration year have an annual base value that is uniform across all indicators within a specific Measure Slate 1 – 5 during a given demonstration year. The annual outcomes and improvement indicator value related to each of the applicable initiatives (Measure Slates 1 – 5) is calculated by dividing the annual total available amount of PHTII outcomes and improvement indicator funds by the number of applicable initiatives for a given year.

	DY 21	**DY 22**	**DY 23**	**DY 24**	**DY 25**
Measure Slate 1	$7.725M	$6.075M	$2.5M	$2.5M	$2.5M
Measure Slate 2	$7.725M	$6.075M	$2.5M	$2.5M	$2.5M
Measure Slate 3	$7.725M	$6.075M	$2.5M	$2.5M	$2.5M

Measure Slate 4	$7.725M	$6.075M	$2.5M	$2.5M	$2.5M
Measure Slate 5	Not Selected	Not Selected	Not Selected	Not Selected	Not Selected
Total	$30.90M	$24.30M	$10.00M	$10.00M	$10.00M

The PHTII at-risk outcomes and improvement indicator funds will be earned by Measure Slate based on the individual achievement of established performance goals for the specified number of indicators for each respective measure slate as outlined in Section III, paragraph 8. For each Measure Slate, the available funds are divided by the established number of measures specified for achievement during a given demonstration year. Payment will be made to the Public Hospital when a measure is individually achieved and reported, up to the established number of measures assigned funding in a given demonstration year.

c. Funding Allocation for PHTII Initiatives and Measure Slate 6

In DY 21, 85% of total PHTII funds are available as incentive payments for successful achievement of progress reporting on PHTII initiative activities as described in Section V, paragraph 12. The funding allocation available for PHTII initiatives is 85% in DY 22, 80% in DY 23, 75% in DY 24, and 70% in DY 25.

Of such annual PHTII funds available for successful achievement of reporting initiative activities in DYs 21 – 25, five percent of such annual initiative metric funding is associated with Measure Slate 6 (Population-Wide Public Health Measures), which is pay-for-reporting throughout the demonstration. The table below specifies the annual base values for PHTII initiatives and Measure Slate 6.

	DY 21	**DY 22**	**DY 23**	**DY 24**	**DY 25**
PHTII Initiatives Progress Reporting	$249.52M	$196.22M	$76.00M	$71.25M	$66.50M
Measure Slate 6	$13.1325M	$10.3275M	$4.00M	$3.75M	$3.50M
Total PHTII Initiatives Progress Reporting and Measure Slate 6	$262.65M	$206.55M	$80.00M	$75.00M	$70.00M

19. PHTII Improvement Measurement Approach

As stated in Section V, paragraph 12 of this attachment, the Public Hospital will report outcomes and improvement indicators related to PHTII Initiatives (Measure Slates 1 – 4). The public hospital will also follow the reporting process as defined by EOHHS for the Medicaid DSRIP performance accountability measures for the Public Hospital's attributed panel, outlined in paragraph 13.

a. PHTII Measure Slates 1 – 5

In order to receive funding for Measure Slates 1 – 5, the Public Hospital must achieve established performance goals for a specified number of indicators which are individually payable when an indicator is individually achieved and reported up to the established number of outcomes and improvement indicators assigned funding in a given demonstration year, as described in Section III, paragraph 8. Payment-for-performance on the outcomes and improvement indicators on the Measure Slates will be based on an objective demonstration of

improvement over baseline or achievement of established performance thresholds using a valid, standardized method, as described below.

The following is the PHTII Measure Slate 1 – 5 payment framework for outcomes and improvement indicators.

i. DY 21 - 25 – This is pay-for-performance for designated measures.
   (a) The Public Hospital must achieve established performance goals for the specified number of indicators for the demonstration year, as outlined in Section III, paragraph 8.
   (b) Baselines will also be reported for designated measures in specified demonstration years.

ii. In the event that the Public Hospital meets the specified performance benchmark in a particular demonstration year, the organization must maintain performance at or above the benchmark in the remaining demonstration years. Variation in performance is acceptable as long as the performance for each demonstration year is at or better than benchmark in this case. Beginning in DY22, the Public Hospital would also be required to achieve at least one measure in each measure slate for which it did not meet or exceed the benchmark in the previous year.

iii. The Public Hospital must have a target for outcome and quality improvement indicators in Measure Slates 1 – 5. The specified targets will be used to determine whether or not success is achieved on the associated outcomes or improvement indicator. Measure Slate 6 is pay-for-reporting only on population-wide public health measures, and is not included in the at-risk funding for outcomes and improvement indicators, as described in Section VI, paragraph 18.

iv. The following is a guiding hierarchy for the selection of improvement benchmarks or targets for outcomes and improvement indicators on Measure Slates 1 – 5. All performance targets are set forward in this protocol for Measure Slates 1 – 5 and will be in place for the entire demonstration period.
   (a) Select the latest available 90th percentile Massachusetts Medicaid at the time of protocol development. For CMS core inpatient measures and other inpatient measures, utilize available Massachusetts performance data.
   (b) If above is not available, select the latest available 90th percentile National Medicaid data at the time of protocol development. For CMS core inpatient measures and other inpatient measures, utilize available National performance data.
   (c) If above is not available, select other available benchmark (such as other latest available National benchmark) or hospital-defined target at the time of protocol development. If above is not available or if the specific measure is more appropriate to improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures), any improvement over DY21/SFY18 hospital baseline will be the improvement measurement method or as specified.

v. Outcomes and Improvement Indicators Classifications for Measure Slates 1 – 5
   (a) Outcomes and improvement indicators will be classified into the following groups: (i) Clinical care delivery improvement measures; (ii) Clinical outcomes measures; and (iii) other delivery/outcomes measures where there is not a standardized benchmark and/or if the specific measure is more appropriate to improvement over hospital baseline.
      (i) Clinical care delivery improvement measures quantify a performance exhibited by clinical care practices, such as health screenings, and therefore are usually directly observable and can be directly impacted. In general, these metrics fit with a gap-to-goal methodology. All metrics classified as clinical care delivery measures must have an acceptable benchmark. To meet the threshold for success, the Public Hospital must achieve closure of 10% of the difference between the Public Hospital's baseline performance and the established benchmark or maintain at or

above the benchmark. Each subsequent year would continue to be set with a target using the most recent year's data, unless otherwise specified.

Performance Year – Baseline >= (Benchmark – Baseline) * 10%

An example of a clinical care delivery measure is influenza immunization (NQF 0041).

(ii) Clinical outcome measures are metrics influenced by patient case mix, multiple processes, and environmental factors. In general, these metrics fit with a gap-to-goal methodology, depending on the availability of performance benchmarks. Since improvement on outcomes measures requires considerable amounts of resources and time and is dependent on foundational care delivery improvements and patient factors, closure of 10% of the difference between the Public Hospital's baseline performance and the established benchmark is included, unless otherwise specified. To meet the threshold for success, the Public Hospital must meet the 10% gap to goal, where the Public Hospital must achieve a closure of a minimum of 10% of the difference between the benchmark and the baseline performance or maintain at or above the benchmark. Each subsequent year would continue to be set with a target using the most recent year's data, unless otherwise specified.

Performance Year – Baseline >= (Benchmark – Baseline) * 10%

Examples of clinical outcome measures are Controlling High Blood Pressure (NQF 0018) and Comprehensive Diabetes Care: Hemoglobin A1c Control (NQF 0575).

(iii) Non-standardized benchmark delivery/outcomes measures are metrics that do not have an available or acceptable benchmark and/or are specific measures that are more appropriate for improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures). For example, to meet the threshold for success, for pay-for-performance measures applicable to DY 22, the Public Hospital must show improvement from baseline (DY 21) to performance year (DY 22). To meet the threshold for success, for pay-for-performance measures applicable to DY 23, the Public Hospital must show improvement from baseline (DY 21) to performance year (DY 23) or as specified.

Examples of a non-standardized benchmark delivery/outcomes measure are emergency department utilization rates and reducing the proportion of out-of-network referrals, thereby improving patient continuity of care. These measures are influenced by many factors (which may include patient case mix, multiple processes, and environmental factors). Given that these measures are not risk-adjusted approach, the use of the Public Hospital's historical performance is a pragmatic approach to PHTII. Other examples of a non-standardized benchmark delivery/outcomes measures are the CMS Inpatient Psychiatric Facility Quality Reporting Screening for Metabolic Disorders in Inpatient Psychiatric Care, which is a new measure for which a benchmark is unavailable.

b. <u>MassHealth DSRIP Performance Accountability Funds Incorporated into PHTII Funding Stream</u>

The Public Hospital will follow the reporting process established for the MassHealth DSRIP accountability measures. A DSRIP Accountability Score will be calculated for the Public Hospital using the methodology as described in the DSRIP Protocol, except that the

Accountability Score will be calculated based specifically on performance for MassHealth members related to the Public Hospital's primary care panel (versus the whole ACO's primary care panel, if the ACO includes other primary care providers in addition to the Public Hospital). The amount of these at-risk funds the Public Hospital earns will be determined as outlined in the DSRIP Protocol. The DSRIP domains and measures, and the methodology for calculating accountability scores, are further defined in the DSRIP Protocol.

VII. INITIATIVE MODIFICATION, GRACE PERIODS, AND CARRY FORWARD AND RECLAMATION

20. Initiative Modification Process

a. Consistent with the recognized need to provide the Public Hospital some flexibility to evolve its initiatives over time and take into account evidence and learning from experience and from the field, as well as for unforeseen circumstances or other good cause, the hospital may request modifications to the PHTII Toolkit for an initiative or to its portfolio of selected PHTII initiatives, with the exception of ACO performance accountability, which may not be modified except at EOHHS' direction and as applicable to the broader DSRIP program. The hospital must submit a request for modification to EOHHS. Requests for initiative modification must be in writing and must describe the basis for the proposed modification. Updates to technical specifications of outcomes and improvement measures in the Measure Slates (1 – 6) shall not require a plan modification and can be implemented by the Commonwealth without further approval.

b. Initiative modifications include proposed changes to core components of the initiative, replacement metrics on the improvement and outcome measure slates (Measure Slates 1 – 5), replacement measures to Measure Slate 6, or a change to the overall portfolio of selected PHTII initiatives. Acceptable reasons to approve an initiative modification request are:

   i. Learning and knowledge acquired from initiative experience and/or external sources indicate that revising or reorienting initiative components or metrics would improve and/or enhance the initiative;
   ii. Information that was believed to be available to achieve or report on a metric or measure is unavailable or unusable, necessitating a modification to the hospital initiative to revise or replace the metric or measure;
   iii. The hospital identifies superior information to demonstrate achievement of a metric and requests a modification to incorporate that data source;
   iv. External issues occur outside of the hospital's control that require the hospital to modify or replace a metric, measure, or core component of an initiative;
   v. New federal or state policies are implemented, or changes in Massachusetts market dynamics occur, that impact a PHTII initiative and the hospital seeks to update the affected initiative to reflect the new environment;
   vi. The hospital encounters an unforeseen operational or budgetary change in circumstances that impacts initiative components or metrics; and
   vii. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the PHTII program.

c. The Public Hospital may request initiative modifications during DYs 21 – 25. Initiative modification requests must be submitted to EOHHS a minimum of 75 days prior to the end of the Demonstration Year. EOHHS must take action on the initiative modification request and submit recommended requests to CMS for approval within 15 days of receiving a modification

request. CMS must take action on the initiative modification request within 30 days of receipt from EOHHS. Any CMS approved initiative modification must be considered an approved modification to the PHTII protocol.

d. Plan modifications associated with grace period requests, including EOHHS and CMS review timeframes, are further addressed in paragraph below.

21. Grace Periods

a. If the Public Hospital needs additional time to achieve a metric beyond the demonstration year, a grace period may be granted for up to 180 days from the end of the demonstration year if it requests. However, no grace period is available for DY 25 beyond June 30, 2022, with the exception of specified outcomes and improvement measures where there is state and federal approval for a later reporting date in recognition that the data will be not be available for reporting until after the July 31, 2022 report for payment. The hospital must have a valid reason, as determined by the Commonwealth and CMS, why it should be granted a grace period and demonstrate that the hospital is able to achieve the metric within the timeframe specified in the request. Grace periods will not be granted for ACO performance accountability. Acceptable reasons to approve a grace period request include:

i. Additional time is needed to collect and prepare data necessary to report on a metric;
ii. Unexpected delays by third parties outside of hospital's control (e.g., vendors) impact the timing of a metric achievement date;
iii. An approved plan modification delays the timing for completing an approved metric; and
iv. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the PHTII program.

b. The Public Hospital may submit a grace period request in writing to EOHHS accompanied by a proposed initiative modification if the initiative modification is deemed necessary by the Public Hospital, pursuant to paragraph 21 above. The hospital must submit the request 75 days prior to the end of the Demonstration year for which the grace period is being sought. EOHHS must determine its recommended action on a grace period request and initiative modification, if the grace period request is accompanied by an initiative modification, and submit the request to CMS, with its recommendation, within 15 days. CMS must take action on the request within 30 days of receipt from EOHHS. The grace period request and any associated initiative modification must be decided by the Commonwealth and CMS 30 days prior to the end of the Demonstration year.

c. The Public Hospital that requests a grace period related to a metric is not precluded from alternatively claiming the incentive payment associated with the same metric under the carry-forward policy described in paragraph 22 below.

d. If after submitting the grace period request, a hospital achieves the metric before June 30, the hospital may withdraw the grace period request and claim the incentive payment associated with the metric under the regular PHTII reporting process described in Section V.

e. Allowable Time Periods for Grace Period Requests: the allowable time period for a grace period is 180 days from June 30 for DYs 21 – 24. No grace period is available for DY 25 beyond June 30, 2022 except as expressly described in paragraph 21(a) above.

22. Carry Forward and Reclamation

The Public Hospital may carry forward unclaimed incentive payments applicable to PHTII initiative reports and PHTII Measure Slates 1 – 6 for up to 12 months from the end of the demonstration year and be eligible to claim reimbursement for the incentive payment according to the rules below. No carry-forward is available for DY 25 or for DSRIP performance accountability.

a. If the Public Hospital does not achieve improvement on a measure that was specified for achievement in a particular year, it will be able to carry forward the available incentive funding associated with that measure for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the corresponding measure associated with the year in which the payment is made. For purposes of carry-forward in this paragraph, a corresponding measure is a measure that is a continuation of a prior year measure and is readily quantifiable. An example of corresponding measures includes a metric that shows a number or percentage increase in the same specific activity from the previous year.

b. If there is no corresponding measure associated with the year in which the payment is made, the hospital will be able to carry forward the available incentive funding associated with the missed measure for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed measure in addition to at least 25 percent of measures associated with that initiative in the year in which the payment is made. If at the end of that subsequent demonstration year, an eligible safety net hospital has not fully achieved a measure, it will no longer be able to claim that funding related to its completion of that measure.

VIII. MENU OF PHTII INITIATIVES AND CORRESPONDING OUTCOMES AND IMPROVEMENT MEASURE SLATES

23. PHTII Initiatives and Measure Slates

This section presents a menu of PHTII Initiatives and corresponding outcomes and improvement Measure Slates from which an eligible public hospital may select. Cambridge Health Alliance has selected PHTII Initiatives 1 – 4 and corresponding Measure Slates 1 – 4 and 6.

Initiative Title	1. Integration of Behavioral Health and Primary Care

Description/Rationale

To continue the advancement in integrated medical and behavioral health care in the context of population health management and alternative payment models, this initiative will leverage evidence-based practices to advance screening, treatment and improved access to behavioral health care based in the primary care setting for adults, children and adolescents.

This suite of initiatives will include a focus on population health, quality outcomes, patient engagement and experience of care improvements, coordinated, cross continuum care, and effective care management and follow-up on targeted conditions including depression, anxiety, and substance use disorders. This will be enabled through the optimization of screening and follow-up workflows, expansion of evidence-based treatment options, provider and staff training and engagement, building relationships among staff and providers across the system, and building community connections to support patient care.

Collaborative care, an evidence based delivery model, has been shown to support the Triple Aim among patients with depression, the most prevalent mental disorder. [39] [40] The key elements of collaborative care models include: the use of a mental health registry, stepped care approach to depression management (i.e. intensifying treatments when needed), use of validated instruments (such as the Patient Health Questionnaire (PHQ-2 or PHQ-9) for depression, Generalized Anxiety Disorder scale (GAD-7) for anxiety, National Institute on Alcohol Abuse and Alcoholism single item screening tool (NIAAA-1), Alcohol Use Disorders Test (AUDIT), National Institute on Drug Abuse quick screen test (NIDA-1) and the Drug Abuse Screening Test (DAST), and regular caseload consultations by the psychiatrist and the behavioral care manager. Additional elements of integration include the co-location of behavioral health staff (such as therapists and psychiatrists) into primary care settings, meetings held by primary care and behavioral health team members to discuss cases, training of primary care and behavioral health staff on effective screening and collaborative care, and strategies to address substance use disorder (such as SBIRT) in primary care.[41]

Collaborative care models, structured care involving a greater role of non-medical specialists to augment primary care and provide care management, have been shown to be more effective than standard care in improving depression outcomes in the short- and long-term. [42] There is strong evidence supporting benefits of care management for depression.[43] Findings from more than 80 studies demonstrated that collaborative care increased adherence to evidence-based depression treatment by twofold and improved outcomes, including in low-income populations.[44] Studies have also revealed value in terms of cost-effectiveness, cost-benefit analysis, and improved patient satisfaction with care.[45] The Agency for Healthcare Research and Quality has found in

[39]Institute for Clinical and Economic Review. March, 2015. Integrating Behavioral Health into Primary Care.
[40]Unützer J, Katon WJ, Williams JW, Callahan CM, Harpole L, Hunkeler EM, Hoffing M, Areán PA, Hegel MT, Schoenbaum M, Oishi SM, Langston CA. Improving primary care for depression in late life: the design of a multi-center randomized trial. Medical Care. 2001; 39:785-799.
[41]The Diamond Model is based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT Study by Jurgen Unutzer, MD as well as numerous other controlled trials from Institute for Clinical Systems Improvement and Minnesota Family Health Services presentation to the Institute for HealthCare Improvement Annual Forum, Dec 2010.
[42]Gilbody S, Bower P, Fletcher J, Richards D, Sutton A. "Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes." ARCH INTERN MED/VOL 166, NOV 27, 2006
[43]Williams J et.al. "Systematic review of multifaceted interventions to improve depression care." General Hospital Psychiatry, 29 (2007) 91–116.
[44]Archer, Janine, et al. "Collaborative care for depression and anxiety problems." *The Cochrane Library* (2012).
[45]Katon WJ. "Collaborative Depression Care Models: From Development to Dissemination." American Journal of Preventive Medicine, 012;42(5):550–552.

Initiative Title	1. Integration of Behavioral Health and Primary Care

their research that the integration of mental health/substance abuse and primary care has achieved positive outcomes.[46] Furthermore, the Center for Integrated Health Solutions sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) include evidence-based practices in integrated primary care and behavioral health services to better address the needs of individuals with mental health and substance use concerns and that have demonstrated positive impacts, including on health care costs, for integration in many environments.[47]

Substance use and addiction are significant challenges for society and for public payer populations. Unidentified mental health and substance use treatment needs contribute to higher costs and poor health outcomes. Alcohol and substance use disorders are frequently co-occurring with other mental health and physical health conditions. A recent publication released by the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that in Massachusetts, only 53.8 % of adults with any mental illness (approximately 522,000 individuals per year in 2010-2014) actually received mental health treatment within the year prior to being surveyed, and only 7.5% of those with alcohol abuse or dependence received treatment in the prior year.[48] Furthermore, the national problem of death related to opioid use disorder and overdose is increasing year by year in Massachusetts.[49].

Utilization of necessary treatments has been shown to have a return on investment with impacts in health care and other public programs. According to the National Institute on Drug Abuse, for every dollar spent on addiction treatment programs there is an estimated $4 to $7 reduction in the criminal-justice-related costs and a $12 reduction in costs if health-care costs are included.[50] Evidence-based approaches are available to support population health strategies and address such conditions in primary care. The United States Preventive Services Task Force has given a rating of 'B' to alcohol misuse screening for adults, indicating strong recommendation of this service and high certainty of moderate to substantial net benefit.[51]

Over the past few years, efforts have been initiated to build a system for screening for high risk alcohol use and substance use disorder in primary care, and interventions as appropriate. With this initiative, future work may entail: a) increasing the percentage of the primary care patient population who receives these screenings; b) improving the quality of the interventions provided for those who screen 'positive'; c) expanding the range of treatment offerings provided in primary care, and d) optimizing primary-care-based pain management offerings including alternatives to chronic opioid therapy, as providers increasingly optimize the use of opioid-based regimens for patient that require this modality of treatment.

According to the American Academy of Pediatrics, behavioral and emotional problems during childhood are common, often undetected, and frequently untreated despite primary role in

[46]Agency for Healthcare Research and Quality website: http://www.ahrq.gov/research/findings/evidence-based-reports/mhsapctp.html
Integration of Mental Health/Substance Abuse and Primary Care, Structured Abstract. October 2008. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/tp/mhsapctp.htm
[47]Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Integrated Health Solutions research: http://www.integration.samhsa.gov/about-us/CIHS_NACHC_BH_Integration_September_19_2013_FINAL.pdf
[48]Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Massachusetts, 2015*. HHS Publication No. SMA-16-BARO-2015-MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
[49]http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf
[50]https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment
[51]http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care

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significant morbidity and mortality. According to current estimates, approximately 11% to 20% of children in the United States have a behavioral or emotional disorder at any given time.[52] [53] Estimated prevalence rates are similar in young 2- to 5-year-old children. Developmental and behavioral health disorders are now the top 5 chronic pediatric conditions causing functional impairment.[54] [55] [56] The American Academy of Pediatrics (AAP) urges clinicians to screen for developmental and behavioral problems at all health supervision visits using quality tools.[57] Indeed, population health starts with population screening.

Children and adolescents comprise a significant portion of the patient panel or public providers and Medicaid populations. Primary care providers caring for children and adolescents in the Commonwealth are required to use routine screening for developmental, behavioral and mental health disorders and the evidence and practice standards around screening in this population have evolved significantly in recent years. As such, there is an opportunity to update routine, comprehensive screening for behavioral and developmental conditions in the child and adolescent population, using validated screening instruments such as the Survey of Wellbeing of Young Children (SWYC) for developmental screening, the Pediatric Symptom Checklist (PSC) and PHQ-9 for depression, and CRAFFT (mnemonic acronym of first letters of key words in the six screening questions) short clinical assessment tool for substance related risks and problems, and to develop the associated registries and analyze utilization patterns and service gaps. In addition, the identification and deployment of key, evidence-based interventions intended to have a beneficial impact on the behavioral and developmental outcomes in the patient population of children and adolescents. In conjunction with implementation of the CRAFFT instrument for alcohol and substance use among adolescents, primary care providers will optimize follow-up workflows according to the evidence base for SBIRT among adolescents.[58]

Goals/Objectives

Goals include leveraging the foundation for primary care-behavioral health (BH) integration to advance integrated approach for adults and pediatrics to improve key intermediate and outcomes measures for high-prevalence BH conditions (e.g. depression, anxiety, alcohol and substance use disorder (SUD)). Additional goals include optimizing primary care based treatment for pain and opioid addiction. Furthermore, aims include cardiovascular, metabolic, and diabetes monitoring for patients on antipsychotic medications, and cross-disciplinary care coordination improvements for mental illness.

Specific objectives include:

- Increase screening and follow-up for high prevalence behavioral health conditions

[52]Costello EJ, Mustillo S, Erkanli A, Keeler G, Angold A. Prevalence and development of psychiatric disorders in childhood and adolescence. *Arch Gen Psychiatry*. 2003;60(8):837–844

[53]*Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

[54]Slomski**,** A. Chronic Mental Health Issues in Children Now Loom Larger Than Physical Problems *JAMA. 2012;308(3):223-225.*

[55]Halfon N, Houtrow A, Larson K, Newacheck PW. The changing landscape of disability in childhood. *Future Child.* 2012;22(1):13–42

[56]Promoting Optimal Development: Screening for Behavioral and Emotional Problems. Carol Weitzman, Lynn Wegner, the Section on Developmental and Behavioral Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, Council on Early Childhood and Society for Develop Mental and Behavioral Pediatrics. *Pediatrics* Feb 2015, 135 (2) 384-395.

[57]Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, Medical Home Initiatives for Children With Special Needs Project Advisory Committee *Pediatrics* Jul 2006, 118 (1) 405-420.

[58]Massachusetts Department of Public Health Bureau of Substance Abuse Services. Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment Using the CRAFFT Screening Tool. Boston, MA. Massachusetts Department of Public Health, 2009.

Initiative Title	1. Integration of Behavioral Health and Primary Care

(depression, anxiety, SUD) among adults, adolescents and pediatric patients.

- Improve depression response and remission.
- Improve rates of screening, intervention, engagement for drug and alcohol use disorder
- Improve training and competency among relevant providers.
- Improve provider satisfaction and confidence in diagnosing and managing key conditions.
- Improve management of opioid prescribing, as a means for preventing opioid dependence and promoting alternative treatments for chronic pain management.
- Improve management and expand options for treatment of pain.
- Improved collaboration related to the care continuum for mental health and substance use, including cardiovascular risk optimization for persons on antipsychotic medications
- Improve transitions in care.
- Ongoing evaluation of evidence-base supporting the expansion of treatment options for behavioral health and pain management in primary care.

Core Components

This initiative, if undertaken, may include the following components:

1. Improve screening, treatment, and outcomes for depression and anxiety

- Build upon overall adult wellbeing screening using validated instruments including the PHQ-9, GAD-7, NIAAA-1, NIDA-1, AUDIT and DAST
- Evaluate local and national protocols for suicide risk assessment and management; design and implement appropriate local practices.
- Improve referral management across the care continuum according to the Stepped Model of Care, including ongoing assessment of patient severity and type seen by integrated behavioral health staff and those referred to specialty mental health. Work to formalize tools to manage capacity and prioritization of patients as appropriate.
- Promote patient engagement in care by expanding access to initiatives such as mindfulness-based stress reduction groups, self-help mobile technology, and peer-support groups.
- Monitor and continuously improve primary care and behavioral health staff confidence in managing appropriate behavioral health conditions, satisfaction and skills with Primary Care Behavioral Health Integration.
- Optimize care for moderate and severe mood disorder patients in primary care (i.e. those who require specialty mental health care for conditions like bi-polar and schizoaffective disorders, but do not connect there)
- Improve rates of screening/follow-up/improvement /remission in depression/anxiety

2. Optimize primary care screening, diagnosis, and treatment for substance use disorders (SUD)

- Enhance offerings for patients with substance use disorders in primary care (e.g. medication treatment for severe alcohol use disorder). Medication-assisted treatment (MAT) in combination with counseling and behavioral therapies can provide a whole-person approach to treatment of substance use disorders.
    - Expand offerings in groups in primary care setting (peer support or staff-facilitated)
    - Enhanced training for primary care providers
    - Expand use of medication-assisted treatment (MAT) for opioid use disorders in primary care, including buprenorphine and naltrexone, which are medications currently approved by the Food and Drug Administration for the treatment of opioid dependence through medication-assisted treatment. Naltrexone may also be used in the treatment of alcohol use disorders.[59]

[59] http://www.samhsa.gov/medication-assisted-treatment

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- Conduct ongoing program evaluation and adaptation of protocols for Screening, Brief Intervention and Referral to Treatment (SBIRT) for treatment of less-severe disorders in primary care
- Improve communication and shared decision-making among staff at points of transition in care, including inpatient/outpatient.
- Develop peer support programming for SUD.

3. Develop programming for chronic pain management in primary care

- Explore alternatives to chronic opioid therapy for pain management as warranted
- Evaluate evidence base, payor coverage, landscape of local services, feasibility, and patient needs for chronic pain management services (including psychotherapy, mindfulness, acupuncture, biofeedback, and tai chi / yoga)
- Build and expand group- and individual-based Cognitive Behavioral Therapy and mindfulness treatment strategies, based on above-mentioned evaluation (including through training of integrated mental health staff)
- Develop expedited referral pathways to physical therapy to support effective chronic pain management.
- Establish a system-wide provider-to-provider peer committee for review of challenging cases
- Create a registry for chronic opioid and other high-risk prescriptions and develop a system for reviewing and optimizing care
- Ensure screening and monitoring of chronic pain co-morbidities.

4. Screen and follow-up for high prevalence BH conditions for children and adolescents

- Ensure routine behavioral health screening for the child and adolescent population using validated screeners, such as the SWYC, PSC, and CRAFFT, that comply with Massachusetts legal requirements and support the most current clinical practice guidelines.
- Standardize screening for developmental and behavioral health conditions, including depression and substance use.
- Incorporate routine screening for post-partum depression into pediatric primary care visits.
- Develop and deploy registries to facilitate and track appropriate referrals and care.
- Introduce SBIRT for adolescents with or at risk for substance use disorders
- Assess and analyze gaps in services and care for other childhood behavioral and developmental conditions, and improve care as warranted.
- Improve referral management across the care continuum, including ongoing assessment of patient severity and type seen by integrated behavioral health staff and those referred to specialty mental health. Work to formalize tools to manage capacity and prioritization of patients as appropriate.

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).*										
Measure Slate 1		**1: Behavioral Health and Primary Care Integration**			**Achieve 2 of 4 Measures**	**Achieve 4 of 11 Measures**	**Achieve 5 of 11 Measures**	**Achieve 6 of 11 Measures**	**Achieve 7 of 11 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
1	Depression Response at 6 Months - Progress Towards Remission (across all core primary care sites)	NQF 1884	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	This target is based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved[60].
2	Depression Response at 12 Months - Progress Towards Remission (across all core primary care sites)	NQF 1885	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	This target is, based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved[61].
3	Primary Care Provider confidence in management of depression, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 90%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on evidence-based depression programming in primary care.
4	Primary Care Provider confidence in management of substance use disorders, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 70%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on newness of initiative introducing universal screening for substance use disorders in primary care and care management initiatives.

[60]Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

[61]Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

Baseline (B) / Outcome and Improvement (O)

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).*										
Measure Slate 1		**1: Behavioral Health and Primary Care Integration**			**Achieve 2 of 4 Measures**	**Achieve 4 of 11 Measures**	**Achieve 5 of 11 Measures**	**Achieve 6 of 11 Measures**	**Achieve 7 of 11 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
5	Screening and Brief Intervention for Alcohol Use for adults (across all core primary care sites)	NQF 2152	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target based on literature review of best practice performance levels.[62]
6	Screening and Brief Intervention for Drug Use for adults (across all core primary care sites)	NQF 2152, adapted to include substance use	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Same as above.
7	Patients on Chronic Opioid Therapy with a Controlled Substance Agreement (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target aligned to initiative to optimize opioid prescribing practice.
8	Patients on Chronic Opioid Therapy with urine drug screening (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target aligned to initiative to optimize opioid prescribing practice.
9	Patients with chronic pain who had functional assessment (across all core primary care sites)	NQF 0050, adapted to include all chronic pain conditions	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on newness of initiative, and literature indicating the value of functional assessment in patients with chronic pain[63].

[62]Bertholet N, Daeppen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of Alcohol Consumption by Brief Alcohol Intervention in Primary Care. Archives of Internal Medicine. 2005;165:986-995; Babor TF, Higgins-Biddle JC, Dauser D, Burleson JA, Zarkin GA, Bray J. Brief Interventions for At-Risk Drinking: Patient Outcomes and Cost-Effectiveness in Managed Care Organizations. Alcohol and Alcoholism. 2006;41(6):624-631.

[63]Institute for Clinical Systems Improvement, Assessment and Management of Chronic Pain 2013

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).*										
Measure Slate 1		**1: Behavioral Health and Primary Care Integration**			**Achieve 2 of 4 Measures**	**Achieve 4 of 11 Measures**	**Achieve 5 of 11 Measures**	**Achieve 6 of 11 Measures**	**Achieve 7 of 11 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
10	Screening and Brief Intervention for Alcohol and Drug Use for adolescents (across all core primary care sites)	NQF 2152, adapted to expand to new age range for adolescents	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Expansion of measure to the adolescent patient population. Improvement target based on newness of initiative for adolescent patients.
11	Maternal Depression Screening (across all core primary care sites)	NQF 1401	No external benchmark; hospital specific improvement target = 75%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on literature indicating value of maternal depression screening in conjunction pediatric visits to identify developmental risk factors.[64]

[64] *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions

Description/Rationale

Poor access to appropriate levels of care is a leading barrier to recovery for individuals with mental health and substance use (MHSU) conditions.[65] A comprehensive system for MHSU treatment – offering the right care to the right people at the right time – requires a wide range of services and delivery methods to meet the unique needs of individuals and families. Among others, these services include outpatient counseling (including primary care integration), intermediate care (intensive outpatient, partial hospital), residential and inpatient facilities, support for care transitions, and triage and emergency services. A robust continuum of care helps people access services when they need and want them, improving patient experience and the value of care (quality/cost).

A comprehensive treatment system allows individuals and their providers to develop an optimal care plan most likely to help them stay connected to their communities and succeed in daily activities, such as work or school. This, in turn, promotes greater engagement of family and community supports, ensuring that more resources are in place to support one's recovery. Individuals who do receive appropriate treatment early in their onset of illness may require less intensive care, experience fewer relapses,[66] and have better long-term health outcomes.[67] New programs offering integrated, person-centered MHSU care show promising results – greater use of community-based outpatient care, fewer hospital and emergency department (ED) admissions, better health outcomes[68-69] – and offer hope for developing more effective, sustainable care models.

However, left untreated, behavioral health disorders and co-occurring health conditions have harmful economic, interpersonal, and social impacts for the population as a whole.[70] This troubling impact is most evident in the 20 to 30 year gap in life expectancy among people living with serious mental illnesses (SMI).[71-72] This disparity is driven largely by higher rates of chronic disease (e.g. diabetes, hypertension, hyperlipidemia, and obesity), delayed diagnosis and treatment of medical conditions,[73] fragmented delivery of inadequate care, medication side effects,[74] and higher rates of modifiable risk factors[75] – all of which are more common among people with SMI and/or substance use disorders (SUD).

[65]American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf.
[66]Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. Managing Managed Care: Quality Improvement in Behavioral Health. Washington (DC): National Academies Press (US); 1997. Available from: http://www.ncbi.nlm.nih.gov/books/NBK233235/
[67]Kane JM, Robinson DG, Schooler NR, et al. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry AJP*. 2016;173(4):362-372. doi:10.1176/appi.ajp.2015.15050632.
[68]Krupski A, West II, Scharf DM, et al. Integrating Primary Care Into Community Mental Health Centers: Impact on Utilization and Costs of Health Care. *PS Psychiatric Services*. 2016. doi:10.1176/appi.ps.201500424.
[69]Gilmer TP, Henwood BF, Goode M, Sarkin AJ, Innes-Gomberg D. Implementation of Integrated Health Homes and Health Outcomes for Persons With Serious Mental Illness in Los Angeles County. *PS Psychiatric Services*. 2016. doi:10.1176/appi.ps.201500092.
[70]American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf.
[71]Druss BG, Zhao L, Esenwein SV, Morrato EH, Marcus SC. Understanding Excess Mortality in Persons With Mental Illness: 17-year Follow Up of a Nationally Representative US Survey. *Medical Care*. 2011;49(6):599-604. doi:10.1097/mlr.0b013e31820bf86e.
[72]Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*. 2006;3(2):1-14.
[73]Nasrallah HA, Meyer JM, Goff DC, et al. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: Data from the CATIE schizophrenia trial sample at baseline. *Schizophrenia Research*. 2006;86(1-3):15-22. doi:10.1016/j.schres.2006.06.026.
[74]Meyer JM, Davis VG, Goff DC, et al. Change in metabolic syndrome parameters with antipsychotic treatment in the CATIE Schizophrenia Trial: Prospective data from phase 1. *Schizophrenia Research*. 2008;101(1-3):273-286. doi:10.1016/j.schres.2007.12.487.
[75]SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions

Based on data from 2010 to 2014, on average 4.2 percent of Massachusetts residents are living with SMI and 10 percent have a SUD,[76] and the majority of state residents who need MHSU services do not receive any. Among adult residents with any mental illness, about 46 percent receive no care each year; for SUD, the figure is closer to 90 percent.[77] Even for those who do access care, not all treatment is appropriate or sufficient. Among adults who access mental health care, 30 percent still report unmet needs, and more than one-third of those treated in the state's public mental health system say it has not improved their functioning.[78]

Massachusetts' MHSU service gaps are due in part to shortages across the entire care continuum, from outpatient care to emergency services, inpatient beds, partial hospital programs, crisis stabilization units, detoxification, residential programs, and so on. This can result in sub-optimal wait times for outpatient therapy; extended hospitalizations due to lack of community-based services; and "boarding" in emergency departments (ED) as people await transfer to intermediate or acute care. These access issues can be more pronounced for MassHealth enrollees because many providers do not contract with Medicaid to serve its members. Massachusetts now faces an opioid use epidemic that has doubled the rate of overdose deaths from 2012 to 2015.[79] The problem and need for care is growing exponentially. Improving access to opioid treatment will require expanding capacity for Medication-Assisted Treatment (MAT) and providing more timely access to comprehensive evidence-based outpatient care for SUD.

A substantial portion of the public care system for individuals with the most disabling conditions extends beyond health care services to rehabilitative and support services, including housing, job counseling, literacy, and other programs. The coordination of these services requires collaborative and cooperative relationships among many agencies, service providers, and community organizations. Most of these services are not covered by private insurance and have not been developed by most private behavioral health care companies. Poor linkage and fractured funding impedes the ability to provide access to these services in a coordinated and integrated way.[80] One strategy that may be employed to address this barrier to care is formalization of agreements between healthcare providers and community-based providers who offer complementary services, and providing integrated population case management.

Along with improving access to MHSU treatment and reliable coordination among all service providers, a focus on health promotion is essential to impact health outcomes for this population. A national study estimated 85 percent of the life expectancy gap for people living with schizophrenia was attributable to "natural" causes, such as cardiovascular disease, cancers, pneumonia, diabetes, and so on.[81] Early screening and intervention for these medical conditions is essential to improving health outcomes. This is particularly true for patients taking antipsychotic medications that increase the risk for certain medical conditions, most notably metabolic syndrome.

[76]Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral Health Barometer: Massachusetts, 2015. HHS Publication No. SMA–16–Baro–2015–MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
[77]Massachusetts Department of Public Health. State Health Plan: Behavioral Health, Dec 2014. Available at: http://www.mass.gov/eohhs/docs/dph/health-planning/hpc/deliverable/behavioral-health-state-health-plan.pdf.
[78]Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*. 2006;3(2):1-14.
[79]Massachusetts Department of Public Health. Data Brief: Opioid-related Overdose Deaths Among Massachusetts Residents. May 2016. Available at: http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf.
[80]Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. Managing Managed Care: Quality Improvement in Behavioral Health. Washington (DC): National Academies Press (US); 1997. Available from: http://www.ncbi.nlm.nih.gov/books/NBK233235/
[81]Kane JM, Robinson DG, Schooler NR, et al. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry AJP*. 2016;173(4):362-372. doi:10.1176/appi.ajp.2015.15050632.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions

While these diseases can develop for numerous reasons, modifiable factors such as smoking, diet, physical activity, substance use, and social needs are key drivers. Promoting healthy living through education, skills training, and behavioral therapy will be necessary to improve population health. Certain interventions have improved health outcomes among people with psychotic disorders.[82-83]

Improving access to MHSU care overall requires attention to all aspects of the care continuum, from the professional care provided by trained clinicians to self care and social support. Expansion of services in those areas of the continuum that are most lacking, particularly in the intermediate levels of care that provide step-down and diversionary services, will assist with shifting care away from more intensive levels and providing patients with care at the appropriate level of service. Providers must also consider adopting treatment modalities that can improve efficiency and create capacity within existing services, such as shorter term evidence-based treatments and technology-based services, such as telemedicine consultations. Patient care teams may be redefined to include all who work with the patient, including clinicians, paraprofessionals, peer specialists/coaches, community-based providers, social support providers, etc., with the patient at the center of the team.

Goals/Objectives

The ultimate goal of this project is to achieve Triple Aim results – improved population health, better experience of care, and lower costs – and deliver higher-value care for people with serious mental illness and/or substance use disorders. To pursue the Triple Aim for this vulnerable population, the initiative aims to:

- Improve access (proximity and timeliness) to specialty MHSU care;
- Provide access to outpatient appointments within 7 days for patients discharged from inpatient psychiatry units and within 14 days for non-urgent MHSU referrals;
- Expand capacity for Medication-Assisted Treatment (MAT) for patients with SUD;
- Increase utilization of routine primary care and outpatient behavioral health services;
- Increase utilization of alternatives to traditional care, including tele-medicine consultations;
- Implement population health management initiatives that support integrated specialty behavioral health and physical health and improved patient outcomes;
- Improve the population's metabolic and cardiovascular health, both modifiable causes of premature death;
- Provide key screening and intervention activities for hospitalized patients;
- Improve the experience of care among people using specialty MHSU treatment services;
- Improve reliable communication and coordination among entire care teams across different levels of care, including primary care/medicine, behavioral health, medical specialty, and community-based service providers;
- Increase utilization of patient-informed plans of care;
- Reduce utilization of avoidable emergency department visits for adults with serious mental illness (target population of high acute care and/or emergency services utilization);
- Provide alternatives to higher cost services for this particularly high-cost Medicaid sub-population.[84]

Core Components

This initiative, if undertaken, may include the following components:

Health promotion and chronic disease management for populations with mental health and substance use (MHSU) disorders

- Identify evidence-based practices for development and implementation of metabolic and cardiovascular

[82]Bartels S, Desilets R. Health Promotion Programs for People with Serious Mental Illness (Prepared by the Dartmouth Health Promotion Research Team). Washington, DC. SAMHSA-HRSA Center for Integrated Health Solutions. Jan 2012.
[83]Bruins J, Jörg F, Bruggeman R, Slooff C, Corpeleijn E, Pijnenborg M. The Effects of Lifestyle Interventions on (Long-Term) Weight Management, Cardiometabolic Risk and Depressive Symptoms in People with Psychotic Disorders: A Meta-Analysis. *PLoS ONE*. 2014;9(12). doi:10.1371/journal.pone.0112276.
[84]Buck JA, Teich JL, Miller K. Use of mental health and substance abuse services among high-cost Medicaid enrollees. *Administration and Policy in Mental Health*. Sep 2003;31(1):3-14. PMID: 14650645.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions

screening protocols for people prescribed antipsychotic medications.
- Reliably screen for frequent co-morbid diseases that are key drivers of premature mortality: diabetes, hyperlipidemia, hypertension, obesity, etc.
- Offer health promotion activities, such as behavioral activation strategies for healthy eating, exercise, weight management.
- Develop processes to screen for social service needs and develop follow-up plan.
- Perform screening, brief intervention, and referral to treatment for tobacco cessation.
- Reliable medication management and reconciliation across multiple providers.
- Evaluation and screening for use of long-acting antipsychotics for people for serious mental illness.
- Screen patients hospitalized on inpatient psychiatry units for unhealthy alcohol use, and initiate treatment if indicated by providing brief intervention during the patient's hospitalization.
- Improve screening for medical conditions for patients on inpatient psychiatry units, with special attention to metabolic disorders and other medical conditions that may result from use of psychiatric medications.

Promote timely access to ambulatory MHSU treatment through greater variety and efficiency of services
- Distribute ambulatory MHSU services across service area based on panel size and local needs.
- Expand capacity for more evidence-based group treatment modalities, such as Problem Solving Therapy, Cognitive Behavioral Therapy, Internal Family Systems Therapy, neurobiofeedback, etc.
- Increase capacity for Medication-Assisted Treatment (MAT) for opioid use disorder among primary care and specialty BH providers, and improve access to MAT for patients with opioid use disorder.
- Partner (informally or contractually) with community-based providers of social and health services to reliably link patients to local supports.
- Greater adoption of tele-medicine technology for specialty mental health and addiction care in order to provide ready access to psychiatric consultation for medical service providers, other community-based providers, and/or direct consultation with patients.
- Enhance administrative systems to increase provider productivity by reducing unused appointments.
- Expand resources for case management and service coordination so all providers can work to the top of their license.
- Integrate paraprofessional service providers and peer specialists/recovery coaches into existing clinical teams.

Fill service gaps with greater variety and volume of intermediate and ambulatory MHSU care options
- Increase access and decrease wait times for patients in need of ambulatory services through development of assessment service.
- Improve access to Partial Hospital Programs (PHP) and Intensive Outpatient Programs (IOP) as part of the continuum to provide appropriate treatment and decrease utilization of high intensity inpatient care.
- Provide greater access to more immediate outpatient care through a transition or bridge service that serves as a holding place for patients transitioning through different levels of care, and/or patients who have a longer wait for an appointment with an outpatient provider.
- Explore ways to expand the continuum of care for substance use, which may include adding new capacity for inpatient detoxification and residential services through partnerships.
- Expand MHSU services in geographic areas with limited capacity.
- Improve access to timely post-discharge follow-up appointments for patients discharged from inpatient psychiatry via direct access to transition service, PHP and IOP.

Comprehensive coordination and management of care for populations
- Use risk stratification approaches to identify high-risk cases and/or frequent service users.
- Provide access to intensive case management for individuals identified as having greater risk/cost, such as patients with SMI who are high utilizers of acute care and ED services.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions

- Develop centralized preventative management capabilities for patients with opioid use disorder, which may include electronic registry functionality to facilitate management and coordination of care.
- Enhance patient outreach, either through the use of paraprofessionals or through partnership with community-based providers.
- Promote use of a central, integrated care plan in EMR shared by primary care and specialty providers.
- Implement an integrated approach to coordinate both the primary care and behavioral health needs for patient populations with SMI and SUD.
- Develop systems for providing comprehensive transitional care.
- Proactively monitor the quality of care and outcomes experienced by MHSU patients.
- Develop systems to facilitate transitions of care for patients discharged from inpatient psychiatry units through the development of a transition record with clinically important information that is given to the patient upon discharge.

Develop new EMR functionality and IT tools that enable coordinated management of population health

- Create patient registries in the electronic medical record (EMR) for discrete MHSU subpopulations to support delivery of best practice.
- Implement real-time electronic alerts for acute care admissions, discharges, or transfers.
- Build discharge follow-up reports (for ED and inpatient discharges) within EMR for target sub-populations.
- Educate and train providers to improve adoption of EMR functionality and other IT tools that support efficient documentation, care coordination, care transitions, and population management.

Promote greater patient engagement and self-management of their health needs

- Support patients in developing skills to effectively collaborate in care planning with their providers.
- Foster integrated approaches to chronic illness care.
- Address self-management challenges posed by behavioral health conditions.
- Educate patients about wellness recovery, maintenance, and crisis prevention/recovery planning using evidence-based practices.
- Integrate peer specialists/recovery coaches into discharge planning process and overall care delivery system.
- Support development of a robust peer recovery community and facilitate the process of connecting patients with MHSU conditions to these services.
- Develop and implement mechanisms to obtain ongoing patient and/or family satisfaction and feedback.
- Continue to assess patient, family, community, and provider needs to address ongoing gaps in the MHSU continuum of care.
- Evaluate ED and readmission utilization to identify candidates for specialized consultation in integrated care planning.
- Establish relationships with home health and/or other community-based providers to provide home-based education, monitoring, and self-care support for patients with significant barriers to care.

Reliably connect patients and families to necessary health resources and services in community

- Screen for social determinants of health conditions.
- Promote strategies for addressing social determinants of health in care planning.
- Develop collaborative referral relationships with appropriate community-based services.
- Evaluate progress in addressing social determinants of health in the population served.
- Collaborate with community-based partners to reduce the impact of social factors on health outcomes.
- Integrate community-based providers into care team meetings and discharge planning for hospitalized patients.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions

Develop a clinical workforce that successfully integrates medical and behavioral health care

- Provide training and education in strategies that address the unique self-management challenges posed by co-morbid physical and behavioral health conditions.
- Provide team-based consultation designed to improve clinical skills and treatment plans for individuals with such co-morbid conditions.
- Provide education in behavioral medicine for providers across the care delivery system.
- Align competency assessment with goals for improving clinical outcomes for population served.
- Provide training for the next generation of clinicians and providers that incorporates strategies for integrating medical and behavioral health care.

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 2		**2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions**			**Achieve 2 of 5 Measures**	**Achieve 5 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
1	Controlling high blood pressure for people with serious mental illness (for BH Home population)	NQF 2602	MA Medicaid (HEDIS) 2015 75th percentile: 65.09% (proxy benchmark from NQF 0018 for overall population)	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Using related benchmark for NQF 0018 for overall population.
2	Proportion of patients with identified opioid use disorder accessing medication-assisted treatment (MAT)	N/A	No external benchmark; Hospital target = 50.00%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target of 50% informed by experience with patient engagement in opioid treatment
3	Hospitalized patients screened within 72 hours of admission using a validated screening tool for unhealthy alcohol use (all public hospital system inpatient psychiatric discharges, age 18 and above)	NQF 1661 SUB-1	Joint Commission (2014) 75th percentile = 94.20%	Gap to Goal (10%) or attainment at target	**O** (CY2017)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	Using Joint Commission benchmark for SUB-1
4	Alcohol use brief intervention provided or offered (during public hospital system psychiatric hospitalization, age 18 and above)	NQF 1663 SUB-2	Joint Commission (2014) average = 48.20%	Gap to Goal (10%) or attainment at target	**B** (CY2017)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	New measure as of 1/1/16; using related benchmark for NQF 1663, which is a similar measure for all inpatient admissions
5	Follow-up after hospitalization for mental illness (for BH Home population) – 7 days for public hospital system hospitalizations	NQF 0576 (7-day)	National (HEDIS) Medicaid 2015 90th percentile = 63.85%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	

Baseline (B) / Outcome and Improvement (O)

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 2		**2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions**			**Achieve 2 of 5 Measures**	**Achieve 5 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
6	Transition record with specified elements received by discharged patients(for public hospital system psychiatric hospitalizations)	NQF 0647	MA IPFQR-HBIPS 2014 average = 83.27%	Gap to Goal (10%) or attainment at target	**B** (CY2017)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	New IPFQR measure to be implemented 1/1/17; using related measure for NQF 0557, which is HBIPS-6 for creation of the transition continuing care plan
7	Access to public hospital system ambulatory mental health care: Scheduled intakes within 14 days of referral (for in-network referrals)	N/A	National Medicaid (HEDIS) 2015 90th percentile = 48.10%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Using proxy benchmark derived from National Medicaid (HEDIS) Initiation and Engagement of AOD treatment (initiation component only), NQF 0004.
8	Increase number of synchronous and asynchronous tele-consultations with psychiatrists	N/A	No external benchmark; Hospital target = 400 per year	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target informed by roll-out and expansion of tele-psychiatry
9	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications (for active primary care patients and BH home patients)	NQF 1932	MA Medicaid (HEDIS) 2015 90th percentile = 86.96%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	
10	Cardiovascular health screening for people with Schizophrenia or Bipolar Disorder who are prescribed antipsychotic medications (for active primary care patients and BH home patients)	NQF 1927	No external benchmark; hospital-specific target = 75.00%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target informed by experience with screening measures for other populations

Baseline (B) / Outcome and Improvement (O)

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 2		**2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions**			**Achieve 2 of 5 Measures**	**Achieve 5 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
11	Diabetes Monitoring for People with Diabetes and Schizophrenia (for active primary care patients and BH home patients)	NQF 1934	National (HEDIS) Medicaid 2014 90th percentile = 76.67%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	
12	Screening for metabolic disorders (psychiatric inpatient discharges on routinely-scheduled antipsychotic screened during/before stay)	CMS IPFQR	No external benchmark	Improvement over CY 2017 baseline	**B** (CY2017)	**O** (CY2018) 2% increase over CY2017	**O** (CY2019) 5% increase over CY2017	**O** (CY2020) 8% increase over CY2017	**O** (CY2021) 10% increase over CY2017	No existing benchmark; CMSIPFQR measure to be implemented 1/1/17
13	Increase the percentage of BH Home target population patients who have a care plan (care plans may include CHA coordinated care plan and/or ACO behavioral health community partner care plan)	NCQA Medical Home	NCQA 2014 Medical Home Standard = 75.00%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 75% is 2014 NCQA Medical Home standard.

Initiative Title	3. Referral Management and Integrated Care Management
Description/Rationale	

Toward the goals of better health and optimal, more coordinated and cost-effective care, this suite of initiatives is aimed at increasing patient access to high-quality care, promote appropriate referrals and access (i.e. the right provider in the right setting) based on the complexity of the patient's needs. Providing integrated care across the continuum of care through effective referral management and care coordination is foundational to the accountable care model and alternative payment arrangements with quality, cost and health care utilization accountability. This is particularly important for Medicaid and other vulnerable patient populations that often face barriers to care and care fragmentation.

This initiative builds and supports systems to maintain a preferred, high value network and simultaneously provide highly coordinated and quality care. This initiative aims to accomplish this in four ways: focus on public hospital system access and effective operational improvements in primary care and specialties, encourage public hospital referrals and the use of care within the public hospital system and with clearly defined high value preferred provider networks enabled to coordinate care, build relationships with key community-based partners such as visiting nurse associations (VNAs), skilled nursing facilities (SNFs), and detoxification facilities, and leverage proven technology to improve access and convenience for the patient panel to specialty opinions and care. The Massachusetts Office of the Attorney General's report published in September, 2015 found wide variation in the prices health insurance companies pay providers for similar services, unexplained by differences in quality, complexity of services, or other common measures of consumer value. The report found that higher priced providers are drawing patient volume from lower priced providers, which increases costs as care is shifted from less costly community settings to higher relative price settings.[85] To address this, payers and employers in Massachusetts have embraced referral networks comprised of high value providers as an opportunity to address costs. Initial analysis of this strategy based on state experience within a Massachusetts state employees plan has shown up to a 36% reduction in expenditures for patient panels that switch to a narrow network insurance plan.[86]

Encouraging a preferred and narrow network requires multidisciplinary leadership, systems and collaboration in primary care, medical and surgical specialties, behavioral health and the emergency department. Providers and patients need to feel confident that the choice in care is patient-centered and high-quality. Integration and clinical teams will work to develop relationships and business arrangements to align the value-based interests of non-traditional caregivers often critical during care transitions such as VNAs and SNFs. This initiative will expand the capacity of the public hospital's medical, surgical and behavioral health specialists to coordinate and manage referrals internally, including redirected referrals from higher cost, lower-value external referrals. Toward this end, this initiative will focus on monitoring and improving the rate of referrals within the public hospital system and with in-network clinical affiliates, and measures of quality, productivity and access to specialists.

In addition, this initiative will refine emergency department (ED) and inpatient case management capabilities to offer alternative treatment modalities and community-based care to patients who do not need admission. This initiative will expand e-consults beyond tele-dermatology based on success and evidence from both the public hospital and other systems in order to increase access

[85]Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12, § 11N Report for Annual Public Hearing Under G.L. c. 6D, § 8

[86]Gruber J, & McKnight R. (2014). Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees." NBER working paper #20462.

Initiative Title	3. Referral Management and Integrated Care Management

to consultations with specialists, reduce cost and enable more capacity for face-to-face visits when appropriate.[87] This initiative may also focus on facilitating transportation to in-network care providers for patients who lack transportation by utilizing a non-medical transportation support service. Convenience and effectiveness also drives efforts to examine and take advantage of text-messaging in care management. Evidence for the potential of text messages providing improvements in disease prevention and management interventions have been observed for weight loss, smoking cessation, and diabetes management. These effects appeared to exist among adolescents and adults, among minority and non-minority populations, and across nationalities.[88]

Goals/Objectives

This initiative will use referral and outmigration processes to drive high value, coordinated care for patients and advance Accountable Care Organization (ACO), total cost of care strategies, and increased retention of appropriate care within the public hospital system.

- Improve patient care coordination, continuity of care, and referral to services within a high value, clinically integrated network with emphasis on the public hospital system, other community-based services, and with clinical affiliates.
- Increase access and efficiency of the public hospital system's clinical services by retaining services when appropriate.
- Reduce out-migration of inpatient and ED services for patient panel to non-public hospital facilities, where appropriate. Preliminary analysis of Medicaid inpatient stays and ED utilization outside the public hospital system confirms the opportunity to improve performance through care coordination within integrated community networks. Data reveals that a significant portion of inpatient care (up to 60%) and ED visits (up to 30%) across various payor cohorts occur outside of the system, frequently at higher-cost institutions, which add cost and care fragmentation.
- Support the delivery of care by the right provider, in the right care setting and at the right time by reducing care received outside of the public hospital system when clinically indicated and increasing access to specialty health care and other community-based services outside of the acute care setting.
- Promote alternate care modalities, as clinically appropriate, as options in lieu of avoidable emergency department and/or inpatient care.
- Launch innovations, such as e-consults, patient care communications/messaging, and patient transportation options to overcome barriers to access to ambulatory care and promote patient self-management of their health conditions.
- Encourage in-depth clinical collaborations and the use of defined provider partnerships, including VNAs, SNFs, and substance use treatment.
- Advance total cost of care strategies.

[87]Utilization, Benefits, and Impact of an e-Consultation Service Across Diverse Specialties and Primary care. Liddy et al. Telemedicine and e-Health 2013 Apr; 19(10):733-738

[88]Text Messaging as a Tool for Behavior Change in Disease Prevention and Management. Epidemiology Reviews 2010 Apr; 32(1) 56-59

Core Components

This initiative if undertaken, may include the following components:

1. Build on current on specialty care coordination within the public hospital system and advance up to three specialty access improvement initiatives along measurable dimensions for timeliness of appointments, access, quality, and reduction in out-of-network specialty care referrals.
2. Develop capabilities for referral systems for mental health and substance use disorder services within the public hospital system and a coordinated care network.
3. Encourage patients to receive care at the public hospital system for inpatient, ED, and specialty services or at high-value preferred partners when clinical conditions such as tertiary care are beyond the scope of the public hospital system.
    - Engage case management in the ED to organize home-based services tailored to the needs of the patient such as community-based integrated transition facilitators, visiting nurses, and/or home visits by nurse practitioners to ensure post-ED aftercare is in place. This builds on the ED committment to providing the highest and most needs-sensitive care possible for patient populations and fosters clinical partnerships with post-ED community-based providers.
    - Patient education by public hospital system primary care teams to reinforce the value and care coordination benefits of "staying within the public hospital system" campaign. This may include patient education materials and after visit summaries that emphasize referrals and follow-up appointments.
    - Use recent and ongoing surveys of public hospital system specialists and primary care teams to develop and communicate standardized specialty-specific key interventions prior to a referral which makes the specialty visit more productive and may prevent avoidable referrals or tests.
    - Review patterns of referrals by primary care region, referring provider, and specialty to determine opportunities to influence decisions to utilize the public hospital system whenever possible.
4. Leverage effective post-acute and community-based providers to address gaps in care or to increase care coordination.
    a. Define, develop and refine formal agreements with post-acute providers, such as VNAs, SNFs and detoxification facilities, with both programmatic support and skilled clinical personnel.
5. Develop transportation solutions (such as Uber / Lyft / taxi) for patients to ensure that they can make their scheduled medical appointments and to facilitate usage of the appropriate facilities and network of providers.
6. Execute newly designed mobile paramedic program which may deploy highly skilled paramedics to the home to assess and evaluate patients with the goal to match the patient's needs with the appropriate level of care, thereby allowing patients to remain in the community and avoid potentially preventable emergency and inpatient utilization when appropriate.
7. Develop tools and processes for active referrals to mental health and addictions providers
8. Further expand the electronic platform for consultations (e-consults) to maximize specialty access and minimize patient inconvenience and cost.
9. Establish patient communication tools to enhance care coordination such as enhanced

use of the patient portal platform of electronic medical record (EMR) as well as texting programs for care management, care coordination and appointment reminders.

10. Expand preferred provider relationships to include clinical services not provided at the public hospital system and include these in the EMR Referral Guidance directory in order to maximize quality and clinical connectivity.
11. Engage an appropriate leadership team including multidisciplinary stakeholders on referral management work.
12. Refine existing patient attribution and outreach efforts to identify and schedule appointments with new or unengaged patients.
13. Restructure primary care triaging processes to address patients' immediate and urgent care needs.
14. Continue to develop/refine reporting tools to support referral management work.
15. Develop, adopt, and monitor referral management policies and procedures that align with defined ACO strategies (such as escalation for ED transfers, etc).
16. Identify practice region and specialty-specific challenges to adopting referral management policies and tailor support to these issues beyond system-wide infrastructure.
17. Support staff and providers in referral management efforts to achieve quality outcomes when they are linked to access.

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 3		**3: Referral Management and Integrated Care Management**			**Achieve 2 of 5 Measures**	**Achieve 4 of 10 Measures**	**Achieve 7 of 13 Measures**	**Achieve 6 of 10 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
1	Overall Reduce proportion of Emergency Department Outmigration to Non-Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service)[89]	No external benchmark; hospital specific improvement target = 25%	Gap to Goal (10%) or attainment at target	**B** (CY2016)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	Target of 25% informed by out-migration improvement opportunity
2	Overall Reduce proportion of Inpatient Outmigration to – Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service)[5]	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	**B** (CY2016)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	Target of 50% informed by out-migration improvement opportunity
3	Overall Reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient)	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**O** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**O** (4/1/20 – 3/31/21)	**O** (4/1/21 - 3/31/22)	Target of 10% informed by out-of-network referral improvement opportunity
4	Selected Public Hospital Primary Care Practice(s) Initiative: Primary care reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient) referrals	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	**B** (4/1/17 - 3/31/18) Initial Practice (s)	**O** (4/1/18 - 3/31/19) Initial Practice (s)	**O** (4/1/19 - 3/31/20) Initial Practice (s) New Practice (s)	**O** (4/1/20 – 3/31/21) New Practice (s)	**O** (4/1/21 - 3/31/22) New Practice (s)	Target of 10% informed by out-of-network referral improvement opportunity

[89]Baseline and outcome measures are dependent on stable populations and relevant claims data. Should there be material changes in populations, payor contracts and access to claims data these measures will need to be re-based.

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 3		**3: Referral Management and Integrated Care Management**			**Achieve 2 of 5 Measures**	**Achieve 4 of 10 Measures**	**Achieve 7 of 13 Measures**	**Achieve 6 of 10 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
5	Reduce the proportion of out-of-network referrals for selected specialty care areas within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2nd Specialty Area) (SFYs 2021 – 2022 will be a 3rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 6%; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**B** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**B** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
6	Completed appointments per FTE or total number of completed appointments for selected specialties within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2nd Specialty Area) (SFYs 2021 – 2022 will be a 3rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 1300 appointments per FTE; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**B** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**B** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
7	Time to first appointment: percentage of referrals to scheduled within 60 days for selected specialties within	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology=50%;	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**B** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**B** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 3		**3: Referral Management and Integrated Care Management**			**Achieve 2 of 5 Measures**	**Achieve 4 of 10 Measures**	**Achieve 7 of 13 Measures**	**Achieve 6 of 10 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
	the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2nd Specialty Area) (SFYs 2021 – 2022 will be a 3rd Specialty Area)		Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty		Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	baseline data
8	Increase the # of E-Consults referrals made by public hospital primary care providers to defined public hospital specialists	Customized Measure	No external benchmark; hospital specific improvement over SFY 2018 baseline	Defined improvement over SFY 2018 baseline	**B** (4/1/17 - 3/31/18)	**O** 10% improvement over SFY18 baseline (4/1/18 - 3/31/19)	**O** 20% improvement over SFY18 baseline (4/1/19 - 3/31/20)	**O** 30% improvement over SFY18 baseline (4/1/20 - 3/31/21)	**O** 40% improvement over SFY18 baseline (4/1/21 - 3/31/22)	Increased access for consultative services to facilitate care and access for patients to critical specialties
9	Demonstrate improvement in colorectal cancer screening rates (for active pubic hospital primary care patients)	NQF 0034	National (HEDIS) Commercial 2014 90th percentile = 72%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 3		**3: Referral Management and Integrated Care Management**			**Achieve 2 of 5 Measures**	**Achieve 4 of 10 Measures**	**Achieve 7 of 13 Measures**	**Achieve 6 of 10 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
10	Improvement in inpatient discharge referral rate to in-network skilled nursing facilities for Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network SNFs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all SNFs[90]	No external benchmark; hospital specific improvement target= 75%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Appropriate post acute placement of patients based on clinical need
11	Improvement in inpatient discharge referral rate to in network Visiting Nurse Association (VNAs) Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network VNAs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all VNAs[91]	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Appropriate post acute community-based care for patients based on clinical need

[90] Any Visiting Nurses Association (VNA) with whom public hospital system has a signed preferred provider agreement. Preferred provider relationships are evaluated annually and are subject to change if VNAs are not in compliance with the terms of the agreement. Changes in preferred VNA relationships may require a rebasing of the measures.

[91] Any Skilled Nursing Facility (SNF) approved by the public hospital network development committee as being "in-network" at any point during the measurement year. The network development committee oversees the collaborative relationships in which the public hospital system participates. The committee abides by specific principles related to access, continuity of care, communication expectations and quality improvement. Changes to in-network SNF relationships may require a rebasing of the measures.

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 3		**3: Referral Management and Integrated Care Management**			**Achieve 2 of 5 Measures**	**Achieve 4 of 10 Measures**	**Achieve 7 of 13 Measures**	**Achieve 6 of 10 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
12	% of patient appointments at which the AVS was printed for the patient at the conclusion of their medical specialty appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	**B** (4/1/17 - 3/31/18)	**O** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**O** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types
13	% of patient appointments at which the AVS was printed for the patient at the conclusion of their surgical appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	**B** (4/1/17 - 3/31/18)	**O** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**O** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types

Initiative Title	4. Evidence-Based Practices for Medical Management of Chronic Conditions
Description/Rationale	

Evidence Based Medicine (EBM) is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.[92] The goal is to improve outcomes, quality, and cost by reducing the variation of care for key conditions and integrate EBM into the health care delivery system across the continuum. The concept of variation of care was outlined in the 2010 Dartmouth Institute's reflections on geographic variations[93]; however, a similar deviation from EBM and variations in care may also be observed *within* health care systems and practices, acknowledging natural differences between patients. Toward safer, higher-quality care, redesigned systems of care, including the use of information technology, can best support clinical and administrative processes to adopt EBM and improve patient outcomes.[94]

Efforts to change the culture of medical practice to adopt EBM include education on recommendations from peer-reviewed groups such as Cochrane or the U.S. Preventive Services Task Force (USPTF), integration of EBM into clinical activities via clinical decision support (CDS), and the application of population health data to prioritize and subsequently develop systems to close quality gaps.[95]

Building on systematic efforts in medical management such as those sponsored by the Institute for Health Care Improvement learning collaborative known as "Pursuing Perfection"[96] and foundational transformation work under the current Waiver, planned future initiatives build on capabilities to develop and use population health databases, risk stratify patients, and help connect the most costly and vulnerable patients with complex care management, transitional facilitators, and palliative care services.

Evidence-based patient engagement strategies may include those such as motivational interviewing in chronic health conditions and for substance use disorders, electronic medical record clinical decision support for chronic conditions and prevention, expansion of nursing, pharmacist, and other care team member roles in chronic disease management, and mental health team integration within primary care. Initiatives may include refining tools, frameworks, analytics, and clinical workforce development in the use of evidence-based guidelines across the care continuum to care for specific populations of patients. A goal is to "hard wire" enhanced quality by utilizing evidence-based practices to support providers and patients in making informed decisions about treatments, medications, risks, costs, and benefits.[97]

[92]Sackett DL, Rosenberg WMC, Gray JAM et al. Evidence-based medicine: what it is and what it isn't. Br Med J 1996;312:71-72
[93]Jonathan Skinner and Elliott S. Fisher "Reflections on Geographic Variations in U.S. Health Care,", The Dartmouth Institute for Health Policy & Clinical Practice, updated May 12
[94]Crossing the Qulity Chasm: A New Health System for the 21st Century Institute of Medicine 2001
[95]McCarthy, Mueller, Wrenn. Geisinger Health System: Achieving the Potential of System Integration through Innovation, Leadership, Measurement, and Incentives. The Commonwealth Fund, Case Study Organized Health Care Delivery System June 2009
[96]Pursuing Perfection: Raising the Bar for Healthcare Performance Robert Wood Johnson Foundation Results Report Grant ID: CPC Updated January 10, 2014
[97]Remarks by Carolyn Clancy, M.D., Director of the Agency for Healthcare Research and Quality (AHRQ) World Healthcare Innovation and Technology Congress, Washington, DC, November 1, 2006

Initiative Title	4. Evidence-Based Practices for Medical Management of Chronic Conditions

Goals/Objectives

A medical management program is one of the pillars of health care reorganization to function effectively as an Accountable Care Organization (ACO) to improve population health outcomes. Medical management programs aim to develop and implement evidence-based clinical guidelines for populations of patients with particular conditions to ensure the right care at the right time in the right context and produce optimal outcomes for quality, safety, cost, and experience. Efforts will focus on improving care and reducing cost for populations of patients with five conditions: chronic obstructive pulmonary disease; congestive heart failure; hypertension; diabetes; and pediatric asthma.
Specific objectives may include:

- Improve health indicators for primary care panel patients with selected chronic health conditions (which may include chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, diabetes, and pediatric asthma), including those with co-occurring mental health conditions and substance use disorders;
- Improve transitions in care and reduce avoidable hospital readmission for patients with targeted chronic health conditions;
- Foster advance care planning and use of palliative care services for patients with advanced stage illness related to the targeted chronic health conditions;
- Articulate institutional evidence-based guidelines for selected chronic health conditions for care across the continuum (self care, primary care, specialty care, emergency department and hospital care) that recognize the importance of attention to co-occurring mental health needs and the social determinants of health;
- Embed evidence-based guidelines into standard workflows and the electronic medical record;
- Train key staff and providers in population health management skills and improving multidisciplinary collaboration and team-based across the care continuum including thoughtful engagement of pharmacists, nurses, and other allied health professionals.
- Engage patients and families as design partners and in effective self management of their health condition(s) through multidisciplinary health education and coaching;
- Develop a registry that permits risk stratification and monitoring of adherence to care guidelines**;**
- Evaluate medical management programs for chronic conditions to determine successful management for decreases in the rate of hospitalization, re-hospitalization, emergency department (ED utilization), and total medical expense, based on the availability of claims data for payer populations;
- Adhere to evidence-based guidelines in selected targeted conditions (COPD, CHF, hypertension, and/or diabetes) that include adherence to nationally validated measures for clinical care processes and treatments; and
- Advance team-based care within a patient centered medical home model with a distinctive approach to medical management that recognizes the importance of integrated mental health care and attention to the social determinants of health.

Core Components

This initiative, if undertaken, may include the following components:
We plan to develop and implement medical management programs for targeted conditions in a staggered fashion over a 5-year period.

1. Essential elements for evidence-based disease management program (s), based on a review of the literature and from experience may include the following:
    - Engage an appropriate leadership team including multidisciplinary clinical stakeholders

Initiative Title	4. Evidence-Based Practices for Medical Management of Chronic Conditions

as well as patients and families;
- Identify key evidence-based practices from review of literature;
    - Build an understanding of the population of patients with the target condition through review of both quantitative and qualitative data;
    - Design strategies for embedding best practices into clinical workflows across the care continuum and build appropriate decision support strategies within the electronic medical record integrating innovative technology platforms whenever possible;
    - Develop materials and forums for enhancing patient and family understanding of the condition and capacity for self care, including the use of care planning with patients and families for selected conditions;
- Develop and use a registry database for risk stratification, for use in identifying and closing gaps in care, and for use in monitoring adherence to best practices;
- Support staff and providers to learn and use new skills in population health management, in multidisciplinary team-based care and collaboration, and in care-giving relationships with patients that enable self care through coaching and goal setting;
    - Build referral pathways to special programs for high risk patients such as complex care management, house calls for frail homebound patients, elder services, palliative care, and emerging partnerships with home care services, skilled nursing facilities, and other community-based partnerships.

2. Improve transitions in care for patients with chronic health conditions with a focus on reducing 30 day hospital readmission through timely follow up phone calls, clinic visits, and home visits after inpatient hospitalization and emergency department visits.
3. Continue to cultivate institutional improvement work in chronic disease management in primary care and through patient-centered medical homes in primary care and expand population health management tools and team-based care into medical specialty clinics.
4. Adopt a holistic approach to chronic disease management that includes attention to mental health and substance abuse, with expanded screening and treatment for depression and appropriate referral to special programs such as the behavioral health home, integrated mental health providers within primary care, and multi-level substance abuse treatment supports, to address the high burden of co-morbid mental health and substance abuse with the target population(s).
5. Evaluate medical management programs for chronic conditions to determine successful management for decreases in the rate of hospitalization, re-hospitalization, emergency department (ED utilization), and total medical expense, based on the availability of claims data for payer populations.
6. Improve end of life care for patients with chronic conditions including more frequent use of advanced directives and referral to specialized palliative care services.

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).*										
Measure Slate 4		**4: Evidence-Based Practices for Medical Management of Chronic Conditions**			**Achieve 2 of 3 Measures**	**Achieve 4 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
	Chronic Obstructive Pulmonary Disease (COPD)									
1	The percentage of active primary care patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	NQF 0577	2015 90th percentile National Medicaid = 47.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid.
2	Percentage of active primary care patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 60% and have symptoms who were prescribed an inhaled bronchodilator.	NQF 102	2015 90th percentile National Medicaid= 90.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid.
3	Improve the percentage of patients with COPD who received patient education for COPD by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 85% reflects best practice adoption of the required workflows.
	Congestive Heart Failure (CHF)									
4	Improve the percentage of patients with CHF who received patient education for CHF by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 85% reflects best practice adoption of the required workflows.
	Diabetes									

Baseline (B) / Outcome and Improvement (O)

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).*										
Measure Slate 4		**4: Evidence-Based Practices for Medical Management of Chronic Conditions**			**Achieve 2 of 3 Measures**	**Achieve 4 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
5	Diabetes: HbA1c Control- % of active primary care patients ages 18 to 75 with diabetes whose most recent HbA1c control is <8.0%	NQF 0575	2015 90th percentile National Medicaid: 59.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid
6	Comprehensive Diabetes Care: Eye Exam (retinal) performed (for active primary care patients)	NQF 0055	2015 90th percentile National Medicaid: 68.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid
7	Improve the proportion of active primary care patients 18-75 years of age with diabetes with poorly controlled Hemoglobin HbA1C (most recent >=8.0%) who have a care plan	NCQA	No external benchmark; hospital specific improvement Target = 75%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 75% is NCQA 2014 Medical Home Standard.
8	Percentage of high risk diabetic primary care patients receiving enhanced diabetes management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure (denominator linked to NQF 0575)	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	**B**	**O**	**O**	**O**	**O**	Target reflects roll-out implementation and capacity for new workflows.
	Hypertension (HTN)									

Baseline (B) / Outcome and Improvement (O)

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).*										
Measure Slate 4		**4: Evidence-Based Practices for Medical Management of Chronic Conditions**			**Achieve 2 of 3 Measures**	**Achieve 4 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
9	Percentage of high risk hypertensive primary care patients receiving enhanced hypertension management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	**B**	**O**	**O**	**O**	**O**	Target reflects roll-out implementation and capacity for new workflows.
	Composite Measures									
10	Hospitalization Follow-up: The percentage of discharges for patients 18 years of age and older (with any of the following conditions Diabetes, Hypertension COPD, and/or CHF) who were discharged to home from public hospital's medical/surgical inpatient services and who had an outpatient visit within 7 days or contact within 2 days with a care team member documented in EMR.	Customized Measure	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve follow up after hospitalization for chronic health conditions

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).*										
Measure Slate 4		**4: Evidence-Based Practices for Medical Management of Chronic Conditions**			**Achieve 2 of 3 Measures**	**Achieve 4 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
11	% of active primary care patients 3 years and older with the following conditions: Diabetes, Pediatric Asthma, Hypertension, COPD, and CHF, for whom a public hospital follow-up contact or visit is completed within seven calendar days post ED discharge	Customized Measure	No external benchmark; hospital specific improvement target =50%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve follow up after ED visits for chronic health conditions
12	Screening for Depression in active primary care patients 18 years and older with Diabetes, HTN, CHF, and/or COPD	Approximate Match- NQF 0418 (Adjusted for Chronic Conditions at high risk)	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve depression screening for patients with chronic health conditions at high risk..
13	Co-morbid Conditions: Depression Follow-Up in active primary care patients with Diabetes, HTN, CHF, and/or COPD	Customized Measure	No external benchmark; hospital specific improvement target = 60%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve follow up for depression care for patients with chronic health conditions.

Baseline (B) / Outcome and Improvement (O)

Initiative Title	5. Community Empowered Population Health Initiative (Not Selected)

Description/Rationale

The Community Empowered Population Health Initiative builds and supports systems to address social determinants of health (SDH) and to address health disparities in patients with chronic conditions. This may be accomplished by implementing a screening and referral system for SDH, leveraging close ties with social service agencies, strengthening communities through collaboration with community and governmental agencies, and developing systems to improve chronic disease disparities.

The initiative is in recognition that social, behavioral and environmental factors account for 70% of what it takes to stay healthy while only 10% are attributable to direct medical care.[98] According to the Institute of Medicine, "an aligned system with a strong interface among public health, health care, and the community and non health sectors could produce better prevention and treatment outcomes for populations living with chronic illness."[99] Understanding the critical role of SDH, Healthy People 2020 highlights the importance of addressing the social determinants of health by including "Create social and physical environments that promote good health for all" as one of the four overarching goals for the decade.[100] Based on emerging evidence that addressing social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs, CMS has prioritized addressing SDH through the Accountable Health Communities model to address critical gaps between clinical care and community services.[101] The initiative also recognizes that health disparities have persisted for families and communities that have systematically experienced social and economic disadvantage and consequently face greater obstacles to optimal health. In appreciation of the importance of addressing health disparities, CMS has laid out work.[102,103]

Improving SDH and health disparities requires supporting communities in addressing their health needs, implementing screening and referral processes to social service agencies and building programs that identify and address health disparities. Community health improvement teams will work with community based organizations and governmental entities to support their efforts to improve community health. Clinical and community health improvement teams will work together to screen for SDH, refer patients with social needs to existing community services, and rescreen patients with social needs. Clinical and community health improvement teams will also work closely to identify populations with disproportionately higher rates of poor control of chronic health conditions, monitor and improve their care through ensuring they receive interventions such as education, outreach, and linkage to primary, specialty and other ambulatory care services.

Goals/Objectives

This initiative will build on community relationships and clinical care infrastructure to drive coordinated care across the medical to community continuum for panel patients and to improve the health of the communities we serve. The initiative aims to increase screening for social determinants of health, referral to social service agencies, and improvement in chronic disease care for patients with disproportionately lower rates of chronic disease control. Thus, this project is intended to support high quality patient-centered care by more completely addressing the full spectrum of needs for patients. This will in turn support efforts to improve the health of patients and communities.

Specific objectives include:

- Address social determinants of health through screening of defined patient panel population in order to

[98]McGinnis et al. The Case for More Active Policy Attention to Health Promotion. Health Affairs 2002: 21(2); 78-93
[99]IOM. Living well with chronic illness: a call for public health action. Washington, DC: The National Academies Press; 2012
[100]Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[101]Alley DE, et al. Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid. N Engl J Med 2016; 374:8-11.
[102]CMS. CMS Equity Plan for Improving Quality in Medicare. Sept 2015. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf
[103]CMS. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-health-disparities.html

Initiative Title	5. Community Empowered Population Health Initiative (Not Selected)

refer to responsive community and social services

- Increase use of social determinant screening tools and implement follow-up rescreening to assess social determinants of health and progress made through active referrals to community and social supports.
- Develop systems for referrals to community and social service organizations.
- Explore and initiate the use of innovative technologies for social determinant screening, referrals to community and social service resources, patient education and/or self-management support.
- Evaluate patient panel for health disparities as defined by disproportionately higher rates of poor control of chronic health conditions such as hypertension and diabetes control to select target population(s) for improvement initiatives.
- As measured by nationally validated measures for hypertension control and diabetes blood glucose control, monitor and improve health outcomes for targeted patient population(s) identified with disproportionately poorer control of their health condition.
- Develop and implement patient-centered education, outreach, and/or other interventions to support the effective management of chronic health conditions.
- Increase community-based, primary care, specialty care, complex care management and ambulatory care utilization for targeted patient populations with higher rates of poor control of their chronic health condition.
- Foster community partnerships that link community and public health with patient panel health promotion initiatives.

Core Components

This initiative, if undertaken, may include the following components:

1. Build systems to screen for social determinants of health across defined patient panel population segment(s), such as vulnerable patients with chronic conditions and/or behavioral health conditions, high risk/ high utilizers, clinical practice sites and/or others.
2. Identify social determinant(s) tools and develop and implement processes for screening and follow-up rescreening to assess social determinants of health and progress made through active referrals to community and social supports.
    - Implementation of innovative technology for initial and reassessment of social determinants of health for selected patient populations.
3. Develop and implement a referral system to community and social services and supports, which may include a range of services such as organizations addressing food insecurity, housing concerns, legal assistance. Establish relationships and referral systems with community services and social services organizations in order to refer patients for services, including those who have been screened for social determinants of health.
4. Based on an assessment of patient populations with disproportionately poorer outcomes on effective control of health conditions such as hypertension and diabetes, develop strategies which may include small tests of change and other population-specific initiatives, to improve how the health care delivery system in partnership with community and social services support patients in managing their health condition(s) and impacts the defined health outcome measure(s).
5. Implement and measure the proportion of patients in the defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control that receive patient education, outreach, or another intervention to support effective chronic health condition management.
6. Devise and implement activities to increase primary care and other ambulatory care utilization for the defined patient population(s) with health disparities as a usual source of care.
7. Build on relationships with communities to:
    - Provide communities with information about the health and well being of their community by providing a health assessment in targeted communities
    - Provide educational programs in the targeted communities on topics to prevent or address chronic medical conditions, such as hypertension/heart health, diabetes, chronic obstructive pulmonary disease, asthma, and/or mental health and substance use.

Initiative Title	5. Community Empowered Population Health Initiative (Not Selected)

- Foster community and clinically-linked population efforts through ongoing collaborations with community, public health and social services organizations to discuss common health priorities, the needs of their communities and to work together on responsive efforts.
  - Work with community, public health and social services organizations to support efforts to address healthy living, physical activity, nutrition and mental illness/substance abuse
- Incorporates social service partners into care planning, coordination and case review efforts to facilitate resolution of identified social determinants for specific regionally-based patient populations.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) *(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).*										
Measure Slate 5		**5: Community Empowered Population Health Initiative**			**Baseline**	**Achieve 3 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 6 of 9 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
1	**Social Determinant Screenings:** Utilizing implemented social determinant(s) screening tool, increase percentage of defined patient panel population segment(s) (such as patients with chronic conditions and/or behavioral health conditions, high risk/high utilizers, specific primary or specialty practices) within the ACO/public payor population) screened for selected Social Determinants	Customized Measure	No external benchmark; hospital specific improvement target =70%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is based on population screening measures for this new initiative.
2	**Referrals to Community and Social Services:** The percentage of defined patient panel screened for social determinant(s) (in measure 1 above) with referrals to community and social services and supports	Customized Measure	No external benchmark; hospital specific improvement target =60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is informed by referrals to community and social services.
3	**Expansion of Social Determinant Screening to Additional Patient Cohorts:** Expand patient panel subpopulations or practice sites whose patients receive social determinant screening	Customized Measure	No external benchmark; hospital specific target = Add at least 1 additional patient subpopulation or practice site per year	Defined Increase Per Year	B	O	O	O	O	Target based on phased implementation of new social determinants initiative.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) *(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).*										
Measure Slate 5		**5: Community Empowered Population Health Initiative**			**Baseline**	**Achieve 3 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 6 of 9 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
4	**Follow-up Social Determinant Screening:** Percentage of identified & active patient panel populations with follow-up social determinant(s) rescreening for appropriate determinants	Customized Measure	No external benchmark; hospital specific improvement Target= 50%	Gap to Goal (10%) or attainment at target		B	O	O	O	Rescreening rates to begin in year two to measure presence or resolution of social determinants
5	**Reducing Health Disparities for Hypertension:** Controlling High Blood Pressure Measure (2015 HEDIS Definition) for defined patient panel population(s) with disproportionately poorer outcomes for good control of hypertension	NQF 0018 (for hospital-defined patient panel population(s) with health disparities	MA Medicaid (HEDIS) 2014 90th percentile = 85.67%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.
6	**Reducing Health Disparities for Hypertension Control in Patients with Diabetes:** Comprehensive Diabetes Care: Blood Pressure Control (<140/90) for defined patient panel population(s) with diabetes and disproportionately poorer outcomes for good control of hypertension	NQF 0061 (for hospital-defined patient panel population(s) with health disparities	MA Medicaid (HEDIS) 2014 90th percentile = 82.74%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) *(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).*										
Measure Slate 5		**5: Community Empowered Population Health Initiative**			**Baseline**	**Achieve 3 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 6 of 9 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
7	**Comprehensive Diabetes Care:** A1c Poor Control or A1c Good Control for defined patient panel population(s) with disproportionately poorer outcomes for diabetes blood glucose control	NQF 0059 or NQF 0575 (one of the two measures above will be selected and confirmed in the baseline year based on hospital evaluation of health disparities. (for hospital-defined patient panel population(s) with health disparities	NQF 0059 MA Medicaid (HEDIS) 2014 90th percentile = 18.57% or NQF 0575 MA Medicaid (HEDIS) 2014 90th percentile = 59.37%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.
8	**Composite Diabetes & Hypertension Patient Education, outreach or Intervention:** Proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above that received patient education, outreach, or another intervention to support chronic health condition management	Customized Measure (for hospital-defined patient panel population(s) with health disparities	No external benchmark; hospital specific improvement target = 60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve patient education, outreach, and/or interventions for patients with disproportionately poorer health outcomes.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) *(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).*										
Measure Slate 5		**5: Community Empowered Population Health Initiative**			**Baseline**	**Achieve 3 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 6 of 9 Measures**	
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
9	**Primary Care and Ambulatory Care Utilization Among Panel Population(s) with Health Disparities:** Increase the proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above who had at least one community health, primary care and/or other ambulatory care visit during the measurement period	Customized Measure (for hospital-defined patient panel population(s) with health disparities	No external benchmark; Improvement over SFY 2018 baseline by defined % point(s)	Improvement compared to SFY 2018 baseline.	B	O Improve by at least 1% point above the SFY 2018	O Improve by at least 2% point above the SFY 2018	O Improve by at least 3% points above the SFY 2018	O Improve by at least 4% points above the SFY 2018	Target derived to improve utilization of primary care and ambulatory care for patients with disproportionately poorer health outcomes.

Measure Slate 6	Population-Wide Community and Public Health Indicators	Source	Geography	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022
1	Age-adjusted rate* per 100,000 for premature death (below age 75), *by race and ethnicity, as available*	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
2	Age-adjusted rate* per 100,000 for hospital discharges for primary care manageable conditions: asthma - *by age, race and ethnicity as available*	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
3	Age-adjusted rate* per 100,000 for suicide mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
4	Age-adjusted rate* per 100,000 for Hepatitis C incidence	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
5	Percentage of children fully immunized at kindergarten entry	Immunization Program, Massachusetts Department of Public Health and Massachusetts Department of Elementary and Secondary Education	Cambridge, Somerville, Everett, Malden, Statewide	R	R	R	R	R
6	Percent of adolescents reporting specific risk behaviors (as available), from the Youth Risk Behavior Survey (YRBS)- high school and middle school surveys	Youth Risk Behavior Survey (YRBS) (Bi-Annual)	Cambridge, Somerville, Everett, Malden, (as available by community) Statewide	R	R	R	R	R
7	Age-adjusted rate* per 100,000 for Opioid poisoning mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
8	Ranking top cause of 1) hospitalizations and 2) Emergency Department visits, by city: Age-adjusted rate* per 100,000 for hospitalizations (by individual cause) Age-adjusted rate* per 100,000 for Emergency Department visits (by individual cause).	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
9	Age-specific rate* per 100,000 for 1) Emergency Department -visits and 2) mortality related to falls among those age 65 years and over by city.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

Measure Slate 6	**Population-Wide Community and Public Health Indicators**	**Source**	**Geography**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022
10	Age-adjusted rate* per 100,000 for Emergency Department visits related to alcohol or substance use.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
11	Age-adjusted rate* per 100,000 for Emergency Department visits related to Opioid poisoning.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
12	Age-adjusted rate* per 100,000 for hospitalizations related to Hypertension.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
13	Age-adjusted rate* per 100,000 for 1) hospitalizations and 2) Emergency Department visits related to Renal Failure or Renal Disorder.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

**Age-adjusted and age-specific rates are expressed per 100,000 persons.*

^ *Measures are reported using the most recent available data from public sources.*

Appendix: Measure Slates 1-6

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).*										
Measure Slate 1		**1: Behavioral Health and Primary Care Integration**			**Achieve 2 of 4 Measures**	**Achieve 4 of 11 Measures**	**Achieve 5 of 11 Measures**	**Achieve 6 of 11 Measures**	**Achieve 7 of 11 Measures**	**Baseline (B) Outcome (O) Reporting (R)**
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
1	Depression Response at 6 Months - Progress Towards Remission (across all core primary care sites)	NQF 1884	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	This target is based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved[104].
2	Depression Response at 12 Months - Progress Towards Remission (across all core primary care sites)	NQF 1885	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	This target is, based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved[105].
3	Primary Care Provider confidence in management of depression, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 90%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on evidence-based depression programming in primary care.

[104]Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

[105]Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

4	Primary Care Provider confidence in management of substance use disorders, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 70%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on newness of initiative introducing universal screening for substance use disorders in primary care and care management initiatives.
5	Screening and Brief Intervention for Alcohol Use for adults (across all core primary care sites)	NQF 2152	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target based on literature review of best practice performance levels.[106]
6	Screening and Brief Intervention for Drug Use for adults (across all core primary care sites)	NQF 2152, adapted to include substance use	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Same as above.
7	Patients on Chronic Opioid Therapy with a Controlled Substance Agreement (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target aligned to initiative to optimize opioid prescribing practice.
8	Patients on Chronic Opioid Therapy with urine drug screening (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target aligned to initiative to optimize opioid prescribing practice.
9	Patients with chronic pain who had functional assessment (across all core primary care sites)	NQF 0050, adapted to include all chronic pain conditions	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on newness of initiative, and literature indicating the value of functional assessment in patients with chronic pain[107].

[106]Bertholet N, Daeppen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of Alcohol Consumption by Brief Alcohol Intervention in Primary Care. Archives of Internal Medicine. 2005;165:986-995; Babor TF, Higgins-Biddle JC, Dauser D, Burleson JA, Zarkin GA, Bray J. Brief Interventions for At-Risk Drinking: Patient Outcomes and Cost-Effectiveness in Managed Care Organizations. Alcohol and Alcoholism. 2006;41(6):624-631.
[107]Institute for Clinical Systems Improvement, Assessment and Management of Chronic Pain 2013

10	Screening and Brief Intervention for Alcohol and Drug Use for adolescents (across all core primary care sites)	NQF 2152, adapted to expand to new age range for adolescents	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Expansion of measure to the adolescent patient population. Improvement target based on newness of initiative for adolescent patients.
11	Maternal Depression Screening (across all core primary care sites)	NQF 1401	No external benchmark; hospital specific improvement target = 75%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target based on literature indicating value of maternal depression screening in conjunction pediatric visits to identify developmental risk factors.[108]

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).*										
Measure Slate 2		**2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions**			**Achieve 2 of 5 Measures**	**Achieve 5 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	**Baseline (B) Outcome (O) Reporting (R)**
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
1	Controlling high blood pressure for people with serious mental illness (for BH Home population)	NQF 2602	MA Medicaid (HEDIS) 2015 75th percentile: 65.09% (proxy benchmark from NQF 0018 for overall population)	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Using related benchmark for NQF 0018 for overall population.
2	Proportion of patients with identified opioid use disorder accessing medication-assisted treatment (MAT)	N/A	No external benchmark; Hospital target = 50.00%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target of 50% informed by experience with patient engagement in opioid treatment

[108] *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

3	Hospitalized patients screened within 72 hours of admission using a validated screening tool for unhealthy alcohol use (all public hospital system inpatient psychiatric discharges, age 18 and above)	NQF 1661 SUB-1	Joint Commission (2014) 75th percentile = 94.20%	Gap to Goal (10%) or attainment at target	**O** (CY2017)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	Using Joint Commission benchmark for SUB-1
4	Alcohol use brief intervention provided or offered (during public hospital system psychiatric hospitalization, age 18 and above)	NQF 1663 SUB-2	Joint Commission (2014) average = 48.20%	Gap to Goal (10%) or attainment at target	**B** (CY2017)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	New measure as of 1/1/16; using related benchmark for NQF 1663, which is a similar measure for all inpatient admissions
5	Follow-up after hospitalization for mental illness (for BH Home population) – 7 days for public hospital system hospitalizations	NQF 0576 (7-day)	National (HEDIS) Medicaid 2015 90th percentile = 63.85%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	
6	Transition record with specified elements received by discharged patients(for public hospital system psychiatric hospitalizations)	NQF 0647	MA IPFQR-HBIPS 2014 average = 83.27%	Gap to Goal (10%) or attainment at target	**B** (CY2017)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	New IPFQR measure to be implemented 1/1/17; using related measure for NQF 0557, which is HBIPS-6 for creation of the transition continuing care plan
7	Access to public hospital system ambulatory mental health care: Scheduled intakes within 14 days of referral (for in-network referrals)	N/A	National Medicaid (HEDIS) 2015 90th percentile = 48.10%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Using proxy benchmark derived from National Medicaid (HEDIS) Initiation and Engagement of AOD treatment (initiation component only), NQF 0004.
8	Increase number of synchronous and asynchronous tele-consultations with psychiatrists	N/A	No external benchmark; Hospital target = 400 per year	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target informed by roll-out and expansion of tele-psychiatry

9	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications (for active primary care patients and BH home patients)	NQF 1932	MA Medicaid (HEDIS) 2015 90th percentile = 86.96%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	
10	Cardiovascular health screening for people with Schizophrenia or Bipolar Disorder who are prescribed antipsychotic medications (for active primary care patients and BH home patients)	NQF 1927	No external benchmark; hospital-specific target = 75.00%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target informed by experience with screening measures for other populations
11	Diabetes Monitoring for People with Diabetes and Schizophrenia (for active primary care patients and BH home patients)	NQF 1934	National (HEDIS) Medicaid 2014 90th percentile = 76.67%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	
12	Screening for metabolic disorders (psychiatric inpatient discharges on routinely-scheduled antipsychotic screened during/before stay)	CMS IPFQR	No external benchmark	Improvement over CY 2017 baseline	**B** (CY2017)	**O** (CY2018) 2% increase over CY2017	**O** (CY2019) 5% increase over CY2017	**O** (CY2020) 8% increase over CY2017	**O** (CY2021) 10% increase over CY2017	No existing benchmark; CMSIPFQR measure to be implemented 1/1/17
13	Increase the percentage of BH Home target population patients who have a care plan (care plans may include CHA coordinated care plan and/or ACO behavioral health community partner care plan)	NCQA Medical Home	NCQA 2014 Medical Home Standard = 75.00%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 75% is 2014 NCQA Medical Home standard.

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).*							
Measure Slate 3	**3: Referral Management and Integrated Care Management**	**Achieve 2 of 5 Measures**	**Achieve 4 of 10 Measures**	**Achieve 7 of 13 Measures**	**Achieve 6 of 10 Measures**	**Achieve 8 of 13 Measures**	**Baseline (B) Outcome (O) Reporting (R)**

#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Overall Reduce proportion of Emergency Department Outmigration to Non-Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service)[109]	No external benchmark; hospital specific improvement target = 25%	Gap to Goal (10%) or attainment at target	**B** (CY2016)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	Target of 25% informed by out-migration improvement opportunity
2	Overall Reduce proportion of Inpatient Outmigration to – Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service)[5]	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	**B** (CY2016)	**O** (CY2018)	**O** (CY2019)	**O** (CY2020)	**O** (CY2021)	Target of 50% informed by out-migration improvement opportunity
3	Overall Reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient)	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**O** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**O** (4/1/20 – 3/31/21)	**O** (4/1/21 - 3/31/22)	Target of 10% informed by out-of-network referral improvement opportunity
4	Selected Public Hospital Primary Care Practice(s) Initiative: Primary care reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient) referrals	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	**B** (4/1/17 - 3/31/18)	**O** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20) Initial Practice (s)	**O** (4/1/20 – 3/31/21)	**O** (4/1/21 - 3/31/22)	Target of 10% informed by out-of-network referral improvement opportunity
					Initial Practice (s)	Initial Practice (s)	New Practice (s)	New Practice (s)	New Practice (s)	

[109]Baseline and outcome measures are dependent on stable populations and relevant claims data. Should there be material changes in populations, payor contracts and access to claims data these measures will need to be re-based.

5	Reduce the proportion of out-of-network referrals for selected specialty care areas within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2nd Specialty Area) (SFYs 2021 – 2022 will be a 3rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 6%; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**B** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**B** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
6	Completed appointments per FTE or total number of completed appointments for selected specialties within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2nd Specialty Area) (SFYs 2021 – 2022 will be a 3rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 1300 appointments per FTE; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**B** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**B** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
7	Time to first appointment: percentage of referrals to scheduled within 60 days for selected specialties within	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology=50%;	Gap to Goal (10%) or attainment at target	**O** (4/1/17 - 3/31/18)	**B** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**B** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with

	the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2nd Specialty Area) (SFYs 2021 – 2022 will be a 3rd Specialty Area)		Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty		Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	baseline data
8	Increase the # of E-Consults referrals made by public hospital primary care providers to defined public hospital specialists	Customized Measure	No external benchmark; hospital specific improvement over SFY 2018 baseline	Defined improvement over SFY 2018 baseline	**B** (4/1/17 - 3/31/18)	**O** 10% improvement over SFY18 baseline (4/1/18 - 3/31/19)	**O** 20% improvement over SFY18 baseline (4/1/19 - 3/31/20)	**O** 30% improvement over SFY18 baseline (4/1/20 - 3/31/21)	**O** 40% improvement over SFY18 baseline (4/1/21 - 3/31/22)	Increased access for consultative services to facilitate care and access for patients to critical specialties
9	Demonstrate improvement in colorectal cancer screening rates (for active pubic hospital primary care patients)	NQF 0034	National (HEDIS) Commercial 2014 90th percentile = 72%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	
10	Improvement in inpatient discharge referral rate to in-network skilled nursing facilities for Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network SNFs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all SNFs[110]	No external benchmark; hospital specific improvement target= 75%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Appropriate post acute placement of patients based on clinical need

[110] Any Visiting Nurses Association (VNA) with whom public hospital system has a signed preferred provider agreement. Preferred provider relationships are evaluated annually and are subject to change if VNAs are not in compliance with the terms of the agreement. Changes in preferred VNA relationships may require a rebasing of the measures.

11	Improvement in inpatient discharge referral rate to in network Visiting Nurse Association (VNAs) Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network VNAs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all VNAs[111]	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Appropriate post acute community-based care for patients based on clinical need
12	% of patient appointments at which the AVS was printed for the patient at the conclusion of their medical specialty appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	**B** (4/1/17 - 3/31/18)	**O** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**O** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types
13	% of patient appointments at which the AVS was printed for the patient at the conclusion of their surgical appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	**B** (4/1/17 - 3/31/18)	**O** (4/1/18 - 3/31/19)	**O** (4/1/19 - 3/31/20)	**O** (4/1/20 - 3/31/21)	**O** (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types

Required Measure Slate: Improvement and Outcomes Measures *(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).*							
Measure Slate 4	**4: Evidence-Based Practices for Medical Management of Chronic Conditions**	**Achieve 2 of 3 Measures**	**Achieve 4 of 13 Measures**	**Achieve 7 of 13 Measures**	**Achieve 8 of 13 Measures**	**Achieve 8 of 13 Measures**	**Baseline (B) Outcome (O) Reporting (R)**

[111] Any Skilled Nursing Facility (SNF) approved by the public hospital network development committee as being "in-network" at any point during the measurement year. The network development committee oversees the collaborative relationships in which the public hospital system participates. The committee abides by specific principles related to access, continuity of care, communication expectations and quality improvement. Changes to in-network SNF relationships may require a rebasing of the measures.

#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
	Chronic Obstructive Pulmonary Disease (COPD)									
1	The percentage of active primary care patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	NQF 0577	2015 90th percentile National Medicaid = 47.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid.
2	Percentage of active primary care patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 60% and have symptoms who were prescribed an inhaled bronchodilator.	NQF 102	2015 90th percentile National Medicaid= 90.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid.
3	Improve the percentage of patients with COPD who received patient education for COPD by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 85% reflects best practice adoption of the required workflows.
	Congestive Heart Failure (CHF)									
4	Improve the percentage of patients with CHF who received patient education for CHF by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 85% reflects best practice adoption of the required workflows.
	Diabetes									

5	Diabetes: HbA1c Control- % of active primary care patients ages 18 to 75 with diabetes whose most recent HbA1c control is <8.0%	NQF 0575	2015 90th percentile National Medicaid: 59.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid
6	Comprehensive Diabetes Care: Eye Exam (retinal) performed (for active primary care patients)	NQF 0055	2015 90th percentile National Medicaid: 68.0%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target reflects the 2015th 90th Percentile National Medicaid
7	Improve the proportion of active primary care patients 18-75 years of age with diabetes with poorly controlled Hemoglobin HbA1C (most recent >=8.0%) who have a care plan	NCQA	No external benchmark; hospital specific improvement Target = 75%	Gap to Goal (10%) or attainment at target	**O**	**O**	**O**	**O**	**O**	Target of 75% is NCQA 2014 Medical Home Standard.
8	Percentage of high risk diabetic primary care patients receiving enhanced diabetes management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure (denominator linked to NQF 0575)	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	**B**	**O**	**O**	**O**	**O**	Target reflects roll-out implementation and capacity for new workflows.
	Hypertension (HTN)									

9	Percentage of high risk hypertensive primary care patients receiving enhanced hypertension management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	**B**	**O**	**O**	**O**	**O**	Target reflects roll-out implementation and capacity for new workflows.
	Composite Measures									
10	Hospitalization Follow-up: The percentage of discharges for patients 18 years of age and older (with any of the following conditions Diabetes, Hypertension COPD, and/or CHF) who were discharged to home from public hospital's medical/surgical inpatient services and who had an outpatient visit within 7 days or contact within 2 days with a care team member documented in EMR.	Customized Measure	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve follow up after hospitalization for chronic health conditions
11	% of active primary care patients 3 years and older with the following conditions: Diabetes, Pediatric Asthma, Hypertension, COPD, and CHF, for whom a public hospital follow-up contact or visit is completed within seven calendar days post ED discharge	Customized Measure	No external benchmark; hospital specific improvement target =50%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve follow up after ED visits for chronic health conditions

12	Screening for Depression in active primary care patients 18 years and older with Diabetes, HTN, CHF, and/or COPD	Approximate Match- NQF 0418 (Adjusted for Chronic Conditions at high risk)	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve depression screening for patients with chronic health conditions at high risk..
13	Co-morbid Conditions: Depression Follow-Up in active primary care patients with Diabetes, HTN, CHF, and/or COPD	Customized Measure	No external benchmark; hospital specific improvement target = 60%	Gap to Goal (10%) or attainment at target	**B**	**O**	**O**	**O**	**O**	Target derived to improve follow up for depression care for patients with chronic health conditions.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected)
(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).

Measure Slate 5		**5: Community Empowered Population Health Initiative**			**Baseline**	**Achieve 3 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 5 of 9 Measures**	**Achieve 6 of 9 Measures**	**Baseline (B) Outcome (O) Reporting (R)**
#	**Measure Description**	**Measure Steward NQF#**	**Benchmark**	**Improvement Methodology**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022	**Rationale for Improvement Target**
1	**Social Determinant Screenings:** Utilizing implemented social determinant(s) screening tool, increase percentage of defined patient panel population segment(s) (such as patients with chronic conditions and/or behavioral health conditions, high risk/high utilizers, specific primary or specialty practices) within the ACO/public payor population) screened for selected Social Determinants	Customized Measure	No external benchmark; hospital specific improvement target =70%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is based on population screening measures for this new initiative.

2	**Referrals to Community and Social Services:** The percentage of defined patient panel screened for social determinant(s) (in measure 1 above) with referrals to community and social services and supports	Customized Measure	No external benchmark; hospital specific improvement target =60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is informed by referrals to community and social services.
3	**Expansion of Social Determinant Screening to Additional Patient Cohorts:** Expand patient panel subpopulations or practice sites whose patients receive social determinant screening	Customized Measure	No external benchmark; hospital specific target = Add at least 1 additional patient subpopulation or practice site per year	Defined Increase Per Year	B	O	O	O	O	Target based on phased implementation of new social determinants initiative.
4	**Follow-up Social Determinant Screening:** Percentage of identified & active patient panel populations with follow-up social determinant(s) rescreening for appropriate determinants	Customized Measure	No external benchmark; hospital specific improvement Target= 50%	Gap to Goal (10%) or attainment at target		B	O	O	O	Rescreening rates to begin in year two to measure presence or resolution of social determinants
5	**Reducing Health Disparities for Hypertension:** Controlling High Blood Pressure Measure (2015 HEDIS Definition) for defined patient panel population(s) with disproportionately poorer outcomes for good control of hypertension	NQF 0018 (for hospital-defined patient panel population(s) with health disparities	MA Medicaid (HEDIS) 2014 90th percentile = 85.67%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.

6	**Reducing Health Disparities for Hypertension Control in Patients with Diabetes:** Comprehensive Diabetes Care: Blood Pressure Control (<140/90) for defined patient panel population(s) with diabetes and disproportionately poorer outcomes for good control of hypertension	NQF 0061 (for hospital-defined patient panel population(s) with health disparities	MA Medicaid (HEDIS) 2014 90th percentile = 82.74%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.
7	**Comprehensive Diabetes Care:** A1c Poor Control or A1c Good Control for defined patient panel population(s) with disproportionately poorer outcomes for diabetes blood glucose control	NQF 0059 or NQF 0575 (one of the two measures above will be selected and confirmed in the baseline year based on hospital evaluation of health disparities. (for hospital-defined patient panel population(s) with health disparities	NQF 0059 MA Medicaid (HEDIS) 2014 90th percentile = 18.57% or NQF 0575 MA Medicaid (HEDIS) 2014 90th percentile = 59.37%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.
8	**Composite Diabetes & Hypertension Patient Education, outreach or Intervention:** Proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above that received patient education, outreach, or another intervention to support chronic health condition management	Customized Measure (for hospital-defined patient panel population(s) with health disparities	No external benchmark; hospital specific improvement target = 60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve patient education, outreach, and/or interventions for patients with disproportionately poorer health outcomes.

9	**Primary Care and Ambulatory Care Utilization Among Panel Population(s) with Health Disparities:** Increase the proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above who had at least one community health, primary care and/or other ambulatory care visit during the measurement period	Customized Measure (for hospital-defined patient panel population(s) with health disparities	No external benchmark; Improvement over SFY 2018 baseline by defined % point(s)	Improvement compared to SFY 2018 baseline.	B	O Improve by at least 1% point above the SFY 2018	O Improve by at least 2% point above the SFY 2018	O Improve by at least 3% points above the SFY 2018	O Improve by at least 4% points above the SFY 2018	Target derived to improve utilization of primary care and ambulatory care for patients with disproportionately poorer health outcomes.

				Baseline (B), Outcome (O), Reporting (R)				
Measure Slate 6	**Population-Wide Community and Public Health Indicators**	**Source**	**Geography**	**Year 1** SFY 2018	**Year 2** SFY 2019	**Year 3** SFY 2020	**Year 4** SFY 2021	**Year 5** SFY 2022
1	Age-adjusted rate* per 100,000 for premature death (below age 75), *by race and ethnicity, as available*	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
2	Age-adjusted rate* per 100,000 for hospital discharges for primary care manageable conditions: asthma - *by age, race and ethnicity as available*	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
3	Age-adjusted rate* per 100,000 for suicide mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
4	Age-adjusted rate* per 100,000 for Hepatitis C incidence	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

5	Percentage of children fully immunized at kindergarten entry	Immunization Program, Massachusetts Department of Public Health and Massachusetts Department of Elementary and Secondary Education	Cambridge, Somerville, Everett, Malden, Statewide	R	R	R	R	R
6	Percent of adolescents reporting specific risk behaviors (as available), from the Youth Risk Behavior Survey (YRBS)- high school and middle school surveys	Youth Risk Behavior Survey (YRBS) (Bi-Annual)	Cambridge, Somerville, Everett, Malden, (as available by community) Statewide	R	R	R	R	R
7	Age-adjusted rate* per 100,000 for Opioid poisoning mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
8	Ranking top cause of 1) hospitalizations and 2) Emergency Department visits, by city: Age-adjusted rate* per 100,000 for hospitalizations (by individual cause) Age-adjusted rate* per 100,000 for Emergency Department visits (by individual cause).	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
9	Age-specific rate* per 100,000 for 1) Emergency Department -visits and 2) mortality related to falls among those age 65 years and over by city.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
10	Age-adjusted rate* per 100,000 for Emergency Department visits related to alcohol or substance use.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
11	Age-adjusted rate* per 100,000 for Emergency Department visits related to Opioid poisoning.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
12	Age-adjusted rate* per 100,000 for hospitalizations related to Hypertension.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
13	Age-adjusted rate* per 100,000 for 1) hospitalizations and 2) Emergency Department visits related to Renal Failure or Renal Disorder.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

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

Contents

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

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

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

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

Section 1.1 Section 1. Eligible and Enrolled Population

1.1. Performance Period

For ACOs that do not choose to extend, the ACO Pilot performance period will begin December 1, 2016 and end November 30, 2017. ACOs that extend to February 28, 2017 will have two performance periods. Performance Period A will match the original pilot performance period of December 1, 2016 through November 30, 2017. Performance Period B will begin on December 1, 2016 and extend through February 28, 2018.

1.2. Member eligibility

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

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

Rating Category	Description
RC X	Individuals ages 21 through 64 with incomes up to 133% FPL, who are not pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage, who are also receiving EAEDC through the Massachusetts Department of Transitional Assistance

1.3. Member attribution to ACO

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

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

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

2.1. List of services included in Total Cost of Care (TCOC)

Below is a list of service categories included in the TCOC under the ACO Pilot program:

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

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

2.2. Excluded services

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

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

Section 3. Calculation of TCOC target

Prior to the start of the performance year, MassHealth will establish a preliminary TCOC target

for each Pilot ACO. This section describes how that target will be calculated.

3.1. Base data

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

All base data for PCC Plan members and included services will be utilized to inform adjustments such as trend. The base data will consist of MassHealth eligibility records, Primary Care Clinician (PCC) Plan claims and Massachusetts Behavioral Health Partnership (BHP) contractor encounter data for PCC and BHP covered services. Each Pilot ACO's TCOC target will be based on the data for members attributed to that ACO's participating PCCs, specifically, during the base period. For Performance Period B, additional trend and seasonality adjustments will be made to reflect the 15 month performance period.

3.2. Risk/acuity adjustment

For each ACO, MassHealth will adjust for any observed changes in acuity between the members attributed during the base period (October 1, 2014 - September 30, 2015) and the ACO performance periods (December 1, 2016 to November 30, 2017 or December 1, 2016 to February 28, 2018). Specifically, MassHealth will normalize each ACO's risk score to the overall PCC program during the base period, and again for each performance period.

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

3.3. Stop-loss adjustment

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

3.4. Trend

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

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

TCOC will also be excluded from the trend development.

3.5. Program changes

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

Section 4. Calculation of shared savings and losses

4.1. Retrospective calculation of TCOC performance and savings / losses

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

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

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

For ACOs that have signed a contract extension, MassHealth will calculate TCOC performance for both the original 12 month performance period (Performance Period A) and the extended 15 month performance period (Performance Period B), against corresponding PMPM targets. ACOs will be accountable to whichever performance period leads to the larger total shared savings or

smaller total shared losses payment.

4.2. Determination of shared portion of savings / losses

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

- Savings / losses cap: MassHealth will recognize savings or losses for each individual ACO up to a cap of 15% of the ACO's TCOC target. For example, if an ACO's target TCOC is $500 PMPM, then its cap on recognized savings or losses is $500 * 15% = $75 PMPM. If the ACO achieves TCOC performance of $400 PMPM, MassHealth would only recognize $75 PMPM of the savings. Similarly, if the ACO has a TCOC performance of $580 PMPM, only $75 PMPM of losses would be recognized. For the ACO, 100% of savings or losses would be recognized if the ACO performed between $425 and $575 PMPM.
- Share of savings: After the determination of savings and losses, MassHealth will pay 50% of recognized savings to ACOs with TCOC performance below target. In the example where an ACO performs at $400 PMPM on a $500 PMPM target, MassHealth would therefore pay the ACO $75*50% = $37.50 PMPM. Therefore, the maximum financial upside in the ACO Pilot is 7.5% of target.
- Share of losses: MassHealth will recoup 10% of the recognized losses from ACOs with TCOC performance above target. In the example where ACO A performs at $580 PMPM on a $500 PMPM target, MassHealth would therefore recoup from ACO A $75*10% = $7.50 PMPM. Therefore, the maximum financial upside beyond target TCOC is 1.5% of target.
- Minimum savings / loss ratio: If total savings or losses are less than 2% of the TCOC target, MassHealth will not pay shared savings or recoup shared losses. This approach prevents payments or recoupments from being incurred due to random variation. For example, if an ACO's target TCOC is $500 PMPM, and its performance is between $490.01 and $509.99 PMPM, no savings or losses will be shared. If performance was $490.00 and below or $510.00 and above, then the full difference between performance and target would be recognized (per the prior three bullets)

4.3. Impact of quality reporting on shared savings / losses

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

Attachment M

Massachusetts Delivery System Reform Incentive Payment (DSRIP) Protocol

Contents

Section 1. DSRIP Overview and Goals

1.1 MassHealth Medicaid Section 1115 Demonstration

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

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

In accordance with STC 57(e) and as set forth in this document, the State may allocate DSRIP funds to four purposes: (1) Accountable Care Organization (ACO) funding, which supports the implementation of three ACO models, including transitional funding for certain safety net hospitals; (2) Community Partners (CP) funding, which supports the formation and payment of Behavioral Health (BH) and Long Term Services and Supports (LTSS) CPs and funding for Community Service Agencies (CSAs); (3) Statewide Investments, which are initiatives related to statewide infrastructure and workforce capacity to support successful reform implementation; and (4) State Operations and Implementation, which includes the State's oversight of the DSRIP program.

1.3 Goals of DSRIP Program

Massachusetts' DSRIP program provides an opportunity for the State to emphasize value in care delivery, better meet members' needs through more integrated and coordinated care, and moderate the cost trend while maintaining the clinical quality of care. The State's DSRIP goals are to (1) implement payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improve integration among physical health, behavioral health, long-term services and supports and health-related social services; and (3) sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals.

1.4 DSRIP Funding Streams

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

- **Accountable Care Organizations** – Generally provider-led health systems or organizations with an explicit focus on integration of physical health, behavioral health, long term services and supports and health-related social service needs. ACOs will be financially accountable for the cost and quality of their members' care.

- **Community Partners / Community Service Agencies (CSAs)** – Community-based BH and LTSS organizations who support eligible members with BH and LTSS needs.

- **Statewide Investments** – Set of direct state investments in scalable infrastructure and workforce capacity.

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

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

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

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

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

1.4.1 Accountable Care Organizations

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

Massachusetts' three ACO models are:

- **Accountable Care Partnership Plan (a Partnership Plan)**: either a MCO with a separate, designated ACO partner, or a single, integrated entity that meets the requirements of both. Partnership Plans are vertically integrated between the health plan and ACO delivery system, and take accountability for the cost and quality of care under prospective capitation

- **Primary Care Accountable Care Organization**: a provider-led health care system or other provider-based organization, contracting directly with MassHealth, with savings and risk shared retrospectively

- **MCO-Administered ACO:** a provider-led health care system or other provider-based organization that contracts with MCOs and takes financial accountability for shared savings and risk as part of MCO networks

1.4.2 Community Partners and CSAs

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

- Creating explicit opportunities for ACOs and MCOs to leverage existing community-based expertise and capabilities to best support members with LTSS and BH needs

- Breaking down existing silos in the care delivery system across BH, LTSS and physical health

- Ensuring care is person-centered, and avoiding over-medicalization of care for members with LTSS needs

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

Massachusetts will selectively procure two types of Community Partners:

- **Behavioral Health Community Partners** (BH CPs): BH CPs will support eligible adult members with a diagnosis of Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD) as well as adult members who exhibit SMI and SUD needs, but have not been diagnosed, as defined by the State.

- **LTSS Community Partners** (LTSS CPs): LTSS CPs will support eligible members ages three and older with complex LTSS needs, which may include members with physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD) and others, as defined by the State.

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

1.4.3 Statewide Investments

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

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

These eight initiatives are further detailed in Section 4.6.

1.4.4 State Operations and Implementation

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

Investments programs to ensure success and movement towards state goals. This team will manage several contracted vendors that support key aspects of program implementation. In addition, several independent entities will support the State's oversight of the DSRIP program, including the DSRIP Steering Committee, DSRIP Advisory Committee on Quality, Independent Assessor and Independent Evaluator (see Sections 3.4.1.2 and 6.4 for further details on each). The State Operations and Implementation funding stream will support these personnel/fringe and contractual costs.

Section 2. Delivery System Models

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

Section 3. Participation Plans, Budgets, and Budget Narratives

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

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

3.1 DSRIP Budget Periods

3.1.1 ACO Budget Periods

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

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

limited to: health information technology, performance management infrastructure, network development/contracting, project management, and care coordination/management investment.

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

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

EXHIBIT 2 – Schedule of DSRIP ACO Budget Periods

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

The budget period approach will not change the amount of funding that an ACO receives for a given demonstration year. Specifically, the Preparation Budget Period funds will be sourced from demonstration year 1 funds. Budget Period 1 funds will be sourced from demonstration year 1 and year 2 funds. Budget Periods 2 through 4 will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds will be sourced only from demonstration year 5 funds.

3.1.2 Community Partner and CSA Budget Periods

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

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

In order to align CP and CSA Budget Periods with CP and CSA Performance Years, CP and CSA Budget Period 1 will be seven months from June 1, 2018 to December 31, 2018 (aligning with CP and CSA Performance Year 1, which is also seven months). The remaining four budget periods (BP 2-5) will each last for one full calendar year, with Budget Period 2 beginning January 1, 2019 and ending December 31, 2019, etc. If the State changes the schedule for CP and CSA performance years, the State may adjust the

CP and CSA Budget Periods to align with the performance years. Please see Exhibit 3 for the anticipated schedule of the DSRIP CP and CSA Budget Periods.

EXHIBIT 3 – Schedule of DSRIP CP/CSAs Budget Periods

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

This budget period approach will not change the amount of funding that a CP or CSA receives for a given demonstration year. Specifically, the Preparation Budget Period funds will be sourced from demonstration year 1 funds. Budget Period 1 funds will be sourced from demonstration year 1 and year 2 funds. Budget Periods 2 through 4 will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds will be sourced only from demonstration year 5 funds.

3.1.3 Funding Adjustments for Budget Period 5

The second half of Budget Period 5 (July 1, 2022 to December 31, 2022) falls outside of the approved demonstration period (July 1, 2017 to June 30, 2022). To account for this, the following payments will be attributed to the first half of BP5:

- ACO Startup/Ongoing payments (see Section 4.4.1)
- ACO DSTI Glide Path payments (see Section 4.4.3)
- ACO Flexible Services payments (see Section 4.2.2)
- CP and CSA Infrastructure and Capacity Building payments (see Sections 4.5.2, 4.5.5, and 4.5.7)

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

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

3.2 Participation Plans

3.2.1 Preliminary Participation Plans

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

The State may withhold DSRIP funds from an ACO, CP or CSA if there are outstanding State requests for amendments to its Preliminary Participation Plan.

3.2.1.1 ACOs

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

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

3.2.1.2 Community Partners/CSAs

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

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

- Executive Summary: This section will summarize the CP's or CSA's DSRIP Participation Plan and describe the CP's or CSA's five-year business plan, goals and identified challenges.
- Partnerships: This section will list providers with which the CP or CSA will partner and describe these relationships and how they will align with the CP's or CSA's proposed investments and programs, as well as the CP's or CSA's core goals, such as improving the quality of member care.
- Member and Community Population: This section will include a description of the CP's or CSA's member population and surrounding communities, regions and service areas covered and how the CP or CSA will both promote the health and well-being of these individuals, and also actively initiate and maintain engagement with them.
- Narrative: The narrative will describe
    - The CP's Care Model (CPs only):
        - Proposed staffing models
        - Proposed outreach and engagement strategies
        - Proposed process for assessment and person-centered care planning
        - Proposed process for managing transitions of care
        - Proposed methods for how the CP will address members' health and wellness issues
        - Proposed methods for how CP will connect the member to community resources and social services
        - Proposed methods and processes for how the CP will enable continuous quality and member experience improvement
    - The CP's or CSA's investment plan:
        - Identifying specific investments or programs that the CP or CSA will support with DSRIP funds
        - Estimating the amount and structure (e.g., one-time vs. annual) of costs associated with each investment or program
        - Explaining how each investment or program will support the CP's or CSA's core goals, such as improving the quality of member care and ensuring integration of care across different settings of care
        - Specifying goals, internal evaluation, measurement or performance management strategies the CP or CSA will apply to these investments or programs to demonstrate effectiveness and inform subsequent revisions to the Participation Plan
        - Examples of domains for potential CP or CSA investments or programs include but are not limited to:
            - Workforce capacity development
            - Data and analytics
            - HIT
            - Performance management capabilities
            - Contracting/networking development

        - Project management capabilities
        - Care coordination and community linkages

    - Implementation of care model requirements

- Spending Categories and Amounts: This section will include the CP's or CSA's anticipated spend over the five years in broad based funding categories.
- Timeline: This section will include a five-year timeline for the CP's or CSA's proposed investments and programs.
- Sustainability: This section will describe the CP's or CSA's plan to sustainably fund proposed investments and programs after the five-year period. This section may include information about other funding opportunities available to the CP or CSA, as well as information about any tools, resources or processes that the CP or CSA intends to develop using DSRIP funding and continue using after the end of the DSRIP investment.
- Metrics and Measures: This section will describe the CP's or CSA's plan to report on the various DSRIP accountability metrics set forth in Appendix D.

3.2.2 Full Participation Plans

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

3.2.2.1 ACOs

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

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

- The providers and organizations with which the ACO is partnering or plans to partner, the governance structure and a description of how these partnerships will support the ACO's planned activities and proposed investments

- A population and community needs assessment

- The ACO's planned investments and spending plan, including specific investments or programs the ACO anticipates supporting with DSRIP funds. Such investments and programs may include but are not limited to:

    - Care coordination or care management programs, including any programs to manage high-risk populations or other population health initiatives and including the ACO's transitional care management program

    - Efforts to address members' health-related social needs, including expanding community linkages between the ACO and providers, Community Partners or other social service organizations, and including any spending on allowable flexible services to address health-related social needs

- Ensuring appropriate workforce capacity and professional development opportunities to meet increased expectations for care coordination, management and integration
- Investments in the ACO's and providers' data and analytics capabilities
- Programs to shift service volume or capital away from avoidable inpatient care toward outpatient, community-based primary and preventive care or from institutional care towards community-based LTSS, including capital investments to downsize or repurpose inpatient or institutional capacity, investments in expanding outpatient and community capacity and costs associated with piloting new care delivery models, such as those involving alternate settings of care and the use of telehealth or home-based services
- Investments in improved linguistic and cultural competency of care, including hiring translators and providers fluent in members' preferred languages
- Other investments or programs identified and proposed by the ACO that align with other requirements that MassHealth will have of the ACO

- Estimates of the amount and structure (e.g., one-time vs. annual) of costs associated with each investment or program identified in the ACO's Participation Plan
- Descriptions of how each investment or program will support the ACO's performance
- Specific goals, evaluation plans, measurable outcomes and performance management strategies the ACO will apply to each investment or program
- A five-year timeline of the ACO's proposed investments and programs
- A description of the ACO's plan to sustainably fund proposed investments and programs over the five-year period as DSRIP funding levels decrease
- Descriptions of how the ACO will fulfill its contract requirements, including:
  - Investments, value-based payment arrangements and performance management for its primary care providers
  - Care delivery improvement and care management strategies
  - Relationships with other providers, state agencies and other entities involved in the care of its members
  - Relationships with CPs
  - Activities to ensure the ACO's compliance with contract management, reporting and administrative requirements described in the ACO contract
- A plan to increase the ACO's capabilities to share information among providers involved in care of its members. Such plan will include, at a minimum:
  - The ACO's current event notification capabilities and procedures to ensure that the ACO's primary care providers are aware of members' inpatient admissions and emergency department visits
  - The ACO's self-assessed gaps in such capabilities and procedures, and how the ACO

plans to address such gaps

- A description of the ACO's plans, if any, to increase the use of EHR technologies certified by the Office of the National Coordinator (ONC)

- A description of how the ACO plans to ensure the ACO's providers consistently use the statewide health information exchange to send or receive legally and clinically appropriate patient clinical information and support transitions of care

- Attestations to ensure non-duplication of funding

3.2.2.2 Community Partners

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

- The community-based organizations and providers with which the CP or CSA is partnering or plans to partner, the CSA or CP consortium governance structure and a description of how these partnerships will support the CP's or CSA's planned activities and proposed investments

- Descriptions of specific investments or programs the CP or CSA will support with DSRIP funds, including cost estimates, measures, goals and performance management and sustainability plans in the following areas:

    - Relationships with state agencies, community-based organizations, providers and other entities involved in the care of its members

    - Relationships with ACOs and MCOs

    - Activities to ensure the CP's or CSA's compliance with contract management, reporting and administrative requirements described in the CP's or CSA's contract with MassHealth and agreements with ACOs and MCOs

    - Workforce development and stability

- A plan to increase the CP's or CSA's capabilities to share information with ACOs and MCOs and among providers involved in care of its members. Such plan will include, at a minimum:

    - The CP's or CSA's current communication practices and capabilities

    - The CP's or CSA's self-assessed gaps in such capabilities and procedures, and how the CP or CSA plans to address such gaps

    - A description of the CP's or CSA's plans, if any, to increase the use of Electronic Health Record and Care Management technology

    - A description of how the CP or CSA plans to ensure the CP or CSA and its partners consistently use the statewide health information exchange to send or receive legally and clinically appropriate patient clinical information and support transitions of care

- Details about how the CP or CSA will not duplicate existing infrastructure with their planned

DSRIP investments

3.3 Budgets and Budget Narratives

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

3.4 Review and Approval Process and Timelines

3.4.1 Roles and Responsibilities

3.4.1.1 State

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

3.4.1.2 Independent Assessor

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

3.4.1.3 CMS

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

3.4.2 Process for State Approval of ACO Participation Plans

3.4.2.1 Preliminary Participation Plan Approval for ACOs

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

- ACOs submit Preliminary Participation Plans with their procurement response

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

3.4.2.2 Full Participation Plans for ACOs

The process for submission, review and approval of Full Participation Plans for ACOs will be as follows:

- The State notifies ACOs of anticipated BP1 funding amounts and tentative BP2 through BP5 funding amounts and requests a Full Participation Plan
- ACOs submit Full Participation Plans to the State (the State will provide ACOs up to 30 calendar days from the date of notification). The State intends to work with ACOs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Full Participation Plans in parallel. The State intends to complete its review of the Full Participation Plans, including evaluating the Independent Assessor's recommendations, within 45 calendar days of ACOs' submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the ACOs' Full Participation Plans.
- **The State therefore anticipates completing approvals of Full Participation Plans within 75 calendar days of requesting them from ACOs as follows:**
    - The State anticipates approving Full Participation Plans in April 2018

3.4.3 Process for State Approval of CPs and CSAs Participation Plans

3.4.3.1 Preliminary Participation Plan approval for CPs and CSAs

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

- CPs submit Preliminary Participation Plans with their request for funding
- CSAs submit Preliminary Participation Plans with their request for funding
- The State reviews CP and CSA Preliminary Participation Plans within 75 calendar days of their submission
- At the end of this review process, the State will approve, deny or request additional information regarding the Preliminary Participation Plan. The State intends to work with CPs and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission.
- **The State therefore anticipates completing reviews and approvals of Preliminary Participation Plans within 75 calendar days of submission as follows:**
    - The State anticipates approval of Preliminary Participation Plans in August 2017

3.4.3.2 Full Participation Plans for CPs and CSAs

The process for submission, review and approval of Full Participation Plans will be as follows:

- The State notifies CPs and CSAs of actual BP1 funding and tentative BP2 through BP5 funding amounts and requests a Full Participation Plan
- CPs and CSAs submit Full Participation Plans to the State within 30 calendar days from the date of notification).
    - The State intends to work with CPs and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Full Participation Plans in parallel. The State intends to complete its review of the Full Participation Plans, including evaluating the Independent Assessor's recommendations, within 45 calendar days of CPs' and CSAs' submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the Full Participation Plans.

- **The State therefore anticipates completing approvals of Full Participation Plans within 75 calendar days of requesting them from CPs and CSAs as follows:**

    - For CPs and CSAs, the State anticipates approving Full Participation Plans in May 2018

3.4.4 Process for State approval of Budgets and Budget Narratives

3.4.4.1 Process for State approval of ACO Budgets and Budget Narratives

The process for submission, review and approval of Budgets and Budget Narratives for Budget Period 1-5 for ACOs will be as follows:

- The State notifies ACOs of the upcoming budget period's anticipated funding amounts, and requests each ACO submit a Budget and a Budget Narrative for the upcoming budget period (See Section 4.4).
- ACOs submit to the State their Budgets and Budget Narratives for the upcoming BP within 30 calendar days of receiving the State's request. The State intends to work with ACOs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Budgets and Budget Narratives in parallel. The State intends to complete its review of the Budgets and Budget Narratives, including evaluating the Independent Assessor's recommendations, within 45 calendar days of their submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the Budgets and Budget Narratives.

    - After approval, the State will disburse the first quarterly DSRIP payment for the new Budget Period.
- If the data required to calculate funding amounts for a given budget period are not available by August of the preceding Budget Period, then the State may provide ACOs with a preliminary funding amount to construct their Budgets and Budget Narratives. The State would disburse the first quarterly payment based on the preliminary funding amount, and then calculate final funding amounts as well as a reconciliation amount to be added to or subtracted from the ACO's subsequent quarterly DSRIP payments in that Budget Period, such that payments for the budget period total the final funding amount for that budget period.
    - If the funding amount for a given ACO changes by more than 20% from the preliminary funding amount on which the ACO based its Budget and Budget Narrative, the State will

ask the ACO to revise and resubmit its Budget and Budget Narrative. The State may also request revisions in its discretion.

- **The State therefore anticipates completing approvals of Budgets and Budget Narratives within 75 calendar days of requesting them from ACOs as follows:**
    - For Preparation Budget
        - The State anticipates notifying ACOs of anticipated Preparation Budget funding amounts in June 2017
        - The State anticipates ACOs submitting Preparation Budgets and Budget Narratives in July 2017
        - The State anticipates approving Budgets and Budget Narratives in August 2017
    - For BP 1-5:
        - The State anticipates providing ACOs with anticipated funding amounts in October of the preceding budget period
        - The State anticipates ACOs will submit to the State their Budgets and Budget Narratives and their updated safety net revenue calculation in November of the preceding budget period
        - The State anticipates approving ACOs' Budgets and Budget Narratives in January of the new budget period
        - If the preliminary member count for BP 1 is estimated prior to the Operational Start Date of the program and therefore prior to actual member enrollments being effective, the State may postpone this timeline by several months for BP 1, and delay the first quarterly payment of BP 1 at its discretion. This process may allow the State to adjust for changes in enrollment levels if, for example, member movement exceeds expectations

3.4.4.2 Process for State Approval of CP and CSA Budget and Budget Narratives

CPs will receive bi-annual infrastructure development funding as well as be reimbursed monthly for care management and care coordination activities based on the number of members assigned and engaged. CSAs will receive DSRIP funding for Infrastructure development only.

The process for submission, review and approval of CP and CSA Budgets and Budget Narratives for Budget Period 1-5 will be as follows:

- The State notifies CPs and CSAs of preliminary upcoming budget period's funding amounts and requests the Budgets and Budget Narratives for the upcoming budget period
    - Infrastructure development payments will be based on a member snapshot
    - For CPs, the BP1 member snapshot will be an estimate of member engagement
    - For CSAs, the member snapshots will be based on actual caseload
- Within 30 calendar days, CPs and CSAs submit to the State their Budgets and Budget Narratives for the upcoming BP
    - The State intends to work with CPS and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Budgets and Budget Narratives in parallel. The State intends to complete its review of the Budgets and Budget Narratives, including evaluating the Independent Assessor's recommendations, within 45 calendar days of their submission. Requests for additional information and resubmissions may require additional time.

- At the end of this review process, the State approves, denies or requests additional information regarding the Budgets and Budget Narratives.

- After approval, the State will disburse funding bi-annually for infrastructure funding and monthly for care coordination funding.
- **The State therefore anticipates completing approvals of Budgets and Budget Narratives within 75 calendar days of requesting them from CPs and CSAs as follows:**

    - For Preparation Budget

        - The State anticipates notifying CPs and CSAs of Preparation Budget funding in August 2017

        - The State anticipates CPs and CSAs submitting Preparation Budgets and Budget Narratives in September 2017

        - The State anticipates approving Budgets and Budget Narratives in October 2017

    - For BP 1:

        - The State anticipates providing CPs and CSAs with a preliminary version of their anticipated payments in February 2018
        - The State anticipates that CPs and CSAs will submit their BP1 Budgets and Budget Narratives to the State in March 2018
        - The State anticipates approving CP and CSA Budgets and Budget Narratives in May 2018
    - For BP 2-5:

        - The State anticipates providing CPs and CSAs with a preliminary version of their anticipated payments in December of the preceding budget period
        - The State anticipates that CPs and CSAs will submit their current year budget period Budgets and Budget Narratives to the State in January of the budget period
        - The State anticipates approving CP and CSA Budgets and Budget Narratives in March of the budget period
        - The State anticipates making bi–annual infrastructure payments in April and October of the budget period and monthly care coordination payments

3.4.5 Process for State Approval of Modifications to Participation Plans, Budgets and Budget Narratives

ACOs, CPs and CSAs may submit ad hoc requests to amend their Participation Plans, Budgets, and Budget Narratives at any time except within 75 days of the end of the Budget Period. ACOs, CPs or CSAs will not be allowed to materially deviate from their approved spending plans without formally requesting such modification and having the modification approved by the State. The State has sole discretion to determine whether an amendment request is a material deviation, and thus a modification. In addition, the State may require ACOs, CPs or CSAs to modify their Full Participation Plans, Budgets or Budget Narratives in certain circumstances (e.g., if a primary care practice where an ACO had previously proposed making investments goes out of business).

The State's process for submission, review and approval of modification requests will be as follows:

- ACOs, CPs or CSAs submit a modification request
- The State and Independent Assessor review the modification request in parallel. The State intends to complete its review of modification requests, including evaluating the Independent

Assessor's recommendations, within 45 calendar days of their submission. Further requests for additional information and resubmissions may require additional time.

- At the end of this review process, the State approves, denies or requests additional information
- The State therefore anticipates completing approvals of modification requests within 45 calendar days of requesting them from ACOs, CPs and CSAs

If the State denies the modification request, the State and Independent Assessor will provide feedback about why the request was denied, and the State may allow the entity to resubmit their modification request after revisions, as appropriate. The timeline for review would restart upon resubmission, and the same processes would be followed as for an initial submission.

Section 4. DSRIP Payments (ACOs, CPs, CSAs and Statewide Investments)

DSRIP funding will support four streams, as described in Section 1. This Section (Section 4) outlines parameters for DSRIP payments to ACOs, CPs, CSAs and Statewide Investments including sub-streams. A portion of payments from the State to ACOs, CPs and CSAs are at risk based on the ACO, CP and CSA Accountability Framework described in Section 5. Section 5 also describes the linkage between ACO, CP and CSA accountability to the State. Section 4 explores DSRIP payments to ACOs, CPs or CSAs and the sub-streams within them.

Each of ACO and CP payment streams has several "sub-streams," which differ from each other with respect to three characteristics: (1) purpose/allowable uses; (2) calculation methodology; (3) and accountability. These three characteristics are detailed for each sub-stream in the following three subsections 4.1-4.3, respectively. Section 4.5 provides additional detail on how Accountability Scores are calculated using the accountability framework laid out in Section 4.4.

- Section 4.1: provides an overview of the sub-streams of DSRIP funding for ACOs, CPs and CSAs, as well as their amounts and the process for the State to vary those amounts
- Section 4.2: provides detail on purpose and allowable uses for ACO sub-streams
- Section 4.3: provides detail on purpose and allowable uses for CP and CSA sub-streams
- Section 4.4: provides detail on payment calculation and timing for ACO sub-streams
- Section 4.5: provides detail on payment calculation and timing for CP and CSA sub-streams
- Section 4.6: provides funding information on Statewide Investments
- Section 4.7: provides detail on DSRIP carry forward capacity

4.1 Overview and Outline

The State has divided the ACO, CPs and CSA DSRIP funding streams into eleven sub-streams: four for ACOs, three each for BH CPs and LTSS CPs and one for CSAs.

EXHIBIT 4 – ACO, CP and CSA Sub-Streams

ACO Funding Stream **4 sub-streams**	**CP and CSA Funding Stream** **7 sub-streams**		
	BH CPs: *3 sub-streams*	**LTSS CPs:** *3 sub-streams*	**CSAs:** *1 sub-stream*

● Startup/Ongoing: primary care investment ● Startup/Ongoing: discretionary ● Flexible services ● DSTI Glide Path	● Care coordination ● Infrastructure and Capacity Building ● Outcomes-based	● Infrastructure and Capacity Building

Per STC 57(e), the State may reallocate funding amounts between the "ACO Funding Stream" and the "CP and CSA Funding Stream" at its discretion. If the actual funding amounts for the ACO Funding Stream or the CP and CSA Funding stream differ from the amounts set forth in Table F of STC 57(e) by more than 15%, the State must notify CMS 60 calendar days prior to the effective reallocation of funds. CMS reserves the right to disapprove any such reallocations prior to the effective date of the reallocation.

Within the "ACO Funding Stream" or "CP Funding Stream", the State may distribute payments for a given demonstration year among the sub-streams to best meet the State's programmatic needs, in its discretion without notifying CMS, subject to the parameters described in STC 57(e). Because the mechanisms for holding ACOs and CPs financially accountable differ among these sub-streams, changes in the distribution of funding among the sub-streams may change the amount of funding for an individual ACO or CP that is at risk. For example, if funding is shifted from the "Startup/Ongoing: Discretionary" ACO sub-stream to the "Startup/Ongoing: Primary Care Investment" ACO sub-stream, this would lead to less at-risk funding because funds have shifted from a sub-stream with an at-risk component to a sub-stream without an at-risk component (see Exhibit 19). Exhibit 5 below shows the State's distribution of DSRIP payments to ACOs, CPs and CSAs by funding stream for each budget period, as well as the State's anticipated sample distribution of DSRIP payments within the ACO and CP funding streams by sub-stream. The table also shows the percent and total funding for each stream and sub-stream that is at-risk based on the ACOs', CPs' and CSAs' accountability to the State (see Section 5 for more information on accountability). This Exhibit is provided for illustrative purposes only and is an estimate of anticipated funding among funding streams and sub-streams at this point in time.

EXHIBIT 5 – Provider Accountability to State

Provider Accountability to State		Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5	Total
ACOs	***Total Funds***	**$118.1M**	**$318.0M**	**$251.4M**	**$197.9M**	**$120.9M**	**$59.2M**	**$1,065.5M**
	At-Risk %	**0%**	**4%**	**10%**	**17%**	**24%**	**11%**	**10%**
	At-Risk Funds	**$0.0M**	**$12.0M**	**$23.9M**	**$34.3M**	**$28.4M**	**$6.3M**	**$104.9M**
Startup/Ongoing: Primary Care Investment (Not At-Risk)	*Total Funds*	*$23.4M*	*$47.5M*	*$36.7M*	*$37.8M*	*$13.0M*	*$13.4M*	*$171.8M*
Startup/Ongoing: Discretionary	*Total Funds*	*$73.1M*	*$204.9M*	*$152.0M*	*$108.6M*	*$66.5M*	*$10.5M*	*$615.7M*
	At-Risk %	*0%*	*5%*	*15%*	*30%*	*40%*	*50%*	*16%*
	At-Risk Funds	*$0.0M*	*$10.2M*	*$22.8M*	*$32.6M*	*$26.6M*	*$5.3M*	*$97.5M*
Flexible Services (Not At-Risk)	*Total Funds*	*$0.0M*	*$31.0M*	*$39.8M*	*$34.7M*	*$29.2M*	*$30.1M*	*$164.7M*
DSTI Glide Path Funding	*Total Funds*	*$21.5M*	*$34.6M*	*$23.0M*	*$16.8M*	*$12.2M*	*$5.2M*	*$113.4M*
	At-Risk %	*0%*	*5%*	*5%*	*10%*	*15%*	*20%*	*7%*
	At-Risk Funds	*$0.0M*	*$1.7M*	*$1.1M*	*$1.7M*	*$1.8M*	*$1.0M*	*$7.4M*
Community Partners	***Total Funds***	**$20.0M**	**$62.9M**	**$105.8M**	**$120.8M**	**$118.4M**	**$118.8M**	**$546.7M**
	At-Risk %	**0%**	**0%**	**5%**	**10%**	**15%**	**20%**	**11%**
	At-Risk Funds	**$0.0M**	**$0.0M**	**$5.3M**	**$11.9M**	**$17.5M**	**$23.5M**	**$58.2M**
Behavioral Health CPs	***Total Funds***	***$9.3M***	***$42.7M***	***$74.6M***	***$90.3M***	***$88.3M***	***$88.3M***	***$393.4M***
	At-Risk %	***0%***	***0%***	***5%***	***10%***	***15%***	***20%***	***11%***
	At-Risk Funds	***$0.0M***	***$0.0M***	***$3.7M***	***$8.9M***	***$13.1M***	***$17.5M***	***$43.2M***
Care Coordination Supports	*Total Funds*	*$0.0M*	*$32.4M*	*$64.7M*	*$82.9M*	*$81.8M*	*$82.2M*	*$344.0M*
	At-Risk %	*0%*	*0%*	*5%*	*10%*	*15%*	*20%*	*12%*
	At-Risk Funds	*$0.0M*	*$0.0M*	*$3.2M*	*$8.3M*	*$12.3M*	*$16.4M*	*$40.2M*
Infrastructure and Capacity Building	*Total Funds*	*$9.3M*	*$10.3M*	*$9.8M*	*$6.4M*	*$5.5M*	*$5.1M*	*$46.4M*
	At-Risk %	*0%*	*0%*	*5%*	*10%*	*15%*	*20%*	*6%*
	At-Risk Funds	*$0.0M*	*$0.0M*	*$0.5M*	*$0.6M*	*$0.8M*	*$1.0M*	*$3.0M*
Outcomes-Based Stream (Incentive Pool, Not At-Risk)	*Total Funds*	*$0.0M*	*$0.0M*	*$0.0M*	*$1.0M*	*$1.0M*	*$1.0M*	*$3.0M*
CSAs *(Infrastructure and Capacity Building only)*	***Total Funds***	***$3.2M***	***$1.8M***	***$1.1M***	***$0.6M***	***$0.5M***	***$0.5M***	**$7.8M**
	At-Risk %	***0%***	***0%***	***5%***	***10%***	***15%***	***20%***	***4%***
	At-Risk Funds	***$0.0M***	***$0.0M***	***$0.1M***	***$0.1M***	***$0.1M***	***$0.1M***	***$0.3M***
LTSS CPs	***Total Funds***	***$7.5M***	***$18.5M***	***$30.1M***	***$29.9M***	***$29.6M***	***$30.0M***	**$145.5M**
	At-Risk %	***0%***	***0%***	***5%***	***10%***	***15%***	***20%***	***10%***
	At-Risk Funds	***$0.0M***	***$0.0M***	***$1.5M***	***$2.9M***	***$4.4M***	***$5.9M***	***$14.7M***
Care Coordination Supports	*Total Funds*	*$0.0M*	*$11.4M*	*$24.8M*	*$26.2M*	*$26.7M*	*$27.1M*	*$116.2M*
	At-Risk %	*0%*	*0%*	*5%*	*10%*	*15%*	*20%*	*11%*
	At-Risk Funds	*$0.0M*	*$0.0M*	*$1.2M*	*$2.6M*	*$4.0M*	*$5.4M*	*$13.3M*
Infrastructure and Capacity Building	*Total Funds*	*$7.5M*	*$7.1M*	*$5.3M*	*$3.1M*	*$2.4M*	*$2.3M*	*$27.8M*
	At-Risk %	*0%*	*0%*	*5%*	*10%*	*15%*	*20%*	*5%*
	At-Risk Funds	*$0.0M*	*$0.0M*	*$0.3M*	*$0.3M*	*$0.4M*	*$0.5M*	*$1.4M*
Outcomes-Based Stream (Incentive Pool, Not At-Risk)	*Total Funds*	*$0.0M*	*$0.0M*	*$0.0M*	*$0.5M*	*$0.5M*	*$0.5M*	*$1.5M*

4.2 Purpose and Allowable Uses for ACO Funding Sub-Streams

4.2.1 ACO Sub-Streams 1 & 2: Startup/Ongoing Funding (Primary Care & Discretionary)

ACO sub-streams 1 and 2 are for Startup/Ongoing funds. Startup/Ongoing funds are split into two sub-streams. Sub-stream 1 is explicitly dedicated for primary care investment. ACOs will be required to spend these funds on state-approved investments that support the ACO's primary care providers such as capital investments in primary care practices (e.g., inter-operable EHR systems), trainings for primary care providers and support staff in population health management protocols, administrative staff to support

front-line providers with clinical quality initiatives, etc. Having a dedicated funding stream for primary care investment is an important mechanism for the State to ensure that ACOs and their PCPs are mutually committed to each other, having mutual discussions about business decisions and working together to meet the State's delivery system reform goals. In order to ensure that primary care investments supported by DSRIP do not duplicate other federal or state investments, ACOs will be required to disclose in their Full Participation Plans what state and federal investments the ACO is using to support primary care investments, and how the ACO is ensuring non-duplication with proposed DSRIP funding uses.

Sub-stream 2 is for discretionary Startup/Ongoing funding and may be used by the ACO for other state-approved investments. Some examples of investment opportunities for ACOs include, but are not limited to: health information technology, contracting/network development, project management, and care coordination/management investment, assessments for members with identified LTSS needs, workforce capacity development and new or expanded telemedicine capability.

The funding amounts for these two sub-streams decrease over the five demonstration years and are intended to support ACO investments as they start their ACO models and provide operating funds to support (during initial years) the ongoing costs of these models. As ACOs progress through the five demonstration years, the State expects ACOs to increasingly self-fund these investments and expenses out of their TCOC-based revenue (e.g., medical gains under capitation rates, or shared savings payments).

4.2.2 ACO Sub-Stream 3: Flexible Services Funding

A portion of ACO DSRIP funds will be dedicated to spending on flexible services. Flexible services funding will be used to address health-related social needs by providing supports that are not currently reimbursed by MassHealth or other publicly-funded programs. These flexible services must satisfy the criteria described in STC 60(b)(iii), 60(c), and 60(d). Flexible services will be retrospectively reimbursed by the State up to a cap set by the State, except for BP5. During the first half of BP5, the State will pay out the full BP5 flexible services funding amount prospectively, based on the ACO's approved BP5 flexible services budgets. ACOs will still need to submit their flex services documentation and claims during BP5. If the ACOs do not use all of their flexible services allocation in BP5, or if the ACOs make expenditures that are deemed unacceptable by the State, then the ACOs will have to return the appropriate amount of flexible services funding to the State. Additional details about flexible services will be delineated in the Flexible Services Protocol (Attachment R), which is to be reviewed and approved by CMS by July 2017.

If CMS does not approve the Flexible Services Protocol by August 2017, then the State may reallocate the Budget Period 1 flexible services funding allocation detailed in Exhibit 5 to other Budget Period 1 DSRIP funding streams so that the State's expenditure authority is not reduced due to non-approval of the Flexible Services Protocol, or it may carry forward the expenditure authority into subsequent Budget Periods without counting against the 15% benchmark described in STC 57(d)(iii). Similarly, the State may continue to reallocate the flexible services funding allocation for each Budget Period to other DSRIP funding streams for that Budget Period if CMS does not approve the Flexible Services Protocol by the July of the preceding Budget Period. Any such reallocation will be included in an updated funding allocation table in the next quarterly progress report to CMS. CMS will have 90 calendar days to request modifications to the reallocation proposal.

4.2.3 ACO Sub-Stream 4: DSTI Glide Path Funding

During the five-year demonstration, the State will restructure demonstration funding for safety net hospital systems to be more sustainable and aligned with value-based care delivery and payment incentives. The seven safety net hospitals currently receiving funding through the Delivery System Transformation Initiatives (DSTI) program will instead receive a reduced amount of ongoing operational support through Safety Net Provider payments authorized under the State's restructured Safety Net Care

Pool. To create a sustainable transition from current funding levels to these new, reduced levels, the State will provide transitional DSRIP funding to these DSTI safety net hospitals.

Payment of the DSTI Glide Path funding is contingent on a safety net hospital's approved participation with a MassHealth ACO (and therefore on their financial accountability for cost and quality). To receive this funding, a safety net hospital must have a provider arrangement or contract with an ACO that demonstrates its participation in that ACO's efforts, including at a minimum documented participation in the ACO's transitional care management and other contractual responsibilities (e.g., data integration), and financial accountability including the potential for the safety net hospital to share gains from savings and share responsibility for losses.

This DSTI Glide Path funding will be paid directly to any ACO that has a provider arrangement or contract with one of these seven DSTI safety net hospitals. The ACO will be required to give the full amount of this funding to the participating safety net hospitals. The amount of DSTI Glide Path funding will decrease each year, sustainably transitioning safety net hospitals to lower levels of supplemental support.

4.3 Purpose and Allowable Uses for CP and CSA Funding Sub-Streams

MCOs and ACOs will delegate comprehensive care management responsibility to the BH CP for members diagnosed with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD), as well as adult members who exhibit SMI and SUD, but have not been diagnosed, and who are assigned to the BH CPs. BH CPs are required to coordinate care for members enrolled with the BH CP across the full healthcare continuum, including physical and behavioral health, LTSS and social service needs. This section describes the purpose and allowable uses for the three funding sub-streams for each CP (care coordination, infrastructure and capacity building and outcome-based payments) and one sub-stream for CSAs (infrastructure and capacity building):

4.3.1 BH CP Sub-Stream 1: Care Coordination Supports Funding

BH CPs will receive funds under BH CP sub-stream 1 to perform the following functions for assigned members:

1. Outreaching to and actively engaging members
2. Identifying and facilitating a care team for every engaged member
3. Person-centered treatment planning for every engaged member
4. Coordinating services across the care continuum to ensure that the member is in the right place for the right services at the right time
5. Supporting transitions between care settings
6. Providing health and wellness coaching
7. Facilitating access and referrals to social services and other community services

4.3.2 BH CP Sub-Stream 2: Infrastructure and Capacity Building Funding

BH CPs will receive funds under BH CP sub-stream 2 to make infrastructure investments to advance their capabilities to support their member populations and to form partnerships with MCOs and ACOs. Infrastructure funding for BH CPs will be disbursed across four categories:

1. Technology – e.g., HIT and care management software, IT project management resources, data analytics capabilities, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring or electronic medication dispensers, and reporting software
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications
3. Business Startup Costs – e.g., staffing and startup costs to develop full caseloads.

4. Operational Infrastructure – e.g., project management, system change resources and performance management capabilities, additional operational support.

4.3.3 BH CP Sub-Stream 3: Outcomes-Based Payments

BH CPs will have the opportunity to earn additional payments under BH CP sub-stream 3 in Budget Periods 3 through 5 by reaching high levels of achievement on avoidable utilization metrics. The State anticipates setting preliminary performance targets by August 2019 (i.e. BP2) following analysis of claims data for BP1. The State will then finalize the performance targets for BP3 by August 2020 (i.e. BP3) once the BP2 claims data is available (see Section 5.4.6 for more details). The State will set the performance standards subject to CMS approval.

4.3.4 LTSS CP Sub-Stream 1: Care Coordination Supports Funding

MCOs and ACOs will have responsibility for conducting the comprehensive assessment for enrollees assigned to LTSS CPs and other enrollees identified by EOHHS as having LTSS needs, as specified in their contracts with the State. The LTSS CP will review the results of the comprehensive assessment with a LTSS assigned member as part of the person-centered LTSS care planning process and will inform the member about his or her options for specific LTSS services, programs and providers that may meet the member's identified LTSS needs. LTSS CPs will receive funds under LTSS CP sub-stream 1 to perform the following functions for assigned members:

1. Providing disability expertise consultation as requested by MassHealth, the member's MassHealth managed care entity, or the member on the comprehensive assessment
2. Providing LTSS care planning using a person-centered approach and choice counseling
3. Participating on the member's care team to support LTSS care needs decisions and LTSS integration, as directed by the member
4. Providing LTSS care coordination and support during transitions of care
5. Providing health and wellness coaching
6. Connecting the member to social services and community resources.

The State also intends to allow LTSS CPs to provide optional enhanced functions for members with complex LTSS needs who would benefit from comprehensive care management provided by a LTSS CP. The enhanced supports care model will be similar to that of the BH CP, including the performance of a comprehensive assessment, although adapted to the specific LTSS population to be served, and will include a PMPM rate reflective of the BH CP model. The State will select LTSS CPs to perform enhanced supports via a competitive procurement.

4.3.5 LTSS CP Sub-Stream 2: Infrastructure and Capacity Building Funding

LTSS CPs will receive funds under LTSS CP sub-stream 2 to make investments to advance the organization's overall capabilities to support its member population and form partnerships with MCOs and ACOs. Infrastructure funding for LTSS CPs will be disbursed across four categories:

1. Technology – e.g., HIT and care management software, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring, electronic medication dispensers and reporting software;
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications;
3. Business Startup Costs – e.g., staffing and startup costs to develop full caseload capacities
4. Operational Infrastructure – e.g., IT project management, system change resources, data analytics capabilities performance management capabilities and additional operational support

4.3.6 LTSS CP Sub-Stream 3: Outcomes-Based Payments

LTSS CPs will have the opportunity to earn additional payments under LTSS CP sub-stream 3 in Budget Periods 3 through 5 by reaching high levels of achievement on avoidable utilization metrics. The State anticipates setting preliminary performance targets by August 2019 (i.e. BP2) following analysis of claims data for BP1. The State will then finalize the performance targets for BP3 by August 2020 (i.e. BP3) once the BP2 claims data is available (see Section 5.4.6 for more details). The State will set the performance standards subject to CMS approval.

4.3.7 CSA Sub-Stream 1: Infrastructure and Capacity Building Funding

CSAs will receive funds under CSA sub-stream 1 to make investments to advance their overall capabilities to support their member populations and to form partnerships with MCOs and ACOs. Infrastructure funding for CSAs will be disbursed across three categories:

1. Technology – e.g., HIT and care management software, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring, electronic medication dispensers reporting software
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications;
3. Operational Infrastructure – e.g., IT project management, system change resources, data analytics capabilities performance management capabilities and additional operational support

4.4 Payment Calculation and Timing for ACO Sub-Streams

4.4.1 ACO Sub-Streams 1 & 2: Startup/Ongoing Funding (Primary Care & Discretionary)

Each ACO will receive an amount of Startup/Ongoing funds (combined across sub-streams 1 and 2) for each Budget Period that is determined by multiplying the number of members enrolled in or attributed to the ACO by a per member per month (PMPM) amount. The State will determine the number of members.

The State will determine each ACO's PMPM amount during the Preparation Budget Period and BP 1 – 5 as follows:

- Step 1: The State will set a base rate
- Step 2: The State will increase this rate for each ACO based on the ACO's safety net category
    - The State will calculate each ACO's payer revenue mix based on the percentage of its gross patient service revenue that comes from care for MassHealth members or uninsured individuals
    - The State will categorize ACOs into five categories based on their payer revenue mix (each category has a percentage increase associated with it)
    - During the DSRIP program, the State may adjust the safety net PMPM adjustment methodology as described later in this section
- Step 3: The State will further increase this rate for each ACO based on the ACO's choice of model and risk track (each model/risk track combination has a percentage increase associated with it – (as detailed in Exhibit 8))

Exhibit 6 shows the State's anticipated average adjusted PMPMs for the ACO Startup/Ongoing sub-streams, after following the steps described above.

EXHIBIT 6 – Average Adjusted PMPMs for ACO Startup/Ongoing Support

Average Adjusted PMPMs for ACO Startup/Ongoing Support					
Prep BP	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
$21.43	$19.16	$18.14	$14.24	$9.17	$3.12

Given the potential for variation in anticipated ACO and member participation, these average adjusted PMPMs represent an estimate, and the State may disburse, on average, PMPMs that differ from the PMPMs displayed in Exhibit 6 by up to +/- $6. Individual ACO PMPMs may vary by greater amounts due to the adjustments described in this section. If a new ACO joins after BP1, e.g. in BP3, it will have the same BP3 base PMPMs as the existing ACOs and will not be assigned PMPMs differently.

ACOs with a higher percentage of revenue generated from Medicaid and uninsured patient services revenue will be placed into a higher safety net category, corresponding to a larger percentage PMPM increase. To determine each ACO's safety net category, ACOs must submit a payer revenue mix attestation form. The form contains detailed instructions on how to calculate revenue as well as the types of revenue that ACOs must provide. For example, the State requires ACOs to include patient health care service revenue from various categories, which include but are not limited to: (1) MassHealth, inclusive of Medicaid and the Children's Health Insurance Plan, (2) Health Safety Net, (3) Medicare, (4) Commercial Health Plans, (5) Other Government Sources, such as Veterans Affairs and Tricare and (6) Other Revenue Sources, such as Self-pay and Workers' Compensation). Using this information, the State will determine the Gross Patient Service Revenue (GPSR) from MassHealth and uninsured patients and place each ACO in the appropriate safety net category. See Exhibit 7 for the PMPM adjustment schedule based on safety net category.

EXHIBIT 7 – Safety Net PMPM Adjustment

Safety Net PMPM Adjustment					
Safety Net Category	**5**	**4**	**3**	**2**	**1**
% PMPM Increase	40%	30%	20%	10%	0%

As mentioned earlier, the State may also adjust the safety net PMPM adjustment methodology during the DSRIP program, as follows:

- Startup/ongoing PMPMs for members attributed to community health centers may receive a higher safety net PMPM adjustment (e.g., the maximum safety net adjustment of +40%), as described in Exhibit 7, regardless of the ACO's safety net category, reflecting the unique safety net status of these providers
- Under this revised methodology, startup/ongoing PMPMs for members attributed to other PCPs would receive a PMPM adjustment based on the ACO's overall safety net category (i.e., unchanged from current methodology)

The State will also apply a PMPM adjustment each year depending on the ACO's chosen model and risk track. This adjustment will be additive with the safety net PMPM adjustment. If an ACO switches models or risk tracks during the DSRIP period, then its PMPM adjustment will be updated to align with the new ACO model type. See Exhibit 8 for the PMPM adjustment schedule based on ACO Model and Risk Track.

EXHIBIT 8 – ACO Model and Risk Track PMPM Adjustment

ACO Model PMPM Adjustment						
ACO Model	**Accountable Care Partnership Plan (Model A)**	**Primary Care ACO (Model B)**		**MCO-Contracted ACO (Model C)**		
		Risk Track 2 (more risk)	Risk Track 1 (less risk)	Risk Track 3 (more risk)	Risk Track 2 (medium risk)	Risk Track 1 (less risk)
% PMPM Increase	40%	40%	30%	30%	10%	0%

For example, using the standard safety net PMPM adjustment methodology, if the base PMPM rate is $10, and the ACO is a Primary Care ACO (Risk Track 2) and a safety net category 3 provider, then the adjusted startup/ongoing PMPM would be $10 * (100% + 40% + 20%) = $16. If the State modifies its safety net PMPM adjustment methodology, as described above, and this ACO has 60% of members attributed to community health centers, then the ACO would have two different PMPMs for the members attributed to CHCs vs. other PCPs:

- PMPM for members attributed to CHC: $10 * (100% + 40% + 40%) = $18
- PMPM for other members: $10 * (100% + 40% + 20%) = $16

The PMPMs would be multiplied by their associated member counts, and the sum of these products would be the ACO's startup/ongoing funding amount.

The amount of funding that ACOs will need to allocate for primary care investment will be based on the following PMPM schedule:

PMPM Schedule for Startup/Ongoing Funds (Primary Care Investment)

	Prep Budget Period	**BP1**	**BP2**	**BP3**	**BP4**	**BP5**
Startup/Ongoing Funds Designated for Primary Care Investment ($PMPM)	$4	$4	$3	$3	$1	$1

All remaining startup/ongoing support (i.e. "discretionary" startup/ongoing funds) can be distributed amongst the ACO's participating providers, as decided by the ACO. This funding could be used to support additional primary care investment or assessments for members with identified LTSS needs, among other things.

Generally speaking, ACO funding sub-streams 1 and 2 will be paid in four quarterly installments for each Budget Period. The State anticipates these installments will be roughly equal; however, the State may alter the payment amounts, frequency, and timing in its discretion. For example, the State may pay a reduced amount for the first quarterly payment, which may be based on preliminary funding amount calculations, to minimize ACO disruption when funding amounts are finalized and the remaining three payments are adjusted accordingly. During BP5, payments will be attributed to the first half of the year; as such, these attributed amounts will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had $100 total of non-at-risk startup/ongoing funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 ($50 each), as opposed to $25 attributed across each of the four quarters of BP5.

4.4.2 ACO Sub-Stream 3: Flexible Services Funding

Each ACO will receive an allotment of flexible services funding for each Budget Period, except for the Preparation Budget Period during which there are no flexible services funds (because ACOs do not yet have enrolled/attributed members). ACOs will submit requests for reimbursement for approved flexible services expenses quarterly, except during Budget Period 5 (see Section 4.2.2). The State will review reimbursement requests and, if approved, will pay retroactive reimbursements to the ACO up to the allotment determined by the PMPMs detailed in Exhibit 9. The allotment will be determined on a PMPM basis, as set forth in Exhibit 9. Any undisbursed funds up to the allotment are forfeited by the ACO. The State may redistribute any undisbursed flexible services funding among the other DSRIP funding streams at the State's discretion, following the same parameters as described in Section 5.1.3 for redistribution of funding not distributed to ACOs, CPs, and CSAs. Any such redistributions would be reported to CMS in the State's quarterly progress reports.

The PMPMs for flexible services allotments will decrease over the DSRIP period as set forth in Exhibit 9. The State may vary these PMPMs in its discretion without obtaining CMS approval.

EXHIBIT 9 – PMPMs for Flexible Services

PMPMs for Flexible Services					
Prep BP	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
$0.00	$3.75	$3.25	$2.75	$2.25	$2.25

4.4.3 ACO Sub-Stream 4: DSTI Glide Path Funding

The amount of DSTI glide path funding the State will pay to each safety net hospital is detailed in Exhibit 10 below.

EXHIBIT 10 – DSTI Glide Path Funding by State Fiscal Year ($ Millions)

DSTI Glide Path Funding ($M) by State Fiscal Year						
Hospital Provider	**SFY 18**	**SFY 19**	**SFY 20**	**SFY 21**	**SFY 22**	**Total**
Boston Medical Center	$23.74M	$13.53M	$10.10M	$7.82M	$6.30M	**$61.49M**
Cambridge Health Alliance	$12.07M	$8.45M	$6.36M	$4.09M	$3.00M	**$33.99M**
Holyoke Medical Center	$2.67M	$1.58M	$1.22M	$0.99M	$0.63M	**$7.09M**
Lawrence General Hospital	$0.58M	$0.34M	$0.26M	$0.20M	$0.43M	**$1.81M**
Mercy Medical Center	$1.18M	$0.69M	$0.53M	$0.13M	$0.00M	**$2.54M**
Signature Healthcare Brockton Hospital	$1.04M	$0.61M	$0.47M	$0.37M	$0.08M	**$2.56M**
Steward Carney Hospital	$1.80M	$1.00M	$0.81M	$0.30M	$0.05M	**$3.96M**

These hospitals will only receive DSTI glide path funding through DSRIP if they participate in a MassHealth ACO, where participation means that the DSTI hospital has a provider arrangement or contract with the ACO that involves financial accountability, including the potential for the safety net hospital to share gains from savings and share responsibility for losses. For the purposes of this glide path funding, a DSTI hospital can only have a provider arrangement or contract with one ACO. This funding is not PMPM-based, but was developed to establish a glide path from current safety net care pool (SNCP) supplemental payments to reduced SNCP payments

This glide path funding needs to be converted from the state fiscal year framework to the Budget Period framework in order to align with the at-risk schedule described in Exhibit 20. Funds for the 6 month

Preparation Budget Period for each DSTI hospital will be equal to half of the hospital's glide path payments in SFY18. Budget Period 1 funds for each DSTI hospital will be equal to the sum of half of the hospital's glide path payments in SFY18 and SFY19. Budget Periods 2 through 4 for each DSTI hospital will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds for each DSTI hospital will be equal to half of the hospital's glide path payments in SFY22. See Exhibit 11 for a table displaying the DSTI glide path funding by Budget Period.

EXHIBIT 11 – DSTI Glide Path Funding by Budget Period ($ Millions)

DSTI Glide Path Funding ($M) by Budget Period							
Hospital Provider	**Prep BP**	**BP 1**	**BP 2**	**BP 3**	**BP4**	**BP5**	**Total**
Boston Medical Center	$11.87M	$18.64M	$11.81M	$8.96M	$7.06M	$3.15M	**$61.49M**
Cambridge Health Alliance	$6.04M	$10.27M	$7.41M	$5.23M	$3.55M	$1.50M	**$33.99M**
Holyoke Medical Center	$1.33M	$2.12M	$1.40M	$1.11M	$0.81M	$0.32M	**$7.09M**
Lawrence General Hospital	$0.29M	$0.46M	$0.30M	$0.23M	$0.32M	$0.21M	**$1.81M**
Mercy Medical Center	$0.59M	$0.93M	$0.61M	$0.33M	$0.07M	$0.00M	**$2.54M**
Signature Healthcare Brockton Hospital	$0.52M	$0.82M	$0.54M	$0.42M	$0.22M	$0.04M	**$2.56M**
Steward Carney Hospital	$0.90M	$1.40M	$0.91M	$0.56M	$0.18M	$0.03M	**$3.96M**

Generally speaking, DSTI glide path funding will be paid in four quarterly installments for each Budget Period. The State anticipates these installments will be roughly equal; however, the State may alter the payment amounts, frequency, and timing in its discretion. During BP5, payments will be attributed to the first half of the year; as such, these attributed amounts will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had $100 total of non-at-risk DSTI glide path funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 ($50 each), as opposed to $25 attributed across each of the four quarters of BP5.

4.4.4 Detail on calculating member-months

Each ACO will be accountable for a defined population of members. Because ACOs' responsibilities scale with their populations, the State will use the size of this population to determine the amount of Startup/Ongoing funding and the Flexible Services allotment for each ACO. For Partnership Plans and Primary Care ACOs, the number of members is simply the number of members enrolled in each ACO. Eligible MassHealth members will either choose to enroll or be assigned to these ACOs. MassHealth records members' enrollments in the agency's MMIS system and Data Warehouse. The State will tally a count of members enrolled in each ACO based on this record; this count will be multiplied by the DSRIP PMPM values to calculate the payment amounts per ACO.

For MCO-Administered ACOs, the State will use the number of members attributed to each ACO for the purposes of cost and quality accountability. These attributed members are the subset of MassHealth MCO enrollees who have primary care assignments in their MCOs to PCPs who participate in MCO-Administered ACOs. Massachusetts will know who these Participating PCPs are for each MCO-Administered ACO, and will record this information in its Data Warehouse. Each MCO will report to the State on a regular basis the primary care assignments for the MCO's enrollees. The State will use this information to determine the number of MCO enrollees who have primary care assignments to each MCO-Administered ACO; this number will be multiplied by the DSRIP PMPM values to calculate the payment amounts per MCO-Administered ACO.

The State may use a point-in-time ("snapshot") count of members for each ACO, or may calculate the average members each ACO has over a particular period (e.g., the most recent quarter) in order to ensure DSRIP payment calculations are robust to temporary fluctuations in member enrollments. Once

Massachusetts has selected ACOs and is able to perform more analytics on historical ACO-level member enrollment movement, Massachusetts intends to finalize such operational details of this calculation.

4.5 Payment Calculation and Timing for CP and CSA Sub-Streams

4.5.1 BH CP Sub-Stream 1: Care Coordination Supports Funding

The State will pay each BH CP a PMPM rate for care coordination supports for each member assigned to and engaged with the BH CP during the month. The PMPM rate has been developed to account, in part, based on the staff required to support the BH CP model, including the need for Registered Nurses, licensed clinicians, and access to a medical director for the performance of supports such as comprehensive assessments and medication reconciliation, as well as community health workers, health outreach workers, peer specialists and recovery coaches for the SMI and/or SUD population. Caseloads for each BH CP are expected to be between 35-50 engaged enrollees per FTE. The rate is anticipated to be $180 PMPM. The State anticipates that the rate will remain constant for the first two years of the program, at which time the State plans to evaluate the program and revisit the PMPM rate. The State may vary the amount of the PMPM in its discretion at any time during the demonstration.

The State will begin to pay the PMPM rate to the BH CP when the member is assigned to the BH CP. Payment for outreach will only be made to a BH CP if outreach is attempted and documented during each month. A member is considered engaged with the BH CP when a comprehensive assessment is completed and care plan is developed. Payments will be made on a monthly basis. Payments for outreach will discontinue if a member is not engaged within 3 months of assignment to the BH CP.

Example payment calculation with PMPM of $160:
Example payment amount for one month = (Total number of members assigned but not engaged + total number of members engaged)*$160

4.5.2 BH CP Sub-Stream 2: Infrastructure and Capacity Building Funding

Each BH CP will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period. BH CPs will propose allocation of funds across the four categories listed in section 4.3.2 in their Preparation Budget Period Budgets and Budget Narratives. The State anticipates disbursing up to $500,000 to each BH CP for initial infrastructure funding. The State may adjust the amount of the Preparation Budget Period funds disbursed to BH CPs in its discretion.

For Budget Periods 1 through 5, BH CPs will receive infrastructure funds based on the number of members engaged with the CP. For Budget Period 1, this will be the anticipated number of engaged members, as determined by the State. Exhibit 12 sets forth the anticipated PMPM schedule for BH CP infrastructure and capacity building funding. The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to BH CPs and CSAs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CP had $100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5. .

EXHIBIT 12 – Anticipated Schedule for BH CP for Infrastructure and Capacity Building (PMPM)

BH CP Infrastructure and Capacity Building PMPMs				
BP 1	**BP 2**	**BP 3**	**BP 4**	**BP 5**
$35.00 - $45.00	$25.00 - $35.00	$15.00 - $25.00	$10.00 - $20.00	$5.00 - $15.00

The State may vary the amount of the infrastructure PMPMs in its discretion.

As part of the Budget and Budget Narratives, BH CPs will indicate how they intend to use the infrastructure funding for amounts up to a maximum amount of possible funding (i.e., the CP's PMPM multiplied by the number of members engaged). The State may approve a lower amount based on its review of the Budgets and Budget Narratives.

For example, for a BH CP with 1,000 engaged members with a PMPM of $40.00:

Maximum amount of Budget Period 1 Infrastructure Funds = $40.00*12*1000 = $480,000

4.5.3 BH CP Sub-Stream 3: Outcomes-Based Payments

Starting in Budget Period 3, the State will designate an annual pool of funding to award to high performing BH CPs based on metrics related to avoidable utilization (see section 5.4.4). The State anticipates this pool be approximately $1M annually, but may vary this amount in its discretion. The State will set the achievement standards following analysis of baseline data from Performance Year 1 and Performance Year 2, subject to CMS approval. The total bonus the State allots yearly will be divided amongst the CPs that meet or exceed the achievement standards based on the number of members engaged with each CP relative to the number of total member engaged with all CPs that achieved the standard.

For example: five BH CPs, who collectively engaged with 7000 members, meet or exceed the achievement standard. With an annual outcomes based payment pool of $1M, a CP who engaged with 1,200 of the 7,000 members would be eligible for 17.14% of the pool or $171,400.

4.5.4 LTSS CP Sub-Stream 1: Care Coordination Supports Funding

The State will pay each LTSS CP a PMPM rate for care coordination supports for each member assigned to and engaged with the LTSS CP during the month. The PMPM rate has been developed, in part, based on the staff required to support the LTSS CP model, including the need for care coordinators with appropriate supervision at sufficient staffing levels to perform LTSS CP supports. Caseloads for LTSS CPs are expected to be between 70-100 engaged enrollees per FTE. The rate is anticipated to be $80 PMPM for each member assigned and engaged with the LTSS CPs during the month. The State will set an additional PMPM for enhanced LTSS CP functions and anticipates caseload for enhanced LTSS CP supports to be 35-50 engaged enrollees. The State may vary the amount of the PMPMs in its discretion at any time during the demonstration.

The State anticipates beginning to pay the PMPM rate to the LTSS CP when the member is assigned to the LTSS CP, provided that outreach is attempted and documented during each month. A member is considered engaged in the LTSS CP when the person-centered care plan is completed. Payments will be made on a monthly basis.

Example payment calculation with PMPM of $80:
Example payment amount for one month = (Total number of members assigned but not engaged + total number of members engaged)*$80

4.5.5 LTSS CP Sub-Stream 2: Infrastructure and Capacity Building Funding

Each LTSS CP will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period. LTSS CPs will propose allocation of funds across the four categories listed in section 4.3.2 in their Preparation Budget Period Budgets and Budget Narratives. The State anticipates disbursing up to $500,000 to each LTSS CP for initial infrastructure funding. The State has the discretion to adjust the amount of the Preparation Budget Period funds disbursed to LTSS CPs without obtaining CMS approval.

For Budget Period 1 through 5, LTSS CPs will receive infrastructure funds based on the number of members engaged with the CP. For Year 1 this will be the anticipated number of members engaged as determined by the State. The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to LTSS CPs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CP had $100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5.

EXHIBIT 13 – Anticipated Schedule for LTSS CP for Infrastructure and Capacity Building (PMPM)

LTSS CP Infrastructure and Capacity Building PMPMs				
BP 1	**BP 2**	**BP 3**	**BP 4**	**BP 5**
$30.00 - $40.00	$20.00 - $30.00	$10.00 - $20.00	$8.00 - $18.00	$5.00 - $15.00

The final PMPM will vary based on actual overall enrollment in CPs. The State may vary the amount for the PMPM without CMS approval.

CPs will submit Budgets and Budget Narratives for approval for amounts up to a maximum amount of PMPM * number of members engaged. The State will review and revise budgets as appropriate.

For example, for a LTSS CP with 1,000 engaged members with a PMPM of $35.00:

The maximum amount of Budget Period 1 Infrastructure Funds = $35.00*12*1000 = $420,000

The State may approve a lower amount based on its review of the Budget and Budget Narrative, without CMS approval.

4.5.6 LTSS CP Sub-Stream 3: Outcomes-Based Payments

Starting in Budget Period 3, the State will designate an annual pool of funding (anticipated to be approximately $500,000 annually) to award to high performing LTSS CPs based on metrics related to avoidable utilization (see section 5.4.4). The State will set the achievement standards following analysis of baseline data from Performance Year 1 and Performance Year 2, subject to CMS approval. Total bonus allotted yearly will be divided amongst the CPs that meet or exceed the achievement standards based on the number of members engaged with each CP relative to the number of total member engaged with all CPs that achieved the standard.

For example: four LTSS CPs, collectively engaged with 5,000 members, meet or exceed achieved the achievement standard. With an annual outcomes based payment pool of $500,000, a CP who engaged with 800 of the 5,000 members would be eligible for 16% of the pool or $80,000.

4.5.7 CSA Sub-Stream 1: Infrastructure and Capacity Building Funding

CSAs will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period of between $75,000 and $350,000. The State will categorize CSAs based on the number of members they serve and the number of CSA contracts held and will advise CSA of their budget for the Preparation Budget Period. CSAs will propose allocation of funds across the three infrastructure categories listed in section 4.3.7 in their Preparation Budgets and Budget Narratives. The State will then disburse initial infrastructure funding to CSAs based on the approved budget. The State may adjust the amount of the Preparation Budget Period funds disbursed to CSAs in its discretion.

Exhibit 14 sets forth the anticipated PMPM schedule for CSA infrastructure and capacity building funding. The State may vary the infrastructure PMPM amount in its discretion.

EXHIBIT 14 – Anticipated Schedule for CSAs for Infrastructure and Capacity Building (PMPM)

CSA Infrastructure and Capacity Building PMPMs				
BP 1	**BP 2**	**BP 3**	**BP 4**	**BP 5**
$35.00 - $45.00	$25.00 - $35.00	$15.00 - $25.00	$10.00 - $20.00	$5.00 - $15.00

The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to CSAs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CSA had $100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5.

4.6 Statewide Investments Funding Determination Methodology

The DSRIP Statewide Investment funding stream may be utilized by the State to fund the following initiatives: (1) Student Loan Repayment Program, (2) Primary Care Integration Models and Retention, (3) Investments in Primary Care Residency Training, (4) Workforce Development Grant Program, (5) Technical Assistance, (6) Alternative Payment Methods Preparation Fund, (7) Enhanced Diversionary Behavioral Health Activities and (8) Improved Accessibility for People with Disabilities or for Whom English Is Not a Primary Language. Exhibit 15 shows the anticipated funding breakdown for each initiative by demonstration year.

EXHIBIT 15 – Statewide Investments Funding Breakdown

Statewide Investments	Y1	Y2	Y3	Y4	Y5	Total
Student Loan Repayment Program	$2.3M	$3.9M	$3.8M	$3.5M	$2.3M	$15.8M
Primary Care Integration Models and Retention	$1.8M	$2.2M	$1.7M	$1.2M	$1.0M	$7.9M
Investment in Primary Care Residency Training	$0.3M	$1.1M	$1.8M	$2.1M	$2.4M	$7.6M
Workforce Development Grant Program	$3.2M	$2.7M	$2.5M	$2.4M	$2.4M	$13.2M
Technical Assistance for ACOs and CPs	$12.3M	$8.6M	$8.6M	$8.3M	$6.2M	$44.0M
Alternative Payment Methodology Preparation Funds	$2.4M	$2.4M	$1.9M	$4.7M	$1.2M	$12.6M
Enhanced Diversionary Behavioral Health Activities	$1.3M	$1.0M	$1.0M	$0.0M	$0.0M	$3.3M
Improved Accessibility for Members with Disabilities or for Whom English Is Not a Primary Language	$0.6M	$2.6M	$2.6M	$2.6M	$2.0M	$10.4M
Total	$24.2M	$24.6M	$23.8M	$24.8M	$17.4M	$114.8M

The State may shift funding among and within the eight Statewide Investment initiatives at its discretion, such that the funding totals for each initiative identified in Exhibit 15 and in initiative descriptions in Appendix B may change. The State must obtain CMS approval for any funding shifts within a demonstration year from one investment to another if the shifted amount is (1) greater than 15% of the original funding amount for the investment contributing the shifted amount or (2) if the shifted amount is greater than $1M, whichever is greater. Otherwise, the State will notify CMS of any funding shifts in its quarterly reports.

Sections 4.6.1 – 4.6.8 discuss the general nature and funding methodology of each Statewide Investment initiative, including which entities or providers will be eligible to apply for DSRIP funds. Appendix B provides additional details on each initiative.

4.6.1 Student Loan Repayment Program

The student loan repayment program will repay a portion of awardees' student loans in exchange for a minimum of a two-year commitment to work in a community setting. Applicants may either be individual providers working at community mental health centers, or the centers themselves. The program will offer a specified amount of funding in each recipient category per year. Provider applicants may be eligible for different amounts of loan repayment based on their discipline and credentialing level. For providers selected to receive awards, the State will pay their student loan servicer directly. The anticipated provider categories and maximum award amounts are as follows:

- Primary Care Physician – Each awardee is eligible for up to $50K in total student loan repayments
- Psychiatrists and psychologists – Each awardee is eligible for up to $50K in total student loan repayments
- Advance Practice Registered Nurses, Physician Assistants and Nurse Practitioners – Each awardee is eligible for up to $30K in total student loan repayments
- Licensed Social Workers and Licensed Behavioral Health Professionals – Each awardee is eligible for up to $30K in total student loan repayments
- Behavioral Health Professionals (community health workers, peer specialists, recovery support specialists and non-licensed social workers) – Each awardee is eligible for up to $20K in total student loan repayments

The State may vary the provider categories and award amounts in its discretion. The State may also develop enhancements to the student loan repayment program, such as learning collaboratives that engage distinct cohorts of student loan repayment recipients, which provide additional training and mentorship for providers and deepen their commitment to careers in community settings. The State will define application criteria and eligibility, and then select awardees through a competitive process that will allow the State to evaluate the applicants relative to the criteria established.

4.6.2 Primary Care Integration Models and Retention

The investment in primary care integration models and retention will support a grant program to community health centers (CHCs), community mental health centers, and entities participating in CPs and CSAs that allows primary care and behavioral health providers to design and carry out one-year projects related to accountable care. The State will define application criteria and eligibility, and will select awardees through a competitive process that will allow the State to evaluate the proposed projects for scope, impact, feasibility, cost and need, among other factors. The State anticipates that awardees will receive up to $40K per project but the amount of funding may vary by project, as determined by the State. The CHC, CMHC, or entity participating in a CP or CSA will be the primary applicant with a primary care or behavioral health provider as a partner. The State will disburse funds directly to the CHC, CMHC, or entity participating in a CP or CSA.

4.6.3 Investment in Primary Care Residency Training

The investment in primary care residency training will help offset hospital and community health center costs of filling community health center (CHCs) and community mental health center (CMHC) residency slots. The State will fund hospitals, community health centers, and community mental health centers that are selected for awards. Hospitals and CHCs/CHMCs will apply jointly for the award in the case of PCPs. The State anticipates that funding will vary based on the resident's discipline as follows:

- Primary Care Provider (PCP) – For each PCP residency slot filled, the State will pay the community health center or community mental health center up to $150K and the hospital up to $20K for a total of up to $170K for each year of residency.

- Nurse Practitioner (NP) – For each NP residency slot filled, the State will pay the community health center or community mental health center up to $85K for each year of residency.

The State will define application criteria and eligibility, and then select awardees through a competitive process that allows the State to evaluate the applications relative to the criteria established.

4.6.4 Workforce Development Grant Program

The workforce development grant program will support a range of activities to increase and enhance the State's healthcare workforce capacity (e.g., creation or support for workforce training programs, help providers to attend educational events, help ACOs/CPs/CSAs develop programs (one-on-one and group), outreach to potential workforce). The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

4.6.5 Technical Assistance for ACOs, CPs and CSAs

The technical assistance (TA) program aims to provide ACOs, CPs and CSAs with the training and expertise necessary to implement evidence-based interventions that meet the needs of the new healthcare landscape. For entities that apply and are awarded funding, the State will pay their TA vendor(s) directly. The State will also use this TA funding to invest in resources to ensure the long-term sustainability of the TA provided to eligible recipients.

Recipients may be required to contribute a certain percentage (e.g., up to 30 percent) of the overall TA costs, which will create an incentive for the recipient to work diligently with the TA vendors and the State to effect change.

TA funding will be allocated to ACOs, CPs and CSAs on a PMPM basis. The State will set the PMPM amount and may vary the amount in its discretion, for example, based on enrollment or TA applicant volume. The PMPM funding amount will represent a funding cap; i.e., the State will not award more than this amount to a recipient, but may ultimately pay less than the full PMPM allocation if the recipient's TA costs are lower than anticipated. The State may redistribute or reallocate unused TA funding in its discretion. If the overall cost of TA exceeds the PMPM allocation and recipient contribution combined, the recipient will be responsible for covering the excess cost. For example, if an ACO is required to pay 30% of the overall TA cost and is allocated $700,000 in PMPM funding:

- ACO could propose TA plan costing $1,000,000
    - ACO pays $300,000 and the State pays $700,000
- ACO could propose TA plan costing $1,100,000
    - ACO pays $400,000 and the State pays $700,000
- ACO could propose TA plan costing $900,000
    - ACO pays $270,000 and the State pays $630,000
    - State may redistribute or reallocate remaining $70,000 funding at its discretion

In order to receive TA funds, applicants must submit on a detailed TA plan that explains how funding will be used and demonstrates that funding is not duplicative of TA efforts supported by other funding sources (e.g., federal, state, private). The State will evaluate the proposed plans for scope, impact, feasibility, cost and need, among other factors prior to approval.

4.6.6 Alternative Payment Methods (APM) Preparation Fund

The APM preparation fund will support providers who are not yet ready to participate in an APM but demonstrate interest in and intent to participate in the near future. The State will define application criteria and eligibility, and will select awardees through a competitive process that will allow the State to evaluate the proposed projects for scope, impact, feasibility, cost and need, among other factors. The State will determine the funding amounts based on its evaluation of successful applications. The APM preparation fund may also be used to raise awareness about APM among providers not yet engaged in a MassHealth ACO, CP, or CSA.

4.6.7 Enhanced Diversionary Behavioral Health Activities

The investment in enhanced diversionary behavioral health activities will support the implementation of strategies to ensure members with behavioral health needs receive care in the most appropriate, least restrictive settings. The State will consider a broad spectrum of strategies for investment (e.g., technological solutions to facilitate providers' access to patients' medical histories upon arrival to the ED, data collection and analysis platforms, etc.).

The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

4.6.8 Improved Accessibility for People with Disabilities or for whom English is not a Primary Language

This investment will fund programs to support providers in the acquisition of equipment, resources and expertise that meet the needs of people with disabilities or for whom English is not a primary language. The State will consider a broad spectrum of strategies for investments (e.g., funding for purchasing items necessary to increase accessibility for members, accessible communication assistance and development of educational materials for providers and members).

The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

4.7 DSRIP Carry Forward

Given that a significant portion of DSRIP funds will be disbursed on a PMPM basis, lower than anticipated member participation in the ACO or CP programs may lead to lower actual expenditures in a given DSRIP year. Therefore, the State may carry forward prior year DSRIP expenditure authority from one year to the next for reasons related to member participation fluctuations. This carry forward authority will extend to the following funding streams; as these areas are directly related to and impacted by member participation fluctuation.

- All ACO funding streams
- All CP funding streams
- Statewide Investments: technical assistance and workforce development grant programs

- State operations/implementation

The State does not have carry forward authority for other funding streams within statewide investments.

Per STC 57(d)(iii), if the expenditure authority carried forward from one year to another is more than 15% of the prior year's expenditure authority, then the State will submit a request to carry forward the expenditure authority for review and approval by CMS. CMS will respond to the State's request within 60 business days. If approved, the State will provide an updated funding allocation table to CMS in the next quarterly progress report to CMS. If the carryforward amount is less than or equal to 15% of the prior year's expenditure authority, then the State will provide an updated funding allocation table to CMS in the next quarterly progress report to CMS. The State must ensure that carry over does not result in the amount of DSRIP expenditure authority for DSRIP Year 5 being greater than the amount for DSRIP Year 4.

Section 5. DSRIP Accountability Framework (State Accountability to CMS; ACO, CP and CSA Accountability to State)

5.1 Overview

The State has structured an accountability framework for its DSRIP program, under which the State is accountable to CMS for the State's achievement of delivery system reform goals. The State's failure to achieve the standards set for these goals may result in the loss of DSRIP expenditure authority according to the at-risk schedule set forth in STC 67(b). Any lost expenditure authority will result in parallel reduced DSRIP expenditures by the State. If the State experiences reduced expenditure authority from CMS, the State has discretion to determine whether and to what extent to reduce any of the four funding streams to best meet the State's programmatic needs while adhering to the State's DSRIP expenditure authority.

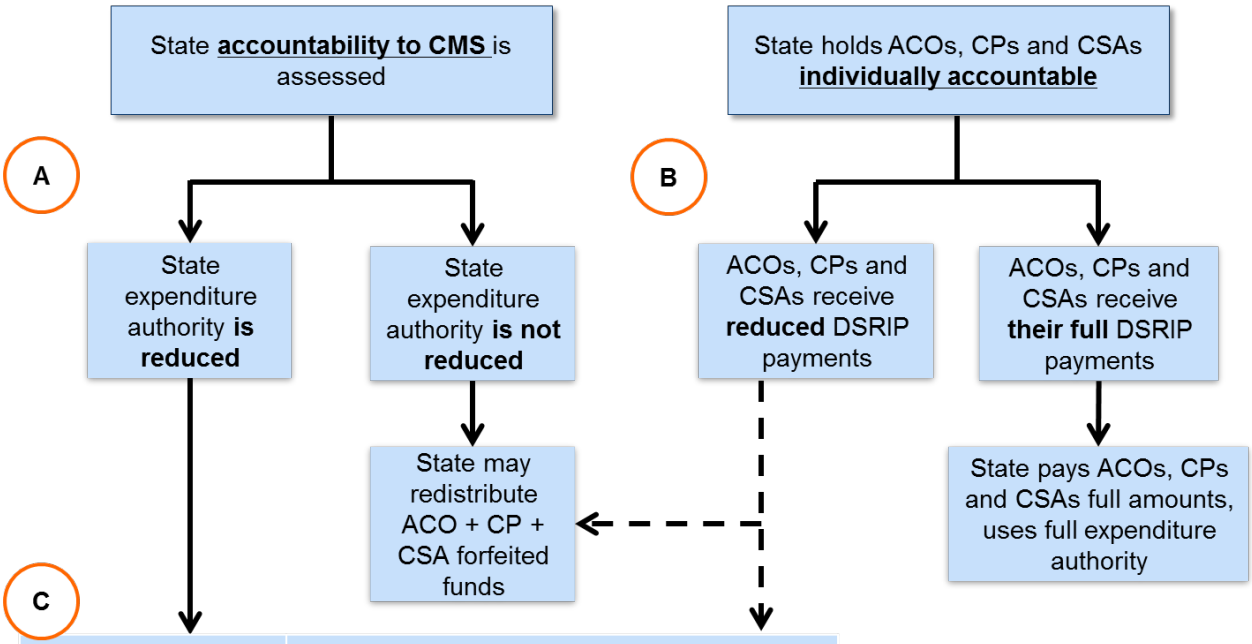
Separately, to maximize incentives for delivery system reform, ACOs, CPs and CSAs that receive DSRIP funds are each accountable to the State for their individual performance. An ACO's, CP's or CSA's failure to achieve the individual accountability standards set by the State may result in the ACO, CP or CSA receiving less DSRIP funding from the state. Any reduction in DSRIP funding experienced by an individual ACO, CP or CSA will not necessarily impact the State's overall DSRIP expenditure authority under the demonstration.

Exhibit 16 below illustrates the State's accountability to CMS, and also illustrates ACOs', CPs' and CSAs' accountability to the State and how these two accountability mechanisms interact.

This section will describe each step of these accountability mechanisms as follows:

- Section 5.1: provides an overview of DSRIP Accountability Framework for the State to CMS and ACOs, CPs and CSAs to the State
- Section 5.2: provides detail on State Accountability to CMS
- Section 5.3: provides detail on accountability framework and performance based payments for ACOs
- Section 5.4: provides detail on accountability framework and performance based payments for CPs and CSAs
- Section 5.5: outlines reporting requirements for ACOs, CPs and CSAs

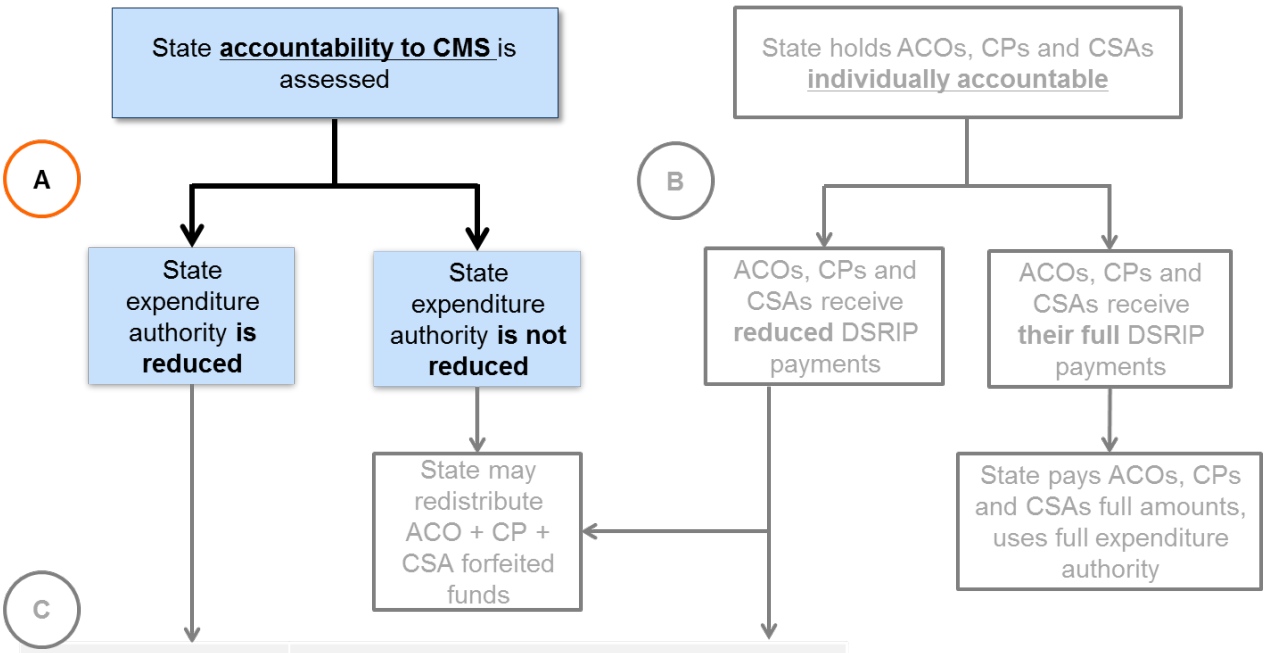
EXHIBIT 16 – Process Flow for State Accountability to CMS and Accountability of ACOs, CPs, and CSAs to the State



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

5.1.1 State Accountability to CMS

EXHIBIT 17 – Process Flow for State Accountability to CMS



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

A portion of the State's DSRIP expenditure authority will be at-risk based on the State's DSRIP Accountability Score according to the schedule set forth in STC 67(b). The portion of the State's DSRIP expenditure authority that is at-risk will follow the same at-risk Budget Period structure as for the ACOs, CPs and CSAs.

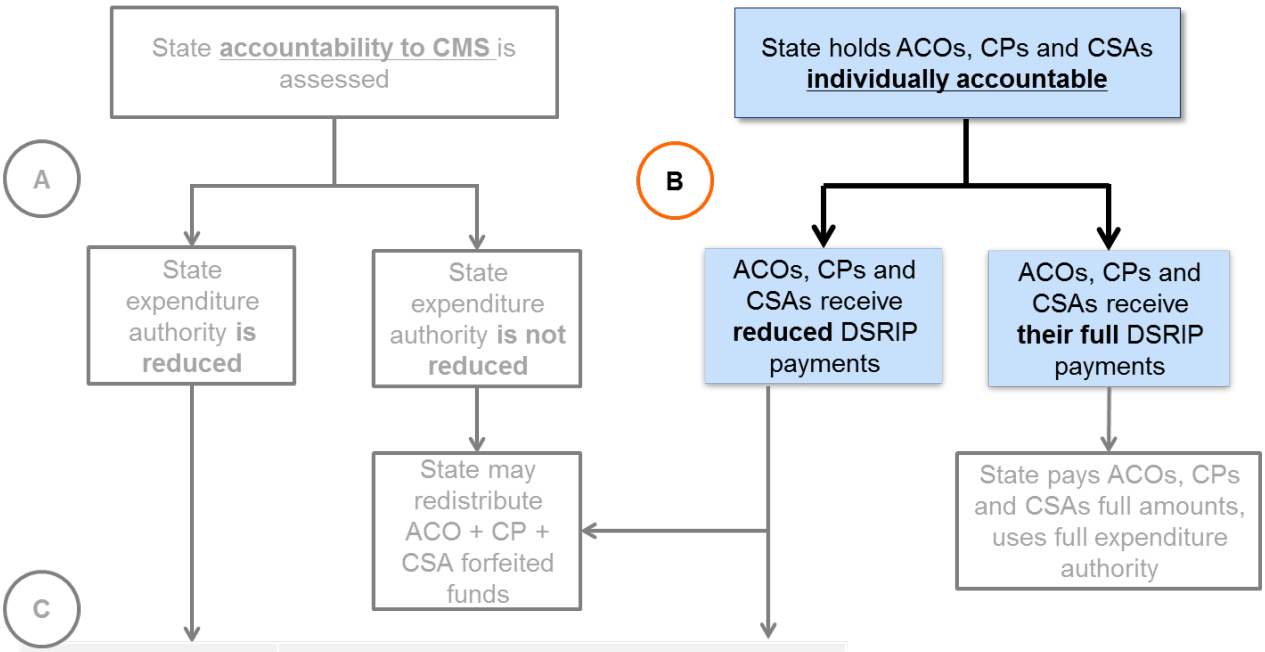
The Preparation Budget Period and BP1 will not have any at-risk expenditure authority. BP 2 has at-risk expenditure authority, and its Accountability Score will not be determined until the fourth quarter of BP3. Thus, the State anticipates that any reduced expenditure authority may be reflected in the State's reduction of DSRIP payments during BP 4. As an example, if the State' Accountability Score for BP 2 is 70%, then the State will lose the remaining 30% of its $20.625M of BP 2 at-risk expenditure authority (i.e., $6.1875M). The State may reflect this by subtracting up to $6.1875M from its anticipated $275M BP 4 DSRIP expenditure authority.

The State may also satisfy any reductions in DSRIP expenditure authority through retroactive recoupments from recipients of DSRIP funds, or through the State paying CMS back for any Federal Financial Participation the State retroactively owes for such reductions. For example, for Budget Periods 4 and 5, the State anticipates that there will be no upcoming Budget Periods for which to reduce DSRIP expenditures by the time the Accountability Scores for these Budget Periods are calculated; the State may therefore satisfy any reductions in DSRIP expenditure authority for these Budget Periods through such recoupments, through paying CMS back, or through identifying other cost savings in the DSRIP program, such as in the statewide investments or implementation/oversight funding streams.

If the State decides to recoup funding from ACOs or CPs, then it will first distribute the recoupment amounts among the ACOs and CPs as a class. One potential approach for this initial distribution is to divide the recoupment amount according to the 5-year DSRIP expenditure authority for the ACO and CP funding streams, as detailed in Table F of the STCs (i.e., ACOs: $1,065.6M, or 66.1%; CPs: $546.6M, or 33.9%). To determine how much funding is recouped from individual ACOs, the State may take each ACO's DSRIP Accountability Score and calculate the difference from 100%. The State will then calculate a weight for each ACO that is equal to that ACO's "difference from 100%" divided by the summed total of all the ACOs' "difference from 100%". That weight will then be multiplied by the ACO portion of the recoupment amount to determine the amount of funding that the State will recoup from the ACO. As an example, if the State needs to recoup $100 for BP4, then it will first divide the recoupment between the ACOs and CPs according to Table F of the STCs (i.e., ACOs and CPs will need to pay back $66.10 and $33.90, respectively). If there are two ACOs, and ACO 1 scored a 90%, and ACO 2 scored a 60% (corresponding to “differences from 100%” of 10% and 40%, respectively), then ACO 1 would need to pay back $66.10 * (10% / (10% + 40%)) = $13.22, and ACO 2 would need to pay back $66.10 * (40% / (10% + 40%)) = $52.88. The State may implement a different methodology for recouping funds from CPs and CSAs. The State will make a final determination of its recoupment methodology once it decides that it will recoup funds, and once it understands why the State had to recoup funds. For example, the recoupment methodology described above may be appropriate for poor statewide quality performance, but inappropriate for poor statewide APM adoption.

5.1.2 ACO, CP and CSA Accountability to the State

EXHIBIT 18 – Process Flow for ACO, CP and CSA Accountability to the State



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

Regardless of the State's performance with respect to its accountability to CMS, the State will separately hold each ACO, CP and CSA that receives DSRIP funds individually accountable for its performance on a slate of quality and performance measures. This structure maximizes performance incentives for these recipients.

This individual accountability is applied to each ACO's, CP's and CSA's at-risk DSRIP funding for each budget period. The State intends to withhold the at-risk portion of ACO's, CP's and CSA's funding until the respective Accountability Scores are calculated. The ACOs, CPs and CSAs will then receive a percentage of their withheld funds based on their Accountability Score (e.g., if an entity scores 0.6, it will receive 60% of the at risk funds) and will not receive the remainder.

As described above, ACOs receive four sub-streams of DSRIP payment. The mechanism for accountability differs slightly by stream, as explained in the table below.

EXHIBIT 19 – ACO Accountability Mechanism by Funding Sub-Stream

ACO Accountability Mechanism by Funding Sub-Stream		
Provider Type	**Funding Sub-Stream**	**Mechanism for Individual Accountability**
ACOs	**Startup/Ongoing:** *Primary Care Investment*	Fixed amount, not withheld or at-risk
	Startup/Ongoing: *Discretionary*	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	DSTI Glide Path	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	Flexible Services	Not at performance risk, but reimbursed retrospectively based on State approval of ACOs' reimbursement requests for costs incurred. ACOs fully at risk for any expenses not approved by the State.

The portion of Startup/Ongoing funding that is provided for each ACO to support primary care investments are not at performance risk in order to provide some measure of predictability and stability in this funding stream, to encourage innovative investments in primary care infrastructure, and to mitigate the risk of costly delays or changes in funding that might make front-line primary care providers more hesitant to invest in practice-level change.

The at-risk withheld amount differs between the discretionary Startup/Ongoing stream, and the DSTI Glide Path. In general, a smaller percentage of the DSTI Glide Path funding is at risk. This difference reflects the safety net status of these hospitals.

EXHIBIT 20 – Percent of ACO Funding At Risk by Budget Period

Percent of ACO Funding At Risk by Budget Period						
DSRIP Budget Period	**Prep BP**	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
Startup/Ongoing (Discretionary) At-Risk	0%	5%	15%	30%	40%	50%
Glide Path Funding At-Risk	0%	5%	5%	10%	15%	20%

For ACOs that join after BP1, their at-risk schedule will start at the BP1 percent (i.e. 5%), and then follow the schedule above with appropriate lag. For example, if an ACO joins in BP3, their at-risk schedule for the discretionary startup/ongoing funds would be: BP3 – 5%, BP4 – 15%, BP5 – 30%

CPs and CSAs also receive several funding streams, as described below. Funds for Care Coordination Supports and Infrastructure and Capacity Building are at risk for BH and LTSS CPs. Infrastructure and Capacity Building funds are at risk for CSAs. The amount of CP funds that are at-risk increases over the course of the program.

The accountability mechanisms for CPs and CSAs also vary by funding sub-streams, as described below. Funds for Care Coordination Supports and Infrastructure and Capacity Building are at risk for BH and LTSS CPs. Infrastructure and Capacity Building funds are at risk for CSAs.

EXHIBIT 21 – CP and CSA Accountability Mechanism by Funding Sub-Stream

CP and CSA Accountability Mechanism by Funding Sub-Stream		
Provider Type	**Funding Sub-Stream**	**Mechanism for Individual Accountability**
BH CPs	*Care Coordination Supports*	Withheld portion is fully at-risk each BP based on CP's Accountability Score
	Infrastructure & Capacity Building	
	Outcome-Based Payments	Incentive pool based on performance on avoidable utilization measures
CSAs	*Infrastructure & Capacity Building*	Withheld portion is fully at-risk each BP based on CSA's Accountability Score
LTSS CPs	*Care Coordination Supports*	Withheld portion is fully at-risk each BP based on CP's Accountability Score
	Infrastructure & Capacity Building	
	Outcome-Based Payments	Incentive pool based on performance on avoidable utilization measures

Exhibit 22 sets forth the amount of CP and CSA funding that is at risk by budget period.

EXHIBIT 22 – Amount of CP and CSA Funding At-Risk by Budget Period

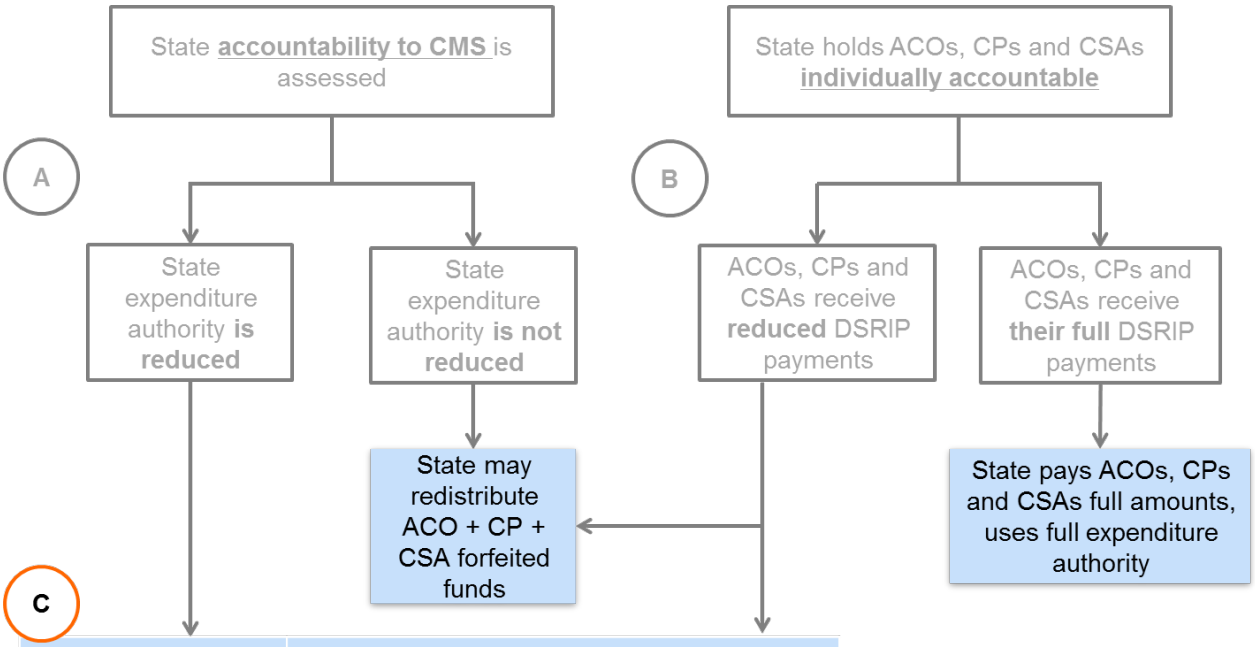
Percent of CP and CSA Funding At-Risk by Budget Period						
DSRIP Budget Period	**Prep BP**	**BP1**	**BP2**	**BP3**	**BP4**	**BP5**
% of CP and CSA Funding At-Risk, excepting Outcome-Based Payments	0%	0%	5%	10%	15%	20%

For CPs or CSAs that join after BP1, their at-risk schedule will start at the BP1 percent (i.e. 0%), and then follow the schedule above with appropriate lag. For example, if a CP joins in BP3, their at-risk schedule for the DSRIP funds would be: BP3 – 0%, BP4 – 5%, BP5 – 10%.

In addition to holding ACOs, CPs, and CSAs accountable by designating a portion of their DSRIP funding as at-risk, the State will manage its contracts with these entities to ensure compliance with and satisfactory performance of contractual requirements related to the DSRIP program. In the event of noncompliance or unsatisfactory performance, the State will determine the appropriate recourse, which may include contract management activities such as, but not limited to: working collaboratively with the ACOs, CPs, or CSAs to identify and implement new strategies to meet their contractual requirements, requiring the ACOs, CPs, or CSAs to implement corrective action plans, or reducing DSRIP payments to the ACOs, CPs, or CSAs. If the State reduces DSRIP payments to ACOs, CPs, or CSAs as part of its contract management efforts, the undisbursed funds may be redistributed among the other DSRIP funding streams at the State's discretion, following the parameters described in Section 5.1.3.

5.1.3 Distribution of Funds Based on Accountability

EXHIBIT 23 – Process Flow for Distribution of Funds Based on Accountability



If ACO + CP + CSA reductions…	The State…
> state authority reduction	May redistribute **the excess** ACO + CP + CSA reductions
= state authority reduction	Holds each ACO, CP and CSA accountable, makes other DSRIP payments as normal
< state authority reduction	Holds each ACO, CP and CSA accountable, reduces DSRIP payments at discretion

Based on the State's assessments of individual accountability for each ACO, CP and CSA, individual ACOs, CPs and CSAs may not receive a certain amount of DSRIP funds each Budget Period, relative to the maximum each could potentially receive.

If the State's expenditure authority is not reduced based on its accountability to CMS, the State has discretion to redistribute the DSRIP funds not distributed to ACOs, CPs, and CSAs (e.g., to determine how much each of the funding streams and sub-streams is increased) to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. For example, the State will identify the amount of forfeited DSRIP funds it has available to redistribute, and then determine how it might reallocate the funds to other DSRIP funding streams. Any such redistributions would be reported with CMS in the State's quarterly progress reports.

For example, in Q4 of BP3, the BP2 Accountability Scores for the State, ACOs, CPs and CSAs will become available. If ACOs lost $1M of at-risk BP2 funds and the State earned a 100% DSRIP Accountability Score, then the State could reallocate that $1M to a different funding stream or sub-stream, at the State's discretion, based on the State's assessment of program needs, in the remaining time left in BP3 (e.g., increase flexible services allocation for ACOs, increase care coordination funding amounts or the outcomes-based incentive pool for CPs, increase statewide investments funding or

implementation/oversight funding), or may be used for future BP4 or BP5 payments. The allowable categories that the redistributed funds could be reallocated to are:

- ACO funding stream
  - Startup/ongoing
  - Flexible services
- Community Partners funding stream
  - Infrastructure and capacity building
  - Care coordination
  - Outcomes-based payments
- Statewide Investments funding stream
  - All statewide investments

If the State's expenditure authority has been reduced based on its accountability to CMS, the State will base its actions on the relative sizes of these reductions, as follows:

- If the amount of funds not distributed to ACOs, CPs and CSAs pursuant to their accountability scores is equal to the State's expenditure authority reduction based on the State's accountability to CMS, the State will satisfy its obligation to reduce DSRIP spending by reducing payments to these ACOs, CPs and CSAs based on their individual accountability arrangements with the State, and will make other DSRIP payments pursuant to this Protocol
- If the amount of funds not distributed to ACOs, CPs and CSAs pursuant to their accountability scores exceeds the State's expenditure authority reduction based on the State's accountability to CMS, the State will satisfy its obligation to reduce DSRIP spending by reducing payments to these ACOs, CPs and CSAs based on their individual accountability arrangements with the State, but the State may have left over expenditure authority after doing so. The State has discretion to redistribute these excess DSRIP funds not distributed to ACOs, CPs, and CSAs pursuant to their accountability scores (e.g., to determine how much each of the funding streams and sub-streams is increased) to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. Such redistribution of funds would follow the same processes described above for when the State's expenditure authority has not been reduced.
- If the amount of funds not distributed to ACOs, CPs and CSAs is less than the State's expenditure authority reduction based on the State's accountability to CMS (including if ACOs, CPs and CSAs receive all DSRIP funds under their accountability arrangements with the State), the State has discretion to determine whether and to what extent each of the four funding streams and sub-streams is reduced for an upcoming Budget Period to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. The State also has discretion to determine whether and to what extent to satisfy the reduced expenditure authority through retroactive recoupments from recipients of DSRIP payments or through separately paying CMS back for the Federal Financial Participation for any such reduced expenditure authority.
  - State DSRIP expenditures can be categorized as (1) non-at-risk payments and (2) at-risk payments which are dependent on the calculation of Accountability Scores. The at-risk payments cannot be disbursed until CMS approves the Accountability Scores that are used to calculate the at-risk payments, as described in Section 5.2.2. The State will make non-at-risk payments and then retroactively claim FFP for those payments. Given that the FFP claiming for the non-at-risk payments for a particular Budget Period may occur before the State's Accountability Score is calculated for that Budget Period, it is possible for the State to claim more FFP than its reduced expenditure authority would allow. In this scenario, the State would reconcile its claimed FFP amount with CMS. If the State retroactively recoups funds from ACOs, CPs, or CSAs, it will follow the process laid out in Section 5.1.1.

5.2 State Accountability to CMS

As set forth in STC 67, a portion of the State's DSRIP expenditure authority will be at-risk. In accordance with STC 67, if the State's DSRIP expenditure authority is reduced based on an Accountability Score that is less than 100%, then the State will reduce future DSRIP payments in proportion to the reduced expenditure authority to ensure sufficient state funding to support the program. The portion of at-risk DSRIP expenditure authority is set forth in Exhibit 24.

EXHIBIT 24 – Percent of DSRIP Expenditure Authority At-Risk

DSRIP Budget Period	Prep BP and BP1	BP 2	BP 3	BP 4	BP 5
DSRIP Expenditure Authority	$637.5aM	$412.5M	$362.5M	$275M	$112.5M
% of Expenditure Authority At-Risk	0%	5%	10%	15%	20%
Actual Expenditure Authority At-Risk	$0M	$20.625M	$36.25M	$41.25M	$22.5M

The amount of at-risk DSRIP expenditure authority lost will be determined by the State's DSRIP Accountability Score. The methodology for calculating the State's DSRIP Accountability Score is discussed in Section 5.2.1.

5.2.1 Calculating the State DSRIP Accountability Score

The State DSRIP Accountability Score will be based on three domains: (1) MassHealth ACO/APM Adoption Rate; (2) Reduction in State Spending Growth; and (3) ACO Quality and Utilization Performance.

Each domain will be assigned a weight that varies by Budget Period. The weights for the State DSRIP Accountability domains are detailed in Exhibit 25:

EXHIBIT 25 – State DSRIP Accountability Domains

State DSRIP Accountability Domain	% Contribution to State DSRIP Accountability Score			
	Prep Budget	**BP 1**	**BP 2**	**BP 3-5**
MassHealth ACO/APM Adoption Rate	NA	NA	30%	20%
Reduction in State Spending Growth	NA	NA	NA	25%
ACO Quality and Utilization Performance	NA	NA	70%	55%

The State will calculate the State DSRIP Accountability Score by multiplying the Score for each State DSRIP Accountability domain by the associated weight and then summing the totals together.

For example, the BP 5 State DSRIP Accountability Score is calculated using the following equation:

State DSRIP Accountability Score = (MassHealth ACO/APM Adoption Rate Score) * 20% + (Reduction in State Spending Growth Score) * 25% + (ACO Quality and Utilization Performance Score) * 55%

If the State is able to earn 100% for the MassHealth/APM Adoption Rate Score, 30% for the Reduction in State Spending Growth Score, and 70% for the ACO Quality and Utilization Performance Score, then the State's DSRIP Accountability Score would be:

State DSRIP Accountability Score = (100%) * 20% + (30%) * 25% + (70%) * 55% = 66%

The State estimates that it will take approximately nine months after the close of a Budget Period to calculate the State DSRIP Accountability Score, due to claims rollout and other administrative considerations. Thus, the State anticipates that it will provide its DSRIP Accountability Score and supporting documentation for a given Budget Period during Q4 of the following Budget Period. If the State DSRIP Accountability Score is not 100%, pursuant to STC 67(d), the State will submit to CMS a proposed Corrective Action Plan at the same time as it submits its State DSRIP Accountability Score and supporting documentation.

Corrective Action Plan

The Corrective Action Plan will include steps the State will take to regain any reduction to its DSRIP expenditure authority; and potential modification of accountability targets. The State's Corrective Action Plan will be subject to CMS approval. CMS will render a decision on approval or disapproval of requested Corrective Action Plan within 60 business days of receipt of Plan and prior to determining the amount of reduction to the State's DSRIP expenditure authority. If CMS does not approve the Corrective Action Plan, then the State's DSRIP expenditure authority will be reduced in accordance with the State DSRIP Accountability Score. If CMS approves the Corrective Action Plan, the State's DSRIP expenditure authority for the relevant Budget Period will be held intact and not reduced, contingent on the State successfully implementing the approved Corrective Action Plan. If the State fails to implement the Corrective Action Plan, then CMS will retrospectively reduce the State's DSRIP expenditure authority in accordance with the State's DSRIP Accountability Score. If the State partially implements the Corrective Action Plan, then CMS has the discretion to require a smaller retrospective reduction in the State's DSRIP expenditure authority.

5.2.1.1 State Accountability Domain 1: Calculating the MassHealth ACO/APM Adoption Rate

Under the MassHealth ACO/APM Adoption Rate accountability domain, the State will have target percentages for the number of MassHealth ACO-eligible members who are enrolled in or attributed to ACOs or who receive service from providers paid under APMs. The State will calculate the percentage of ACO-eligible members enrolled in or attributed to ACOs or who receive services from providers paid under APMs, as follows:

- ACO-eligible members shall be all members who are eligible to enroll in or be attributed to MassHealth ACOs
- The State shall count towards the State's achievement of ACO/APM adoption, all members who:
    - Are enrolled in or attributed to an ACO during the Budget Period
    - Are enrolled with a MassHealth MCO and receive primary care from a PCP that is paid by that MCO under a shared savings and/or shared risk arrangement, or is similarly held financially accountable by that MCO for the cost and quality of care under a State-approved APM contract
    - Receive more than 20% of their non-primary care services (either gross patient service revenue or net patient service revenue) from providers who are paid under episode-based payments, shared savings and/or shared risk arrangements, or who are similarly held

financially accountable for the cost and quality of care under a State-approved APM contract

The target adoption percentages will follow the schedule detailed in Exhibit 26.

EXHIBIT 26 – Target ACO/APM Adoption Rates

DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
ACO/APM adoption (as defined above)	NA	25%	30%	35%	40%	45%

If the State meets or surpasses the target for a given Budget Period, the State will earn a 100% score on this domain for that Budget Period. If the State does not meet the target, then it will earn a 0% score for that Budget Period.

5.2.1.2 State Accountability Domain 2: Reduction in State Spending Growth

In accordance with STC 67(g), the State will calculate its performance on reduction in state spending growth compared to the trended PMPM, as detailed in Exhibit 27 and the domain score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed in STC 67(g). The PMPM used will be as follows:

4.4% - 2017 President's Budget Medicaid Baseline smoothed per capita cost trend, all populations combined, 2017-2022

The State will be accountable to a 2.1% reduction in PMPMs for the ACO-enrolled population, off of "trended PMPMs" (described below) by BP 5. In Budget Periods 3 and 4, the State will have target reductions smaller than 2.1% off of the trended PMPM, as preliminarily detailed in Exhibit 27.

EXHIBIT 27 – Proposed Reduction Targets for ACO-Enrolled PMPMs

DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
% Reduction Target in ACO-enrolled PMPM vs. trended PMPM	NA	NA	NA	0.25% off of trended PMPM	1.1% off of trended PMPM	2.1% off of trended PMPM

Gap to Goal Methodology

In accordance with STC 67(g), the State will calculate its performance on reduction in State spending growth compared to the trended PMPM, and the domain score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed in STC 67(g).

The State will measure spending performance against the PMPM spending reduction target no later than 12 months after the close of each Calendar Year (CY) as follows. Baseline spending trends will be determined no later than January 1st, 2019, according to the following methodology:

- Baseline PMPM spending in CY2017 will be calculated by dividing actual expenditures for dates of service in CY2017 in Included Spending Categories (as defined below), by the number of member months for all MCO and PCC -enrolled members (i.e., ACO-eligible population) for each Rating Category (RC):

- RC 1 – Child: Enrollees who are non-disabled, under the age of 21, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505
- RC 1 – Adult: Enrollees who are non-disabled, age 21 to 64, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505
- RC 2 – Child: Enrollees who are disabled, under the age of 21, and in MassHealth Standard or CommonHealth as described in 130 CMR 505
- RC 2 – Adult: Enrollees who are disabled, age 21 to 64, and in MassHealth Standard or CommonHealth as described in 130 CMR 505
- RC 9: Individuals ages 21 through 64 with incomes up to 133% of the federal poverty level (FPL), who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage
- RC 10: Individuals ages 21 through 64 with incomes up to 133% of the FPL, who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage, who are receiving Emergency Aid to the Elderly, Disabled, and Children (EAEDC) through the Massachusetts Department of Transitional Assistance

- A weighted-average Baseline PMPM will then be calculated by multiplying the PMPM rate for each EG by the proportion of ACO-eligible population member months represented within each RC to derive the Baseline PMPM.

$$Baseline\ PMPM^{CY2017} = \sum_{n} Actual\ PMPM_{RC\,n}^{CY2017} \times ACOeligpopRCproportion_{RC\,n}^{CY2017}$$

- Trended PMPMs for each RC will be calculated by applying a 4.4% annual growth rate to the CY2017 Actual PMPMs for each RC and year from CY2018 through CY2022, summarized as follows:

$$Trended\ PMPM_{RC\,n}^{YEAR\,t} = 1.044^{t} \times Actual\ PMPM_{RC\,n}$$

- For each measurement period, a weighted average Trended PMPM (the "Avg Trended PMPM") will then be calculated by multiplying the Trended PMPM for each RC by the proportion of total ACO-enrolled or ACO-attributed (collectively, the "ACO population") member months represented within each RC, summarized as follows:

$$Avg\ Trended\ PMPM^{YEAR\,t} = \sum_{n} Trended\ PMPM_{RC\,n}^{YEAR\,t} \times ACOeligpopEGproportion_{RC\,n}^{YEAR\,t}$$

  - Note that while the Trended PMPM for each RC will remain constant (4.4% annual increase from CY2017), the base PMPM for each calendar year will change based on the actual composition of the ACO population during each measurement period

- If during the measurement period there are changes to Included Spending Categories or other material program changes not captured in the annual growth rate, the CY2017 Baseline and Trended PMPMs may be recalculated to reflect these changes, subject to CMS approval.
  - In particular, if the State identifies a material difference between the CY2017 ACO eligible population and the population of members and provider networks that participate

in the ACO program during the performance years (e.g., if ACOs that have historically high costs for their member populations join the program), the State may request that CMS adjust the CY2017 baseline to account for such difference; the State shall provide supporting analysis in the event of such a request, and CMS will have 90 calendar days to review and approve the request.

For each Calendar Year, performance of the ACO population will be measured as follows:

- The State will divide actual expenditures in Included Spending Categories by eligible member months during the CY to generate raw PMPM spending for the ACO population and also for the ACO-eligible population within each RC. Actual expenditures will be based on date of service, and will be derived from Medicaid claims data, MCO encounter data, and/or accounting reports, summarized as follows:

$$ACO\ Elig\ Pop\ Raw\ PMPM_{RC\ n}^{YEAR\ t} = Aco\ Elig\ Pop\ Actual\ Expenditures_{RC\ n}^{YEAR\ t} \div ACO\ eligpop\ MM_{RC\ n}^{YEAR\ t}$$

$$ACO\ Pop\ Raw\ PMPM\ _{RC\ n}^{YEAR\ t} = ACO\ Pop\ Actual\ Expenditures_{RC\ n}^{YEAR\ t} \div ACO\ pop\ MM_{RC\ n}^{YEAR\ t}$$

- To adjust for differences in acuity, an average risk score based on data from the measurement period will be calculated for each of these two populations in each RC using the DxCG risk model employed for ACO pricing.

- The risk score for the ACO population will be normalized relative to a score of 1.0 for the full ACO-eligible population.

- Raw PMPMs for the ACO population will be divided by normalized risk scores to calculate risk-adjusted PMPMs, summarized as follows:

$$Adj\ PMPM_{RC\ n}^{YEAR\ t} = \frac{Raw\ PMPM_{RC\ n}^{YEAR\ t}}{ACO\ Pop\ Risk\ Score_{RC\ n}^{YEAR\ t} \Big/ ACO\ Elig\ Risk\ Score_{RC\ n}^{YEAR\ t}}$$

- A weighted average risk-adjusted PMPM for the ACO population will be calculated by aggregating the products of the risk-adjusted PMPMs for each RC multiplied by the proportion of total ACO population member months represented within each RC, summarized as follows:

$$Avg\ Adj\ PMPM^{Year\ t} = \sum_{n} Adj\ PMPM_{\mathrm{RC}n}^{YEAR\ t} \times ACO\ pop\ \mathrm{RC}proportion_{\mathrm{RC}n}^{YEAR\ t}$$

- Savings attributed to the "DSTI Glide Path" sub-stream payments will be subtracted from the weighted average risk-adjusted PMPM on an aggregate basis each CY.

    - DSTI Glide Path payments made during the CY will be subtracted from the DSTI payments made during CY2017 and divided by the total member months included in measurement year's weighted average risk-adjusted PMPM. The resulting savings PMPM will be subtracted from the weighted average risk-adjusted PMPM to derive total PMPM spending for the ACO population ("Actual PMPM"), summarized as follows:

$$Actual\ PMPM^{YEAR\ t} = Avg\ Adj\ PMPM^{YEAR\ t} - \frac{DSTI\ payments^{CY2017} - DSTI\ Glide\ Path\ payments^{YEAR\ t}}{ACO\ pop\ member\ months}$$

- The percent reduction in Actual PMPM will be determined according to the following calculation: percent reduction = (Avg Trended PMPM minus Actual PMPM) / (Avg Trended PMPM), summarized as follows:

$$Percent\ reduction^{YEAR\ t} = \frac{Avg\ Trended\ PMPM^{YEAR\ t} - Actual\ PMPM^{YEAR\ t}}{Avg\ Trended\ PMPM^{YEAR\ t}}$$

Included Spending Categories

Determination of spending baseline and actual performance of the ACO population will take into consideration all expenses included in ACOs' capitation rates and TCOC Benchmark calculations for year 1 of the ACO program. For the population of members attributed to MCO-Administered ACOs, the determination of spending will be based on actual MCO expenditures for services to the population attributed to the ACO, and not on the State's capitated payments to the MCO. These costs include costs for covered services such as physical health, behavioral health, and most pharmacy, but do not include costs for Long Term Services and Supports (LTSS) and certain other costs that are similarly excluded from ACO capitation rates and TCOC Benchmarks. In addition, the following expenditure categories shall be excluded from both baseline and actual performance measurement for the purposes of the state's TCOC accountability to CMS, regardless of their inclusion in or exclusion from ACO TCOC:

- Hepatitis C drugs
- Other high-cost emerging drug therapies (e.g., treatment for cystic fibrosis) that result in a significant increase in spending that is not reasonably in the control of an ACO to manage
- Long-term services and supports (LTSS)
- All DSRIP expenditures except those for the DSTI Glide Path sub-stream as described above
- Payments made in accordance with Attachment Q of the 1115 Waiver Demonstration and other quality incentive payments
- All administrative payments made to ACOs, or to MCOs for MCO-Contracted members

The State may submit requests for additional exclusions or Baseline PMPM adjustments for CMS approval by submitting an amendment to the Protocol. CMS will have 60 business days to review and respond to these methodology modification requests.

PMPM Spending Reporting Tool

The State and CMS will jointly develop a reporting tool (using a mutually agreeable spreadsheet program) for the State to use for annual PMPM spending demonstration and in other situations when an analysis of ACO-enrolled population PMPM spending is required. A working version of the reporting tool will be available for the State's report for the first Budget Period.

5.2.1.3 State Accountability Domain 3: Overall Statewide Quality and Utilization Performance

In accordance with STC 67(h), the State will annually calculate the State performance score for each quality and utilization domain by aggregating the performance scores of all ACOs on a member-month

weighted basis. That is, ACOs with more members will have their domain performance scores weighted more heavily than ACOs with fewer members. The anticipated weighting of each domain to the State Overall Statewide Quality and Utilization Performance is detailed in Exhibit 28. The overall DSRIP quality and utilization domain score will be determined by calculating a weighted sum of the DSRIP domain scores, according to the domain weights detailed in Exhibit 28. Please see Appendix D for example calculations.

EXHIBIT 28 – Anticipated Weighting of ACO Quality and Utilization Domains

Domain	Budget Period 1 (reporting only, focused on clinical quality measure)	Budget Periods 2-5
Prevention & Wellness	20%	10%
Chronic Disease Management	20%	15%
Behavioral Health / Substance Use	25%	15%
Long Term Services and Supports	10%	5%
Avoidable Utilization	0%	20%
Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	25%	20%
Member Care Experience	0%	15%

The measures within the domains are the same measures for the State as for the ACOs (i.e., Appendix D). For an ACO, measures within a given domain all contribute to that ACO's domain score equally. For the State Accountability Domain Scores, ACO domain scores are averaged together and weighted by the number of members per ACO, thereby creating a weighted average of domain scores across all ACOs.

Scoring for All Domains Except Avoidable Utilization

In accordance with STC 67(i), for all domains except the Avoidable Utilization domain, the State will calculate two scores:

- **Aggregate domain score** – the domain score calculated by aggregating scores from all ACOs
- **DSRIP domain score** – the domain score used in the calculation of the State DSRIP Accountability Score; dependent on how aggregate domain scores in a given year compare to pooled scores in all previous DSRIP Budget Periods

The aggregate domain score is calculated by aggregating scores from all ACOs. For example, if the State has three ACOs (ACO_1, ACO_2, ACO_3) with 10, 20 and 30 members respectively, and they achieve domain scores of 30%, 50% and 70% for the Prevention & Wellness (P&W) domain, respectively, then the aggregate domain score for the P&W domain would be:

Aggregate domain score = (ACO_1 contribution) + (ACO_2 contribution) + (ACO_3 contribution) = (30% * (10 / (10 + 20 + 30))) + (50% * (20 / 60)) + (70% * (30 / 60)) = 5% + 17% + 35% = 57%.

The DSRIP domain score for a particular domain will be equal to 100% if the aggregate domain score in the current Budget Period is not statistically worse (i.e., comparable or statistically better, using a stratified Wilcoxon test; i.e., the van Elteren test) than the pooled aggregate domain score from previous Budget Periods. The DSRIP domain score for a particular domain will be equal to 0% if the aggregate domain score in the current Budget Period is statistically worse than the pooled aggregate domain score

from previous Budget Periods. For the purpose of these statistical tests, an alpha value of ≤0.1 will constitute statistically significant improvement or worsening, in alignment with the alpha-value threshold the State will use to evaluate measure improvement for ACOs.

As an example, the pooled aggregate P&W domain score in BP3 for a two-ACO marketplace (ACO_1: 10 members, 40% BP1 score, 60% BP2 score; ACO_2: 20 members, 50% BP1 score, 75% BP2 score) is calculated in the following manner:

Pooled aggregate domain score = ACO_1 BP1 contribution + ACO_2 BP1 contribution + ACO_1 BP2 contribution + ACO_2 BP2 contribution = (ACO_1 BP1 score * (10 / (10 + 10 + 20 + 20))) + (ACO_1 BP2 score * (10 / 60)) + (ACO_2 BP1 score * (20 / 60)) + (ACO_2 BP2 score * (20 / 60)) = (40% / 6) + (60% / 6) + (50% / 3) + (75% / 3) = 58%

Using the Prevention & Wellness (P&W) domain in BP2 as an example:

- If the P&W aggregate domain score in BP 2 is not statistically worse (i.e., comparable or statistically better) than the P&W aggregate domain score in BP 1, then the BP 2 P&W DSRIP domain score is 100%

- If the P&W aggregate domain score in BP 2 is statistically worse than the P&W aggregate domain score in BP 1, then the BP 2 P&W DSRIP domain score is 0%

Using the Prevention & Wellness domain in BP 3 as an example:

- If the P&W aggregate domain score in BP 3 is not statistically worse (i.e., comparable or statistically better) than the pooled P&W aggregate domain scores in BP 1 through BP 2, then the BP 3 P&W DSRIP domain score is 100%

- If the P&W aggregate domain score in BP 3 is statistically worse than the pooled P&W aggregate domain scores in BP 1 through BP 2, then the BP 3 P&W DSRIP domain score is 0%

The State will use a stratified Wilcoxon test (i.e., the van Elteren test) to calculate the statistical difference, given that the aggregate domain score will be a weighted average of the individual ACO domain scores.

Domain Scoring for Avoidable Hospital Utilization

In accordance with STC 67(j), the State's performance on avoidable hospital utilization will be evaluated on two measures:

- Potentially preventable admissions (3M's PPA measure)

- Hospital all-cause readmissions (based off of NQF #1789)

The State will calculate risk-adjusted ratios of observed-to-expected utilization rates for all ACO-attributed members in the State that meet measure eligibility requirements. Calculations will be performed in the following manner:

- Identify all ACO-attributed, measure-eligible members participating in the DSRIP program

- Calculate the observed-to-expected ratio of potentially preventable admission (PPA) weights and observed-to-expected ratio of readmissions for these members. Inherent to these calculations are risk adjustment methodologies for both measures, specifically:

- PPA – Utilize 3M's proprietary risk adjustment methodology whereby weights are assigned to admissions deemed preventable. Weights are based on member Clinical Risk Groupings (CRGs), Diagnosis Related Groups (DRGs) and Severity of Illness (SOI). This process results in a sum of observed PPA weightings in a measure year, and an expected sum of weightings calculated from a baseline period.

- All Cause Readmissions – Utilize and adapt NQF 1789 risk adjustment whereby the expected number of readmissions is adjusted by the populations' diagnostic grouping (DxCG), social determinants of health risk scoring, age, and sex. The observed number of readmissions is not risk-adjusted.

The State has preliminarily identified reduction targets for these risk-adjusted ratios of observed-to-expected PPA and readmissions utilization rates (see Exhibit 29); the reduction targets are expressed as percentages, and represent a relative reduction in the rate of PPAs or readmissions (i.e., the absolute change in the rate, divided by the initial rate). The reduction targets for the two measures will account for the factors set forth in STC 67(j). The average of the scores on these two measures will be the State DSRIP domain score for avoidable hospital utilization.

EXHIBIT 29 – Preliminary Avoidable Utilization Reduction Targets

DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
PPA Reduction Targets	Reporting Only	Reporting Only	3%	7%	12%	15%
Readmissions Reduction Targets	Reporting Only	Reporting Only	3%	9%	15%	20%

The reduction targets displayed in Exhibit 29 were developed based on historical pre-CY2017 data. In accordance with STC 67(j), the State will adjust these reduction targets to reflect CY2017 baseline performance. Specifically, by November 2018, the State will compare CY2017 baseline performance with the original pre-CY2017 baseline data. Should it appear that the reduction targets were set too high or too low based on this baseline comparison, the State will develop a proposal to alter the targets based on in-state historical trended data, data from other DSRIP states, and other comparable data sources. Proposals will be presented to the DSRIP Advisory Committee on Quality for review and input. Proposals will then be submitted to CMS, which will have 90 calendar days to respond to the target modification request.

5.2.2 DSRIP Expenditure Authority and Claiming FFP

The State must use a permissible source of non-federal share to support the DSRIP program. The non-federal share of DSRIP payments consists of revenues deposited in the State's MassHealth Delivery System Reform Trust Fund administered by the Executive Office of Health and Human Services. Sources of funds in the Delivery System Reform Trust Fund are deposited at the direction of the Legislature and include hospital assessments transferred from the Health Safety Net Trust Fund, General Fund dollars, and interest earned. The non-federal share will be used to support claiming of Federal Financial Participation (FFP), up to the State's DSRIP expenditure authority. The amount of DSRIP expenditure authority is dependent on the State DSRIP Accountability Score, which is described above in Section 5.2.1, which describes:

- How the State DSRIP Accountability Score is calculated

- The review and approval process for the State DSRIP Accountability Score, including how the State may submit a Corrective Action Plan to CMS if the State's DSRIP Accountability Score is not 100% for a given Budget Period

Federal Financial Participation is only available for DSRIP payments to ACOs and CPs in accordance with the DSRIP Protocol and Participation Plans; or to other entities that receive funding through the DSRIP statewide investments or DSRIP-supported state operations and implementation funding streams. The State may claim FFP for up to two years after the calendar quarter in which the State made DSRIP payments to eligible entities.

The State may claim FFP for up to $1.8 billion in DSRIP expenditures, subject to all requirements set forth in the demonstration Expenditure Authority, Special Terms and Conditions, and this DSRIP protocol. A portion of DSRIP payments to ACOs, CPs and CSAs are at-risk (Exhibits 15 and 17), and the State will withhold these at-risk payments from the entities until their DSRIP Accountability Scores are calculated by the State and such calculations are approved by CMS. The draw of the FFP match for all at-risk funds, or reporting of payments on the CMS-64 form, will not occur until DSRIP Accountability Scores (see Sections 5.3 and 5.4.1) or DSRIP Performance Remediation Plan Scores (see Sections 5.3.4.2 and 5.4.6.1) have been approved by the State and CMS. As described in Sections 5.3.4.2 and 5.4.6.1, the State will submit the DSRIP Accountability Scores and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the Accountability Scores. Once the at-risk payments are approved, the State will disburse the portion of the withheld at-risk funds that were earned, and the State will report such expenditures on the CMS 64 form and draw down FFP accordingly. The State may not claim FFP for any at-risk expenditures until CMS has issued formal approval.

5.2.3 Modification to State Accountability Targets

The State may modify State Accountability Targets during the demonstration period (e.g., in situations where an expensive, but highly needed prescription drug enters the market). The State will submit modification requests to CMS for review and approval. CMS will review and approve the proposed modifications within 90 calendar days of submission.

5.3 Accountability Framework & Performance Based Payments for ACOs

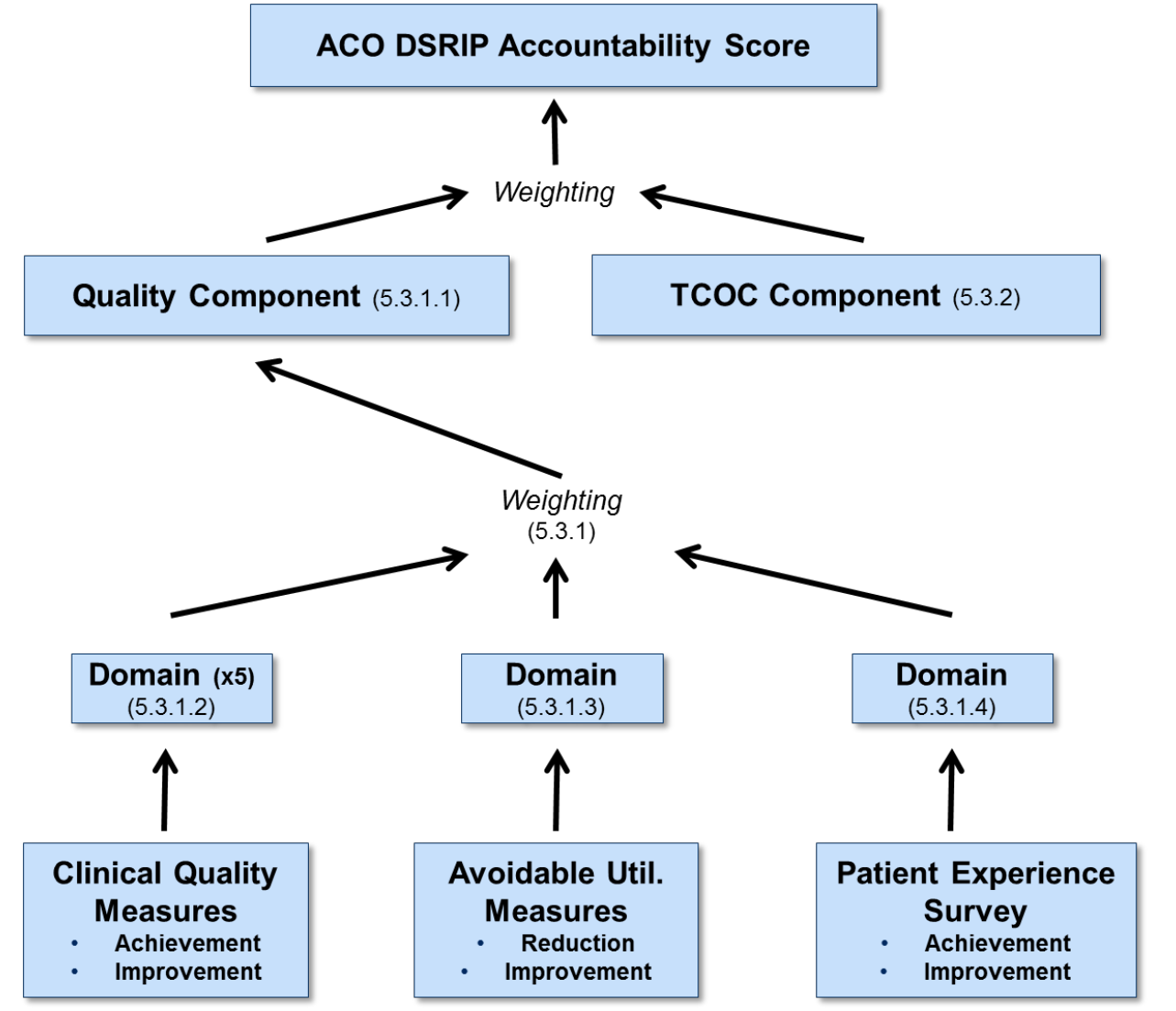
As described in Section 4.4 above, each of the four sub-streams of DSRIP funding that the State will pay to ACOs is subject to an accountability framework that aligns ACO incentives with the State's delivery system reform goals. For two of these sub-streams (Startup/Ongoing: discretionary; and DSTI Glide Path), the State will hold each ACO accountable for the ACO's individual performance by withholding a percentage of the funds each Budget Period, and retrospectively paying out a portion of the withheld amounts to the ACO based on the ACO's performance on clinical quality, avoidable utilization, and member experience measures as well as on Total Cost of Care.

The State will measure ACO performance using a state-calculated score called the "ACO DSRIP Accountability Score." The ACO DSRIP Accountability Score is a value between zero (0) and one (1), expressed as a percentage (i.e., between 0% and 100%). The State will multiply each ACO's withheld funds for a given Budget Period by the ACO's ACO DSRIP Accountability Score for that Budget Period, and will retrospectively pay the ACO the resulting amount. Sections 4.4.1-4.4.3 focus on the technical methodology for calculating these scores. Section 4.4 describes process, timelines, key players and roles and responsibilities for calculating the scores.

- **Section 5.3.1: Quality and TCOC Components of the ACO DSRIP Accountability Score**
- **Section 5.3.2: TCOC Component of the ACO DSRIP Accountability Score**
- **Section 5.3.3: Impact of DSRIP Accountability Scores on Payments to ACOs**

- **Section 5.3.4: Process, Roles, and Responsibilities for calculating the ACO DSRIP Accountability Score**
- **Section 5.3.5: Timeline of ACO DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments**

EXHIBIT 30 – Process Flow for Calculating the ACO DSRIP Accountability Score



5.3.1 Quality and TCOC Components of the ACO DSRIP Accountability Score

Each ACO's ACO DSRIP Accountability Score is produced by blending two separate measures of the ACO's performance during the Budget Period: (1) the Quality component of the ACO DSRIP Accountability Score; and (2) TCOC component of the ACO DSRIP Accountability Score. The Quality component of the ACO DSRIP Accountability Score is a score that the State will calculate that represents the ACO's performance on quality measures during the Budget Period. The TCOC component of the ACO DSRIP Accountability Score is a score that the State will calculate that represents the ACO's performance on TCOC management during the Budget Period. Each of these two scores is a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%).

For each ACO, the State will blend these two scores each Budget Period using a weighted average (i.e., the Quality component of the ACO DSRIP Accountability Score will be multiplied by a weight; the TCOC component of the ACO DSRIP Accountability Score will be multiplied by a weight; and the two resulting products will be summed to produce the ACO's ACO DSRIP Accountability Score). Exhibit 31 below shows the anticipated weights for each Budget Period.

EXHIBIT 31 – ACO DSRIP Accountability Domains

ACO DSRIP Accountability Domain Weights			
	Prep BP	**BP 1-2**	**BP 3-5**
Quality component of the ACO DSRIP Accountability Score	N/A	100%	75%
TCOC component of the ACO DSRIP Accountability Score	N/A	N/A	25%

ACOs do not have ACO DSRIP Accountability Scores during the Preparation Budget Period because no funds are withheld. ACOs will not have enrolled or attributed members during this period, and the State will therefore not be able to calculate performance on quality measures and TCOC metrics. During Budget Periods 1 and 2, the State will not hold ACOs accountable for TCOC performance in the ACO DSRIP Accountability Score, to allow ACOs time to analyze baseline TCOC performance, which will not be finalized for Budget Period 1 until close to the end of Budget Period 2.

5.3.1.1 Calculating the Quality Component of the ACO DSRIP Accountability Score by Combining Domain Scores

The State will calculate each ACO's Quality Component of the ACO DSRIP Accountability Score based on the ACO's performance on a range of State-defined quality measures. The quality measure slate was chosen to support the goals of the DSRIP program including promoting member-driven, integrated, coordinated care and improving integration among physical health, behavioral health, long-term services and supports, and health-related social services. In addition, the ACO measure slate has significant overlap with the CP measure slate, helping to align ACO quality evaluation with CPs and furthering integration.

These measures are organized across seven (7) Quality Domains. The State will calculate a Domain Score for each of these seven Quality Domains; each Domain Score will be a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). The State will combine these seven Domain Scores using a weighted average (i.e., the State will multiply each Domain Score by a weight and will sum the weighted products to produce the ACO's Quality Score for the Budget Period). The seven Quality Domains and their anticipated weights are listed below in Exhibit 32. If an ACO does not meet eligibility requirements for a specific measure, then the weight assigned to the measure within the measure's domain will be redistributed equally among all other measures within that domain. Thus, the overall domain weights will not increase or decrease as a result of measure ineligibility. If an ACO is ineligible to provide data on all measures within a given domain, the redistribution of that domain weight to other eligible domains will be reviewed by the DSRIP Quality Committee and the State, and will be submitted to CMS for review and approval within 90 calendar days prior to final DSRIP Accountability scoring.

EXHIBIT 32 – ACO Quality Domains and Domain Weights

ACO Quality Domain Weights			
Quality Domain		**Domain Weight: BP 1**	**Domain Weight: BP 2-5**
1	Prevention & Wellness	20%	10%
2	Chronic Disease Management	20%	15%
3	Behavioral Health / Substance Use	25%	15%
4	Long Term Services and Supports	10%	5%
5	Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	25%	20%
6	Avoidable Utilization	0%	20%
7	Member Care Experience	0%	15%

Appendix D displays the 39 proposed measures that comprise these seven domains, including an indication as to whether the measure data will be collected via claims and encounters only or whether clinical chart data will be utilized. Additionally, there is an indication of the expected "reporting" and/or "performance" role in the program by Budget Period. Appendix D includes further details regarding the measures including measure descriptions, measure stewards, benchmark sources and reporting frequency. The State will send the initial measure specifications to CMS for review and approval by July 2017

For Quality Measures that are primarily based on national measure specifications (e.g., NCQA HEDIS), where minimal changes have been made to the specification (e.g., a change from health plan population to ACO population), the State will use nationally available Medicaid benchmarks to establish its Attainment Thresholds and Excellence Benchmarks where feasible (see Section 5.3.1.2). The State will propose these Attainment Thresholds and Excellence Benchmarks to CMS by August 2017.

For Quality Measures for which there are related (i.e., same measure description) national measure specifications (e.g., ADA, AMA, CMS) but where changes may be significant (e.g., a change in risk adjustment methodology or a change from all-payer population to Medicaid-only population), the State will research existing data to determine if the related national and/or state/local data is applicable. If the existing data are relevant, the State will propose Attainment Thresholds and Excellence Benchmarks for these measures to CMS by August 2017. If the existing data are not relevant, the State will propose Attainment Thresholds and Excellence Benchmarks for these measures to CMS by November 2018 using CY2017 data (for claims-based measures) or November 2019 using CY2018 (for measures requiring chart review).

For novel measures, including member experience, the State will attempt to identify similar measures with similar specifications from other data sources (e.g., other DSRIP programs, statewide data, etc.) as a source for Attainment Thresholds and Excellence Benchmarks. Should other sources not be available, the State will use state-specific data reported from its ACOs. In particular, the State anticipates using CY2017 historical MassHealth benchmarks for claims-based measures without appropriate national measure specifications, with the benchmark dataset potentially based on performance of MassHealth ACO-eligible members. For these measures, the State will propose Attainment Thresholds and Excellence Benchmarks to CMS by November 2018.

The State anticipates using CY2018 MassHealth ACO-attributed benchmarks for member experience measures, most measures that require chart review, or for most claims-based measures that were not

previously collected prior to DSRIP (e.g. the integration measures in Domain 5). For these measures, the State will propose Attainment Thresholds and Excellence Benchmarks to CMS by November 2019.

All proposed benchmarks that the State submits to CMS will have been reviewed by the DSRIP Advisory Committee on Quality, and will be accompanied by individual rationales for each benchmark. CMS will provide written feedback on the proposed benchmarks and rationale within 90 calendar days. If CMS has not provided written feedback within 90 calendar days, then the benchmarks will be deemed approved, given the necessity of providing these benchmarks to ACOs prior to the start of their next Budget Period.

5.3.1.2 Calculating the Domain Score for Quality Domains 1-5

The first five Quality Domains comprise measures of clinical quality and the Domain Score for each is calculated using a common methodology, described in this section. For each of these five Quality Domains, each ACO will receive a Domain Score that is a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). This Domain Score will be calculated by assigning the ACO a number of points (detailed below) and dividing the assigned number by the maximum number of points available in the Quality Domain.

Each of the first five Quality Domains is each comprised of several Quality Measures. The State will score each ACO on each Quality Measure unless the ACO does not meet eligibility requirements for a specific measure based on the measure specifications (e.g., a minimum denominator required; see Appendix D for specifications source). ACOs will be assigned points based on their performance on each Quality Measure. ACOs can receive two types of points for each Quality Measure: "achievement points" and "improvement points."

Achievement Points

Each ACO may receive up to a maximum of two (2) achievement points for each Quality Measure, as follows:

1. The State will establish an "Attainment Threshold" and an "Excellence Benchmark" for each Quality Measure as follows:

    a. "Attainment Threshold" sets the minimum level of performance at which the ACO can earn achievement points

    b. "Excellence Benchmark" is a high performance standard above which the ACO earns the maximum number of achievement points (i.e., 2 points)

2. The State will calculate each ACO's performance score on each Quality Measure based on the measure specifications which will be reviewed and approved by CMS (see Section 5.3.4.2). Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated.

3. The State will award each ACO between zero (0) and two (2) achievement points for each Quality Measure as follows:

    a. If the ACO's performance score is less than the Attainment Threshold: 0 achievement points

    b. If the ACO's performance score is greater than or equal to the Excellence Benchmark: 2 achievement points

    c. If the performance score is between the Attainment Threshold and Excellence Benchmark: the ACO receives a portion of the maximum 2 achievement points in

proportion to the ACO's performance. The State will calculate the number of achievement points using the following formula:

i. 2 * ((Performance Score – Attainment Threshold) / (Excellence Benchmark – Attainment Threshold))

4. If the State finds that 75% of ACOs have not met the Attainment Thresholds for a particular measure, then the State may reset this benchmark to a lower standard for future Budget Periods with input from the DSRIP Advisory Committee for Quality, and CMS approval. If the State finds that 75% or more of ACOs have met the Excellence Benchmarks for a particular measure, then the State may reset this benchmark to a higher standard for future Budget Periods with input from the DSRIP Advisory Committee for Quality, and CMS approval. If 75% of ACOs meet the adjusted Excellence Benchmark, then the State may retire the measure and replace it with a new measure from the same domain. The new measure will enter into the slate as reporting only (if claims measure) or pay for reporting (if hybrid measure) for its first reporting year, switching over to pay for performance in the second or third year, depending on benchmark availability. Benchmarking for the new measure will follow the same methodology as outlined in Section 5.3.1.1

Exhibit 33 below shows an example calculation of an ACO's achievement points for a Quality Measure.

EXHIBIT 33 – Example Calculation of Achievement Points for Measure A

Measure A Attainment Threshold = 45% (e.g., corresponding to 25th percentile of HEDIS benchmarks)
Measure A Excellence Benchmark = 80% (e.g., corresponding to 90th percentile of HEDIS benchmarks)

Example Calculation of Achievement Points for Measure A		
	Measure A Performance Score	**Achievement Points Earned**
Scenario 1	25%	0
Scenario 2	90%	2
Scenario 3	60%	.86 *

**Achievement points earned = 2*((60% - 45%) / (80% - 45%)) = 0.86 points*

Improvement Points

ACOs may receive up to a maximum of two (2) improvement points for each Quality Measure; however, the total number of improvement points the ACO receives across all the Quality Measures in a given Quality Domain may not exceed 50% of the total number of achievement points available for that Quality Domain. Improvement points will be calculated as follows:

1. The State will calculate each ACO's performance score on each Quality Measure based on the measure specifications. Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated.

2. The State will compare each ACO's performance score on each Quality Measure to the ACO's performance score on that same Quality Measure from the previous Budget Period. The State will award each ACO zero (0) or two (2) improvement points for each Quality Measure as follows:

    a. If the ACO does not have a performance score for the Quality Measure in the previous Budget Period or if the ACO's performance score for the Quality Measure does not show statistically significant improvement (e.g., based on a Chi-square test) over the ACO's performance score during the previous Budget Period with a p-value less than or equal to 0.10: 0 improvement points

    b. If the ACO's performance score for the Quality Measure shows statistically significant improvement (e.g., based on a Chi-square test) over the ACO's performance score during the previous Budget Period with a p-value less than or equal to 0.10: 2 improvement points

Exhibit 34 below shows an example calculation of an ACO's improvement points for a Quality Measure.

EXHIBIT 34 – Example Calculation of Improvement Points for Measure B

Measure B performance score in Budget period 2 (BP2) = 45%
Measure B performance score in BP3 = 50%

Example Calculation of Improvement Points for Measure B		
	P-value for Comparison of Measure B's Performance Scores in BP2 & BP3	**Improvement Points Earned**
Scenario 1	0.12	0
Scenario 2	0.04	2

Domain Score

For each ACO, the State will sum the ACO's achievement and improvement points for all Quality Measures in each Quality Domain, and then divide the resulting sum by the maximum number of achievement points that the ACO is eligible for in the domain (i.e., two points per Quality Measure, multiplied by the number of Quality Measures in the Quality Domain) to produce the ACO's Domain Score. If an ACO does not meet eligibility requirements for a specific measure, then the measure is not factored into the denominator. Note that improvement points do not count towards the denominator; they are therefore "bonus" points. Domain Scores are each capped at a maximum value of 1.

Exhibit 35 below shows an example calculation of an ACO's unweighted Domain Score for a Quality Domain

EXHIBIT 35 – Example Calculations of Unweighted Domain Score

Example Calculations of Unweighted Domain Score		
Example 1	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x2 = 4 points	
	Measure A:	Achievement points: 1.5
		Improvement Points: 0
	Measure B:	Achievement points: 0
		Improvement Points: 2
	Maximum number of improvement points: 4 x 50% = 2	
	Total achievement points: 1.5 + 0 = 1.5	
	Total improvement points: 2 points	
	Sum of achievement and improvement points: 1.5 + 2 = 3.5 points	
	Unweighted domain score = 3.5/4 * 100 = 87.5%	
Example 2	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x2 = 4 points	
	Measure A:	Achievement points: 2
		Improvement Points: 2
	Measure B:	Achievement points: 1.3
		Improvement Points: 2
	Maximum number of improvement points: 4 x 50% = 2	
	Total achievement points: 2 + 1.3 = 3.3	
	Total improvement points: 2 points (points restricted by cap)	
	Sum of achievement and improvement points: 3.3 + 2 = 5.3 points	
	However, total number of points cannot exceed maximum number of achievement points	
	Therefore, achievement + improvement = 4	
	Unweighted domain score = 4/4 * 100 = 100%	

5.3.1.3 Calculating the Domain Score for Quality Domain 6 (Avoidable Utilization)

For the sixth Quality Domain, Avoidable Utilization, the State will use a slightly different methodology to calculate each ACO's Domain Score. This Quality Domain has two measures: (1) potentially preventable admissions (PPAs); and (2) hospital all-cause readmissions.

For each of these two measures, the State will establish a reduction target for each ACO, as follows:

1. The State will rank the baseline performance of all ACOs that are part of the MassHealth ACO Program on each of these two utilization-based Quality Measures. The State anticipates measuring baseline performance using CY2017 data to establish the baseline rankings for Budget Periods 2-5.

2. The State will segment ACOs into quartiles based on the resulting ranking.

3. The State will assign each quartile of ACOs a reduction target for each Budget Period.

Reduction targets are expressed as percentages, and represent a relative reduction in the risk-adjusted actual-to-expected ratios of PPAs or readmissions (i.e., the absolute change in the rate, divided by the initial rate).

Reduction targets will increase each Budget Period, and ACOs in quartiles with worse baseline performance (i.e. higher rates of PPAs or readmissions) will have higher reduction targets.

The State has established preliminary reduction targets, which are listed in Exhibits 36 and 37 below.

EXHIBIT 36 – Preliminary Reduction Targets for 3M's Potentially Preventable Admissions (PPA) Measure

PPA Quartile	Reduction Targets from Baseline Performance				
	BP 1	BP 2	BP 3	BP 4	BP 5
1 *(better)*	Reporting only	3%	4.50%	9%	12%
2		4%	7%	12%	15%
3		5%	10%	15%	18%
4 *(worse)*		6%	13%	18%	21%

EXHIBIT 37 – Preliminary Reduction Targets for NQF #1789 (Hospital All-Cause Readmissions)

NQF #1789 Quartile	Reduction Targets from Baseline Performance				
	BP 1	BP 2	BP 3	BP 4	BP 5
1 *(better)*	Reporting only	3%	7.5%	12.5%	16%
2		4%	9.5%	15%	20%
3		5%	12.5%	18.5%	24%
4 *(worse)*		6%	14%	22%	28%

If the ACO meets or surpasses the reduction target for one of these two Quality Measures, then the State will award the ACO the full two (2) achievement points for that Quality Measure. If the ACO does not meet the reduction target for one of these two Quality Measures, then EOHHS will award the ACO zero (0) achievement points for that Quality Measure. All comparisons will be against the baseline CY2017 data. For example, an ACO in Quartile 1 that reduces its hospital all-cause readmissions by 18% in BP4 compared to baseline will earn 2 achievement points. If that same ACO regresses such that its reduction compared to baseline is 17% in BP5, it will still earn 2 achievement points because all comparisons are made against baseline.

Should a new ACO join the program, the new ACO's CY2017 data will be used to establish baseline data for relevant Quality Measures. Based on these baseline results, the new ACO will be assigned to one of the reduction target quartiles for avoidable utilization-related Quality Measures. An existing ACO's quartile and reduction targets may change if ACOs join or leave the program, or if the provider organizations that comprise the existing ACOs change in such a way that would lead to ACOs switching quartiles.

The process for adjusting quartiles will include stratifying all ACO performance results based on the most recent historical data available. The results will be used to develop quartiles. ACOs could then be

reassigned to new quartiles based on their performance for future budget periods. The State will review the new quartiles with the DSRIP Advisory Committee on Quality for input.

Budget Period (BP) 1 will be reporting only for avoidable utilization measures. To allow for claims run-out, data warehouse functions, and calculations, the BP1 results will be available approximately in Q4 BP2 or Q1 BP3. These data will be compared to the CY2017 baseline data to assess whether the reduction targets are appropriate. Should it appear in the State's discretion that the reduction targets were set too high or too low (e.g. all or most ACOs will exceed the targets, or all or most ACOs will not achieve their targets), the State may develop a proposal to alter the targets for BP2 and later Budget Periods. The State will research and review other reduction target performance (e.g., in the published medical literature, from other DSRIP projects) as the State develops new proposed reduction targets. The proposal, along with the State's research, will be presented to the DSRIP Advisory Committee on Quality for review and input. The proposal, along with the State's research, will then be submitted to CMS for approval. CMS will have 90 calendar days to respond to the target modification request.

5.3.1.4 Calculating the Domain Score for Quality Domain 7 (Member Experience)

Quality Domain 7, Member Experience, will be calculated based on surveying a representative sample of an ACO's attributed members to assess their experience of care. The State anticipates assessing member experience for (1) primary care (commencing in CY2018), (2) BH (commencing in CY2019), and (3) LTSS (commencing in CY2020) services.

The State plans to procure a vendor to administer these member experience surveys for ACOs. The State will work in collaboration with its procured vendor to finalize the survey instruments, and identify questions and methodology for calculating survey results. The State is planning to use or adapt (as appropriate) validated instruments wherever possible to capture member experience for each population. For example, the State may use:

- For the population receiving primary care services:
    - CAHPS Clinician and Group Survey + CAHPS PCMH supplemental questions
- For the population receiving behavioral health services:
    - Massachusetts Department of Mental Health, Massachusetts Consumer Surveys (MCS): Based off of the Substance Abuse and Mental Health Services Administrations (SAMHSA's) Mental Health Statistics Improvement Program (MHSIP) survey
- For the population receiving LTSS Services:
    - HCBS CAHPS Survey: recently released by CMS, is the first cross-disability survey of home and community-based service (HCBS) beneficiary's experience receiving long-term services and supports

ACOs will be evaluated based on surveys of a representative sample of their attributed members. Scores will be based on performance on a combination of composite and specific questions contained in each survey. Examples of question categories include but are not limited to:

EXHIBIT 38 – Examples of Survey Question Categories

Primary Care	Behavioral Health	LTSS
• Access to care • Communications	• Access to services • Quality and appropriateness	• Getting needed services • HCBS staff reliability

• Comprehensiveness • Self-management support • Coordination of care • Helpful, Courteous, and Respectful Office Staff • Patient Ratings of the Provider • Self-management support (composite measure) • Comprehensiveness • Integration or coordination of physical health, BH, LTSS, and health-related social services	• Treatment outcomes • Person-centered planning • Social connectedness • Functioning • Self-determination • Integration or coordination of BH services by Community Partners	• Communication with HCBS staff • Getting help from case managers • Choice of services • Personal safety • Adequacy of medical transportation • Community inclusion and empowerment • Employment (supplement) • Integration or coordination of LTSS services by Community Partners

The scoring approach will be similar to the approach used for clinical quality measures where scoring is based on attainment of benchmarks for excellent performance and/or improved performance off of baseline performance. The State anticipates this methodology will incorporate, for BPs 3-5, benchmarks based on each ACO's performance in BP1 and BP2.

5.3.1.5 Quality Data Collection Approach

Quality measure data will be collected in one of three ways. Claims and encounter data will flow through the normal channels currently used to process and pay claims. Clinical data (i.e., data that will be extracted from EHRs) will initially be submitted to the State by ACOs, using spreadsheets and secure transmission methods (e.g., Secure File Transfer Protocol). The ultimate goal will be to have secure two-way data exchange between the State and ACOs to support continuous sharing of clinical quality data. Member experience will be measured via a patient experience survey performed by a vendor. The State anticipates that the survey will be conducted by typical methodologies such as by mail and/or phone.

5.3.1.6 Pay for Reporting vs. Pay for Performance

As demonstrated in Appendix D, the State anticipates that most Quality Measures will transition from Pay for Reporting (P4R) to Pay for Performance (P4P) over the duration of the program. Budget Period 1 will be P4R only. This will allow time for familiarization with the measures, data collection, reporting, as well as to provide baseline performance. For measures assessed with comparable national benchmarks (e.g. NCQA HEDIS), the State intends to transition the measures to P4P in Budget Period 2. For novel measures and measures without national benchmarks, the State intends to transition measures to P4P in Budget Period 3 of the program to allow for two years of data to confirm, as needed:

- Numerator details
- Denominator details and exclusions
- Sampling methodology
- Data sources
- Measure reliability from year-to-year

5.3.2 TCOC component of the ACO DSRIP Accountability Score

Each ACO's TCOC component of the ACO DSRIP Accountability Score will be a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%) that reflects an ACO's performance at managing

TCOC for its enrolled or attributed members. Each ACO's TCOC component of the ACO DSRIP Accountability Score will be calculated in the following manner:

If the ACO is a Primary Care ACO or MCO-Administered ACO, the State will perform the following comparison:

1. In advance of each Budget Period, the State will establish a Preliminary TCOC Benchmark for each ACO, working with the State's actuaries and following the detailed methodology for setting TCOC Benchmarks outlined in the State's ACO contracts

2. Approximately one year after the Budget Period has ended, the State will retrospectively calculate each ACO's TCOC Performance for the Budget Period

3. The State will retrospectively compare each ACO's TCOC Performance to its Final TCOC Benchmark to determine whether the ACO has achieved savings or losses relative to its Final TCOC Benchmark for the Budget Period. In the process, the State will make several updates to each ACO's Preliminary TCOC Benchmark to produce the ACO's Final TCOC Benchmark, including, for example, actuarial adjustments to account for the ACO's risk profile and population mix during the Budget Period

If the ACO is an Accountable Care Partnership Plan, the State will perform the following comparison:

4. The State will retrospectively compare the Partnership Plan's total medical expense to the Partnership Plan's risk-adjusted medical capitation payments for the Budget Period, following an aligned methodology with how the State applies risk corridors to Partnership Plans. This comparison will determine whether the Plan has achieved medical gains or medical losses. Administrative or underwriting gains or losses will not count towards calculating this TCOC component of the ACO DSRIP Accountability Score

For all ACOs, after performing the above comparisons, the State will calculate the ACO's TCOC component as follows:

5. Based on the comparison, the State will calculate each ACO's TCOC component of the ACO DSRIP Accountability Score as follows:

    - If the ACO has savings or medical gains, then the ACO's TCOC component of the ACO DSRIP Accountability Score equals 100%

    - If the ACO has losses that exceed 5% of the Final TCOC Benchmark or exceed 5% of the ACO's risk adjusted medical capitation payments, then the ACO's TCOC component of the ACO DSRIP Accountability Score equals 0%

    - If the ACO has losses but they do not exceed 5% of the Final TCOC Benchmark or 5% of the ACO's risk adjusted medical capitation payments, then the ACO's TCOC component of the ACO DSRIP Accountability Score is proportionate to the magnitude of the ACO's losses, and is equal to:

        - For Primary Care ACOs and MCO-Administered ACOs: (105% * Final TCOC Benchmark - TCOC Performance) / (5% * Final TCOC Benchmark)

        - For Partnership Plans: (105% * risk-adjusted medical capitation payments – total medical expenditure) / (5% * risk adjusted medical capitation payments)

EXHIBIT 39 – Example Calculations of TCOC component of the ACO DSRIP Accountability Score

Example Calculations of TCOC Component of the ACO DSRIP Accountability Score	
Final TCOC Benchmark = $500 PMPM	
Scenario 1	ACO's TCOC Performance is $490 PMPM
	ACO has savings of $10 PMPM, or 2%
	ACO has achieved savings, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score is 100%
Scenario 2	ACO's TCOC Performance is $550 PMPM
	ACO has losses of $50, or 10%
	ACO has losses that exceed 5% of the TCOC Benchmark, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score is 0%
Scenario 3	ACO's TCOC Performance is $520 PMPM
	ACO has losses of $20, or 4%
	ACO has losses that are less than 5% of the TCOC Benchmark, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score = ((5% of the TCOC Benchmark - $20) / 5% of the TCOC Benchmark) = (($25 - $20) / $25) = ($5/$25) = 20%

5.3.3 Impact of DSRIP Accountability Scores on Payments to ACOs

Once the State has determined the ACO's Quality and TCOC components of the ACO's DSRIP Accountability Score, it will calculate the DSRIP Accountability Score using the methodology described in Section 5.3.1. As an example:

Example Calculation of ACO DSRIP Accountability Score in BP4

- Quality Component of DSRIP Accountability Score in BP4: 75% (calculated as described in Section 5.3.1)
- TCOC Component of DSRIP Accountability Score in BP4: 80% (calculated as described in Section 5.3.2)
- Weight for Quality Component of DSRIP Accountability Score in BP4: 75% (as described in Exhibit 31)
- Weight for TCOC Component of DSRIP Accountability Score in BP4: 25% (as described in Exhibit 31)

ACO DSRIP Accountability Score = (Quality Component * Weight of Quality Component) + (TCOC Component * Weight of TCOC Component) = (75% * 75%) + (80% * 25%) * 100% = 76.2%

The DSRIP Accountability Score will then be applied to the ACO funding sub-streams that have a portion of funds at-risk. Specifically:

- ACO Sub-Stream #1 - Startup/Ongoing Funding (Primary Care): No at-risk funds

- ACO Sub-Stream #2 - Startup/Ongoing Funding (Discretionary): Portion of funds are at-risk, according to schedule detailed in Exhibit 20; DSRIP Accountability Score is multiplied by the at-risk funding amount to determine how much is earned
- ACO Sub-Stream #3 - Flexible Services Funding: No at-risk funds
- ACO Sub-Stream #4 - DSTI Glide Path Funding: Portion of funds are at-risk, according to schedule detailed in Exhibit 20; DSRIP Accountability Score is multiplied by the at-risk funding amount to determine how much is earned

5.3.4 Process, Roles, and Responsibilities for calculating the ACO DSRIP Accountability Score

5.3.4.1 Roles and responsibilities

The State will be responsible for establishing the elements that comprise the ACO DSRIP Accountability Score, including its Quality Measures, the specifications for each Quality Measure, the data sources for calculating the Quality Measures, the methodology for setting the Attainment Threshold and Excellence Benchmark for each Quality Measure (where applicable) and the values of the thresholds and benchmarks themselves. This sub-section 5.3.4.1 details the roles and responsibilities of the State, the State's DSRIP Quality Advisory Committee, and CMS with respect to these elements.

5.3.4.2 The State

The State will establish the elements that comprise the ACO DSRIP Accountability Score, based on the advice of the DSRIP Advisory Committee on Quality as described in this Protocol (see Section 6.2.1). By August 2017, the State will submit the Quality Measure slate and specifications, the benchmark sources, and performance thresholds (i.e., Attainment Thresholds and Excellence Benchmarks) to CMS for review and approval.

The State may request modification to any element that comprises the ACO DSRIP Accountability Score, based on its own assessment or on the recommendation of the State's DSRIP Advisory Committee on Quality. In the event that the State wishes to change a previously approved element that is a component of the ACO DSRIP Accountability Score, the State will submit a formal, written modification request to CMS for review and approval. CMS will have 90 calendar days to review and approve.

As part of its program management and contract oversight processes, the State will establish a structured process for ACOs to seek clarification on or request revisions to certain aspects of their ACO DSRIP Accountability Scores (e.g., if an ACO seeks clarification on the inclusion of certain members in the denominator for a Quality Measure's performance score). Each ACO will identify a key contact, responsible for raising such issues to the State and working with the appropriate State personnel to discuss and resolve issues as appropriate. The State will also identify a reciprocal contact to liaise with each ACO and support these types of requests.

If an ACO does not earn 100% DSRIP Accountability Score, then the State may provide an opportunity for ACOs to submit DSRIP Performance Remediation Plans to earn back a portion of the unearned, withheld funds, at the State's discretion. If the State allows this opportunity, then an ACO may choose to provide the State a DSRIP Performance Remediation Plan within 30 calendar days of receipt of the ACO's DSRIP Accountability Score, in which case the ACO may have the opportunity to earn back up to 60% of the unearned, withheld funds, as further described below.

The DSRIP Performance Remediation Plan will include:

- A detailed assessment of the reason(s) why the ACO did not achieve 100% Accountability Score, separately addressing each measure on which the ACO scored less than full points;
- Discrete project(s) the ACO will undertake to address some or all of the reasons for why it did not achieve 100% Accountability Score, along with rationale for why these activities are

appropriate; or other discrete projects that align with the goals of the ACO's DSRIP Participation Plan

- A workplan, which includes a timeline for the implementation of these activities over the first half of the coming Budget Period, as well as identification of the resources that will be responsible for their completion
- An accountability plan for these activities, including any milestones or metrics the ACO anticipates and when the ACO anticipates realizing them, and also including a proposed model for the State to monitor the ACO's implementation of the proposed activities and their success or failure throughout the first half of the coming Budget Period (e.g., a schedule of site visits, staff interviews, desk reviews, etc.)

Within 45 calendar days of receiving the Performance Remediation Plan, the State and the Independent Assessor will review the Plan in parallel, and the State, considering the Independent Assessor's recommendation, will either request additional information regarding the Performance Remediation Plan, or approve it and submit to CMS for review and approval. During the State's review process, it will determine how much of the 60% of unearned, withheld funds the ACO will be able to earn back, based on the Performance Remediation Plan's relevance to the reasons for why the ACO did not achieve 100% Accountability Score, or to the goals of the ACO's DSRIP Participation Plan. CMS will have 90 calendar days to review and approve the Plan. If CMS has not responded to the State's approval request, then the Performance Remediation Plan will be deemed approved, given the need for ACOs to have as much time as possible to implement their projects, which will need to be completed during the first half of the following Budget Period. The State will monitor the Plan during the implementation period on an ongoing basis. Additionally, the State will assign a Performance Remediation Plan Score to the ACO, based on the State's ongoing monitoring of the Plan, and supporting documentation submitted by the ACO in its semiannual progress report for the first half of the Budget Period in question. The Performance Remediation Plan Score will be a single point value between 0 and 10 inclusive, and will determine how much of the ACO's unearned, withheld funds can be earned back.

For example, if (1) an ACO has $100,000 of unearned, withheld funds; (2) the State determines that an ACO will be able to earn back 50% of the ACO's unearned, withheld funds (out of a 60% maximum percentage); and (3) the ACO achieves a Performance Remediation Plan Score of 7 out of 10, then the ACO's final earned funds will be equal to $100,000 * 50% * (7 / 10) = $35,000.

5.3.4.3 The DSRIP Advisory Committee on Quality

See Section 6.2.1 for discussion of the Advisory Committee on Quality's role.

5.3.4.4 CMS

CMS will review and approve State submissions within 90 calendar days. If CMS does not approve the submission within that timeframe, the State and CMS will work collaboratively to align on appropriate modifications and a timeline for prompt approval.

5.3.5 Timeline of ACO DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments

The timeline for ACO DSRIP Accountability Score calculation and disbursement of DSRIP payments to ACOs is anticipated to be as follows:

- ACO Budget Period Closes
- Member experience survey results 270 calendar days of BP closing

- State determines denominators and sample populations (i.e., the specific members whose data each ACO must submit) for the clinical quality measures within 210 calendar days of BP closing
- ACOs submit clinical quality data within 30 calendar days of receiving the denominators and sample populations for the clinical quality measures
- State calculates ACO DSRIP Accountability Score within 90 calendar days of receiving all underlying required data
- Once ACO DSRIP Accountability Scores have been calculated, State submits Scores and supporting documentation to CMS for review and approval
- CMS has 90 calendar days to review and approve the ACO DSRIP Accountability Scores; if CMS has not responded to State's approval request, then the DSRIP Accountability Scores will be deemed approved, given the need to disburse at-risk funding to ACOs in a timely fashion
- State notifies ACOs of ACO DSRIP Accountability Score within 30 calendar days of determining Score
- State disburses DSRIP at-risk payments to ACOs within 30 calendar days after CMS has approved ACO DSRIP Accountability Scores

5.3.6 ACO Exit from the DSRIP Program

Per STC 65(b)(ii), if an ACO decides to exit the DSRIP program prior to the end of the five year 1115 waiver demonstration period, it will be required to return at least 50 percent of DSRIP startup/ongoing and DSTI Glide Path funding received up to that point.

ACO exit from the DSRIP program is defined as termination of the contract between an ACO and MassHealth for reasons other than the following reasons:

- Material financial losses resulting from poor total cost of care performance, as determined by the State
- Reasons outside of the ACO's control, including but not limited to material changes to the Medicaid program, or material changes to the nature of the ACO's participation in MassHealth resulting from legislation or other developments, as determined by the State

5.3.6.1 Other ACO Contract Terminations

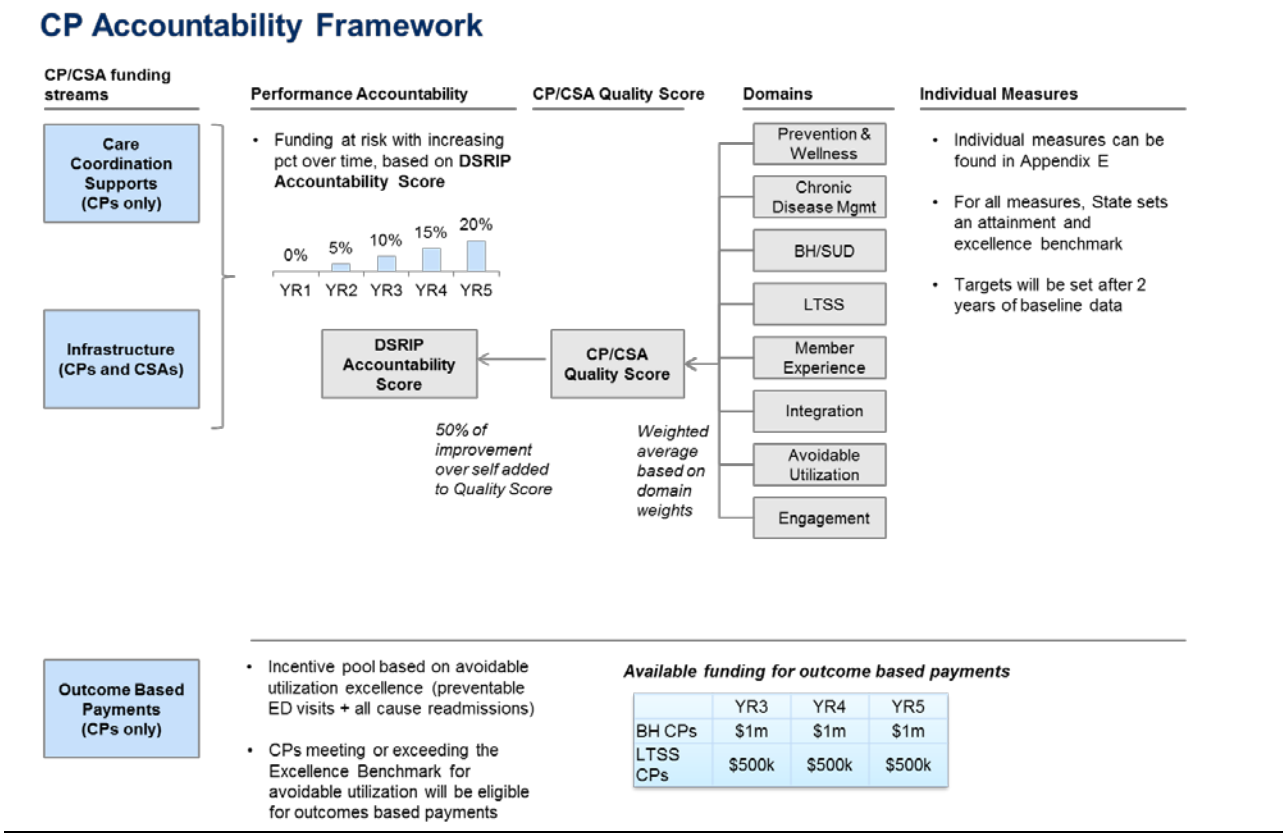
Under its MassHealth contract, an ACO may experience material financial loss, defined as a loss greater than 3% medical losses relative to risk-adjusted medical capitation for Partnership Plans, or relative to the TCOC benchmark for Primary Care ACOs and MCO-Administered ACOs. If an ACO experiences material financial loss in one or more preceding Budget Periods and has a projected material financial loss in the current Budget Period, the contract between the ACO and MassHealth may be terminated and the ACO will be required to return DSRIP startup/ongoing and DSTI Glide Path funding in accordance with percentages established by the State.

5.4 Accountability Framework & Performance Based Payments for CPs and CSAs

5.4.1 Overview

As described in Section 4.5 above, payment streams for CPs and CSAs are subject to an accountability framework that aligns the CPs' and CSAs' incentives with the State's delivery system reform goals. For CPs, a portion of the Care Coordination and Infrastructure funds will be at-risk based on performance. For CSAs, a portion of the Infrastructure funds will be at-risk based on performance.

EXHIBIT 40 – CP and CSA Accountability Framework



5.4.2 Alignment of Quality Measure Slate with Overall Goals of the DSRIP program

The quality measure slate was chosen to support the goals of the DSRIP program including promoting member-driven, integrated, coordinated care and improving integration among physical health, behavioral health, long-term services and supports, and health-related social services. In addition, the CP and CSA measure slate has many cross-cutting measures with the ACO measure slate thus aligning the ACOs with their CPs and with CSAs.

Appendix D contains the measures for the LTSS and BH CPs and CSAs, along with an indication as to whether the measure data will be collected via claims and encounters only or whether chart review will be utilized. Additionally, there is an indication of the expected "reporting" and/or "performance" role in the program by program year. Appendix D includes further details regarding the measures including measure descriptions, measure stewards, benchmark sources and reporting frequency.

5.4.3 Pay for Reporting vs. Pay for Performance

As demonstrated in Appendix D, the State anticipates that most Quality Measures will transition from Pay for Reporting (P4R) to Pay for Performance (P4P) over the duration of the program. All CP measures in the first two performance years are Pay for Reporting (P4R) and transition to Pay for Performance (P4P) starting in Performance Year 3. Given the unique needs and demographics of the member populations supported by the CPs and CSAs, there are challenges to utilizing nationally established benchmarks for performance that reflect the overall population. Therefore, the State will utilize the first two Performance Years of the demonstration to establish an appropriate baseline and achievement targets as described below for the quality measures. This will allow time for familiarization with the measures, data collection, reporting, as well as to provide baseline performance. This will also allow for two years of data to confirm, as needed:

- Numerator details
- Denominator details and exclusions
- Sampling methodology
- Sample size
- Data sources
- Measure reliability from year-to-year

5.4.4 Calculating the CP/CSA DSRIP Accountability Score

The State will measure performance using a state-calculated score called the CP/CSA DSRIP Accountability Score. The CP/CSA DSRIP Accountability Score is a value between zero (0) and one hundred (100), expressed as a percentage (i.e. between 0%-100%). This section details the State's calculation of each CP's and CSA's CP/CSA DSRIP Accountability Score as follows:

- 5.4.4.1 Measure Scoring Methodology for All Measures
- 5.4.4.2 Calculating the Domain Score
- 5.4.4.3 Combining Domain Scores to Produce Quality Score
- 5.4.4.4 Comparing Quality Scores to Calculate the CP/CSA DSRIP Accountability Score

5.4.4.1 Measure Scoring Methodology for All Measures

CPs and CSAs will be accountable for all measures as indicated in Appendix D unless the CP or CSA does not meet eligibility requirements for a specific measure based on the measure's specifications (e.g., a minimum denominator required).

Benchmark Determination

Given that the CP population is defined by utilization criteria and therefore does not have national benchmarks, the State anticipates using the performance of MassHealth CPs in CY2018 to set benchmarks. For example, one of the criteria for inclusion in the BH CP population is anticipated to be a member having a diagnosis of major depression or post-traumatic stress disorder with a behavioral health related inpatient visit or five or more emergency room visits. National benchmarks for a general Medicaid population will be difficult to use for this selected high risk population; accordingly, the State will need to develop state-specific benchmarks. Because CP data will not be available until after the first Budget Period (December 2018) and thus the State will not be able to set benchmarks until that time, the State will submit to CMS for approval measure-by-measure benchmarks in April 2019. All proposed benchmarks that the State submits will have been reviewed by the DSRIP Advisory Committee on Quality, and will be accompanied by individual rationales for each benchmark. CMS will provide written feedback on the proposed benchmarks and rationale within 90 calendar days. If CMS has not provided written feedback within 90 calendar days, then the benchmarks will be deemed approved, given the necessity of providing these benchmarks to CPs so that they have sufficient time to plan accordingly.

Benchmarks will be adjusted based on expert clinical judgment from the DSRIP Advisory Committee on Quality and the State, with approval by CMS. Attainment Thresholds will be reviewed yearly and may be adjusted by the State based on prior CP or CSA performance, in consultation with the DSRIP Advisory Committee for Quality, and CMS approval. If all CPs have high levels of achievement on a particular measure, that measure will be retired and a new one may be added. Excellence Benchmarks will be reviewed yearly and set with respect to the CP performance from the prior year. This will properly reward maintenance of quality, while not overly penalizing CPs.

CPs and CSAs will be assigned achievement points based on their performance on each Quality Measure. The Domain Score will be calculated as the average of the achievement points for all the Quality measures in a given Domain.

Each CP or CSA may receive up to a maximum of one (1) achievement point for each Quality Measure in a given Domain, as follows:

1. The State will establish an "Attainment Threshold" and an "Excellence Benchmark" for each Quality Measure

    a. "Attainment Threshold" sets the minimum level of performance at which the CP or CSA can earn achievement points

    b. "Excellence Benchmark" is a high performance standard above which the CP or CSA earns the maximum number of achievement points (i.e., 1 point)

2. The State will calculate each CP's and CSA's performance score on each Quality Measure based on the measure specifications which will be reviewed and approved by CMS (see section 5.4.6.1). Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated

3. The State will award each CP or CSA between zero (0) and one (1) achievement point for each Quality Measure as follows:

    a. If the CP's or CSA's performance score is less than the Attainment Threshold: 0 achievement points

    b. If the CP's or CSA's performance score is greater than or equal to the Excellence Benchmark: 1 achievement point

    c. If the CP's or CSA's performance score is between the Attainment Threshold and Excellence Benchmark: the CP or CSA receives a portion of the maximum 1 achievement point; this portion is proportional to the CP's or CSA's performance. The State will calculate the achievement point using the following formula:

        i. 1*((Performance Score – Attainment Threshold) / (Excellence Benchmark – Attainment Threshold))

Exhibit 41 below shows an example calculation of a CP's achievement points for a Quality Measure.

EXHIBIT 41 – Example Calculation of Achievement Points for Measure A

Measure A Attainment Threshold = 45%
Measure A Excellence Benchmark = 80%

Example Calculation of Achievement Points for Measure A		
	Measure A Performance Score	**Achievement Points Earned**
Scenario 1	25%	0
Scenario 2	90%	1
Scenario 3	58%	.37 *

**Achievement points earned = 1*((58% - 45%) / (80% - 45%)) = 0.37 points*

5.4.4.2 Calculating the Domain Score

Each Quality Domain comprises several Quality Measures. For each CP or CSA, the State will calculate the average achievement points for all Quality Measures in each Quality Domain.

Exhibit 42 below shows an example calculation of a CP's or CSA's Domain Score for a Quality Domain.

EXHIBIT 42 – Example Calculation of CP or CSA Quality Domain Score

Example Calculation of a CP's or CSA's Domain Score for a Quality Domain				
Measures in Quality Domain	**Attainment Threshold**	**Excellence Benchmark**	**Performance Score**	**Achievement Points Earned**
Measure A	45%	80%	58%	0.37
Measure B	40%	75%	60%	0.57
Measure C	41%	85%	79%	0.86
			Average Achievement Points Earned	**0.60**

5.4.4.3 Combining Domain Scores to Produce the Quality Score

A CP's or CSA's Quality Score will be a weighted average of scores the CP or CSA achieves on the different Domains for which it is accountable. The anticipated Domains and Domain weighting is different across BH CPs, LTSS CPs and CSAs, as set forth in the following Exhibits.

EXHIBIT 43 – Domain Weighting for BH CPs

BH CP Quality Domain Weights		
Quality Domain		**Domain Weight**
1	Prevention & Wellness	5%
2	Chronic Disease Management	5%
3	Behavioral Health / Substance Use	10%
4	Member Experience	10%
5	Integration	10%
6	Avoidable Utilization	10%
7	Engagement (Care Planning Completed)	50%
TOTAL		**100%**

See Appendix D for the full list of BH CP Quality Measures

EXHIBIT 44 – Domain Weighting for CSAs

CSA Quality Domain Weights		
Quality Domain		**Domain Weight**
1	Prevention & Wellness	10%
2	Behavioral Health / Substance Use	20%
3	Member Experience	10%
4	Avoidable Utilization	10%
5	Engagement (Care Planning Completed)	50%
TOTAL		100%

See Appendix D for the full list of CSA Quality Measures.

EXHIBIT 45 – Domain Weighting for LTSS CPs

LTSS CP Quality Domain Weights		
Quality Domain		**Domain Weight**
1	Prevention & Wellness	5%
2	Member Experience	20%
3	Integration	15%
4	Avoidable Utilization	10%
5	Engagement (Care Planning Completed)	50%
TOTAL		**100%**

See Appendix D for the full list of LTSS CP Quality Measures

EXHIBIT 46 – Example Calculation of the Quality Score for a BH CP

Example Calculation of Total Quality Score			
Domain	**Weighting**	**Average Attainment Score**	**Weighted Attainment Score**
Prevention & Wellness	5%	0.51	5%*0.51= 2.55%
Chronic Disease Management	5%	0.6	5%*0.60= 3.00%
Behavioral Health / Substance Use	10%	0.73	10%*.73= 7.30%
Member Experience	10%	0.88	10%*0.88= 8.80%
Integration	10%	0.56	10%*0.56= 5.60%
Avoidable Utilization	10%	0.67	10%*0.67= 6.70%
Engagement (Care Planning Completed)	50%	0.93	50%*0.93= 46.50%
	Total Quality Score		**80.45%**

5.4.4.4 Comparing Quality Scores to Calculate the CP/CSA DSRIP Accountability Score

For each Performance Period, CPs and CSAs will be measured on their (1) Total Quality Score and on (2) Improvement Over Self from the previous Performance Period. For each Performance Period, the State will set a Minimum Quality Score Threshold and an Excellence Quality Score Benchmark for LTSS CPs, for BH CPs and for CSAs. Improvement Over Self will be calculated as 50% of the CP's or CSA's improvement year over year in percentage points.

The CP/CSA DSRIP Accountability Score, therefore, will be the sum of the (1) Total Quality Score and the (2) Improvement Over Self contribution. CP/CSA DSRIP Accountability Scores will be calculated as follows:

- An entity with a Total Quality Score at or above the Excellence Quality Score Benchmark will receive a DSRIP Accountability Score of 100% and be eligible for 100% of at-risk funds.
- An entity with a Total Quality Score below the Minimum Quality Score Threshold will receive a DSRIP Accountability Score for Total Quality of Zero and will be eligible for only that portion of at-risk funds equal to the Improvement Over Self contribution. The entity would receive a Quality Score equal to 50% of the Improvement Over Self percentage points.
- An entity with a Total Quality Score between the Minimum Quality Score Threshold and the Excellence Quality Score Benchmark will receive a DSRIP Accountability Score = (Total Quality Score) + (50% of the Improvement Over Self percentage points) and will be eligible for that proportion of the at-risk funds.

For example:

In a Performance Period in which, for BH CPs, the Minimum Quality Score Threshold is set at 45% and the Excellence Quality Score Benchmark is set at is 85%

- A BH CP with a Total Quality Score ≥85% has a DSRIP Accountability Score of 100% and is eligible for 100% of the at-risk funds

- A BH CP with a Total Quality Score <45% and with no improvement from the previous period has a DSRIP Accountability Score of 0% and is eligible only for improvement points. If a CP's Total Quality Score = 40% and a previous period Total Quality Sore of 30%, then they would receive half of their Improvement Over Self percentage points, or 50% *10% = 5% of at-risk DSRIP funds.

- A BH CP with a Quality Score of 75% and a previous period Quality Score of 65% has a DSRIP Accountability Score of 80% (75% + 50% of (75%-65%))

Performance Periods 1 and 2 are reporting only. CPs and CSAs will be eligible for funds at risk in Budget Period 2 provided they comply with reporting requirements. For example, if 90% of reporting requirements are met, the entity will be eligible for 90% of the at-risk funds.

Should a new CP or CSA join the program, the new CP's or CSA's first Budget Period will be used to establish baseline data for relevant Quality Measures. Should significant numbers (e.g., 10% increase in members) of new CPs or CSAs join the program, achievement targets may need to be re-calculated. The State will submit any such modification requests as described below in Section 5.4.6.1.

5.4.5 Outcomes Based Payments

Beginning in Performance Year 3, the State will establish an annual outcome-based payment pool for BH and LTSS CPs. Any CP achieving a score of "1" for the Avoidable Utilization domain (i.e., met or exceeded the Excellence Benchmark for each Measure), which includes preventable ED visits and all cause readmissions, will be eligible for Outcomes Based Payments. The CP will receive a portion of funds from the outcome-based payment pool based on their proportion of engaged members relative to all members engaged by all CPs eligible for the pool. For example, if the total number of members engaged with CPs who achieve the Excellence Benchmarks for the Avoidable Utilization domain measures is 5,000 and a CP had 1,000 of those engaged members then that CP would receive 20% of the outcomes-based payment pool.

5.4.6 Process for calculating CP/CSA DSRIP Accountability Scores

5.4.6.1 *Roles and responsibilities*

The State will be responsible for establishing the elements that comprise the calculating CP/CSA DSRIP Accountability Scores, including its Quality Measures, the specifications for each Quality Measure, the data sources for calculating the Quality Measures, the methodology for setting the Attainment Threshold and Excellence Benchmark for each Quality Measure (where applicable), and the values of the thresholds and benchmarks themselves. The State will also establish the Minimum Quality Score Threshold and the Excellence Quality Score Benchmark used to calculate the CP/CSA DSRIP Accountability Score. This sub-section 5.4.6.1 details the roles and responsibilities of the State, the State's DSRIP Advisory Committee, and CMS with respect to establishing these elements.

The State

The State will establish the elements that comprise the CP and CSA DSRIP Accountability Score, based on the advice of the DSRIP Advisory Committee on Quality (see Section 6.2.1). The State will submit the Quality Measure slate and specifications to CMS for review and approval by November 2017.

Given that the State will be using the first two Budget Periods to gather baseline data to inform performance target setting for BP3 (i.e. CY 2020), it will not have finalized data to calculate the BP3 targets until Q4 of BP3. As such, the State will submit benchmark sources and preliminary performance thresholds (i.e., Attainment Thresholds and Excellence Benchmarks) to CMS for review and approval by August 2019 (i.e. BP2), based on 9 months of BP1 data. CMS will have 90 calendar days to review and approve. Once the State has processed the BP2 data, in August 2020, it will submit finalized performance

targets based on both BP1 and BP2 data to CMS for review and approval. CMS will have 90 calendar days to review and approve.

The State may request modification to any element that comprises the CP/CSA DSRIP Accountability Score, based on its own assessment or on the recommendation of the State's DSRIP Advisory Committee on Quality. In the event that the State wishes to change a previously approved element that is a component of the CP/CSA DSRIP Accountability Score, the State will submit a formal, written modification request to CMS for review and approval. CMS will have 90 calendar days to review and approve.

As part of its program management and contract oversight processes, the State will establish a structured process for CPs and CSAs to seek clarification on or request revisions to certain aspects of their CP/CSA DSRIP Accountability Scores (e.g., if a CP seeks clarification on the inclusion of certain members in the denominator for a Quality Measure's performance score). Each CP and CSA will identify a key contact, responsible for raising such issues to the State and working with the appropriate State personnel to discuss and resolve issues as appropriate. The State will also identify a reciprocal contact to liaise with each CP and CSA and support these types of requests.

If a CP or CSA does not earn 100% DSRIP Accountability Score, then the State may provide an opportunity for CPs or CSAs to submit DSRIP Performance Remediation Plans to earn back a portion of the unearned, withheld funds, at the State's discretion. If the State allows this opportunity, then a CP or CSA may choose to provide the State a DSRIP Performance Remediation Plan within 30 calendar days of receipt of the CP or CSA's DSRIP Accountability Score, in which case the CP or CSA may have the opportunity to earn back up to 60% of the unearned, withheld funds, as further described below.

The DSRIP Performance Remediation Plan will include:

- A detailed assessment of the reason(s) why the CP or CSA did not achieve 100% Accountability Score, separately addressing each measure on which the CP or CSA scored less than full points;
- Discrete project(s) the CP or CSA will undertake to address some or all of the reasons for why it did not achieve 100% Accountability Score, along with rationale for why these activities are appropriate; or other discrete projects that align with the goals of the CP or CSA's DSRIP Participation Plan
- A workplan, which includes a timeline for the implementation of these activities over the first half of the coming Budget Period, as well as identification of the resources that will be responsible for their completion
- An accountability plan for these activities, including any milestones or metrics the CP or CSA anticipates and when the CP or CSA anticipates realizing them, and also including a proposed model for the State to monitor the CP or CSA implementation of the proposed activities and their success or failure throughout the first half of the coming Budget Period (e.g., a schedule of site visits, staff interviews, desk reviews, etc.)

Within 45 calendar days of receiving the Performance Remediation Plan, the State and the Independent Assessor will review the Plan in parallel, and the State, considering the Independent Assessor recommendation, will either request additional information regarding the Performance Remediation Plan, or approve it and submit to CMS for review and approval. During the State's review process, it will determine how much of the 60% of unearned, withheld funds the CP or CSA will be able to earn back, based on the Performance Remediation Plan's relevance to the reasons for why the CP or CSA did not achieve 100% Accountability Score, or to the goals of the CP or CSA's DSRIP Participation Plan. CMS will have 90 calendar days to review and approve the Plan. If CMS has not responded to the State's approval request, then the Performance Remediation Plan will be deemed approved, given the need for

CPs or CSAs to have as much time as possible to implement their projects, which will need to be completed during the first half of the following Budget Period. The State will monitor the Plan during the implementation period on an ongoing basis. Additionally, the State will assign a Performance Remediation Plan Score to the CP or CSA, based on the State's ongoing monitoring of the Plan, and supporting documentation submitted by the CP or CSA in its semiannual progress report for the first half of the Budget Period in question. The Performance Remediation Plan Score will be a single point value between 0 and 10 inclusive, and will determine how much of the CP or CSA's unearned, withheld funds can be earned back.

For example, if (1) a CP or CSA has $100,000 of unearned, withheld funds; (2) the State determines that a CP or CSA will be able to earn back 50% of the CP or CSA's unearned, withheld funds (out of a 60% maximum percentage); and (3) the CP or CSA achieves a Performance Remediation Plan Score of 7 out of 10, then the CP or CSA's final earned funds will be equal to $100,000 * 50% * (7 / 10) = $35,000.

The DSRIP Advisory Committee on Quality

See Section 6.2.1 for discussion of the Advisory Committee on Quality's role**.**

CMS

CMS will review and approve State submissions within 90 calendar days. If CMS does not approve the submission, the State and CMS will work collaboratively together to align on appropriate modifications and a timeline for prompt approval.

5.4.7 Timeline of CP DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments

The timeline for CP DSRIP Accountability Score calculation and disbursement of DSRIP payments to CPs is anticipated to be as follows:

- CP and CSA Budget Period Closes
- Member experience survey results within 270 calendar days of BP closing
- State determines denominators and sample populations (i.e., the specific members whose data each CP must submit) for the clinical quality measures within 210 calendar days of BP closing
- CPs and CSAs submit clinical quality data within 30 calendar days of receiving the denominators and sample populations for the clinical quality measures
- State calculates CP and CSA DSRIP Accountability Score within 90 calendar days of receiving all underlying required data
- Once CP and CSA DSRIP Accountability Scores have been calculated, State submits Scores and supporting documentation to CMS for review and approval
- CMS has 90 calendar days to review and approve the CP and CSA DSRIP Accountability Scores; if CMS has not responded to State's approval request, then the DSRIP Accountability Scores will be deemed approved, given the need to disburse at-risk funding to CPs and CSAs in a timely fashion
- State notifies CPs and CSAs of CP and CSA DSRIP Accountability Score within 30 calendar days of determining Score
- State disburses DSRIP at-risk payments to CPs and CSAs within 30 calendar days after CMS has approved CP and CSA DSRIP Accountability Scores

5.5 Reporting Requirements for ACOs, CPs and CSAs

5.5.1 Semiannual Participation Plan Progress Reports

ACOs, CPs, and CSAs participating in the DSRIP program will submit semiannual reports to the State demonstrating progress with their Participation Plans, plans for continued implementation of the approved

Participation Plan, areas for improvement and an account of budget expenditures. The State will provide templates for the semiannual progress report which will specify the data that ACOs, CPs and CSAs will need to submit. ACOs, CPs and CSAs must submit their semiannual progress reports in order to receive further DSRIP funding. For example, if an ACO, CP or CSA submits a semiannual progress report three months after the end of BP2, then it will be able to receive DSRIP payments from three months after the end of BP2 until the next required semiannual progress report submission date (i.e. two months after the midway point of BP3).

ACO semiannual progress reports will be submitted in a form and format prescribed by the State, and may include information such as:

- The ACO's progress toward implementation of the Participation Plan
- The progress and status of specific investments and programs supported by DSRIP funds, including any findings from or modifications to these investments and programs
- Descriptions of recent activities and accomplishments
- Descriptions of upcoming activities and challenges
- Budget expenditures for all DSRIP funding
- If relevant, supporting documentation for a DSRIP Performance Remediation Plan
- Additional information as requested by EOHHS.

As noted above, ACOs will submit progress reports twice annually. The Progress Report 1 will be due two months after the midway point of a given BP and Progress Report 2 will be due three months following the close of the Budget Period. The below provides the timeline for submission of such reports for the Preparation Budget Period as well as Budget Period 1. Budget Periods 2-5 will follow the same pattern as Budget Period 1, adjusted for the respective years.

- **Preparation Budget Period Progress Report**: This report is due no later than **March 31**, **2018** and shall include the information detailed above for the **Preparation Budget Period (July 1 – December 31, 2017)**
- **BP1 Progress Report 1:** This report is due no later than **August 31, 2018** and shall include the information detailed above for the period of **January 1 - June 30, 2018**
- **BP1 Progress Report 2:** This report is due no later than **March 31, 2019** and shall include the information detailed above for the period of **January 1 - December 31, 2018**

The content for ACO Progress Reports 1 and 2 for a given Budget Period may differ, as Progress Report 2 provides detailed information about the entire Budget Period, whereas Progress Report 1 only covers the first half of the Budget Period.

For CPs and CSAs, semiannual progress reports will be submitted in a form and format prescribed by the State, and may include:

- Descriptions of successes, barriers, challenges, and lessons learned regarding, at a minimum, outreach, care coordination, and integration of care
- Summary of CP care coordination supports activities

- Budget expenditures for all DSRIP funding
- Supporting documentation for DSRIP Performance Enhancement Plans (if relevant)
- Additional information as requested by EOHHS

The below provides the timelines for submission of such reports for the CPs/CSAs Preparation Budget Period as well as Budget Periods 1 and 2. Budget periods 3-5 will follow the same pattern as Budget Period 2 adjusted for the respective year

- **Preparation Budget Period Progress Report**: This report is due no later than **August 31, 2018** and shall include the information detailed above for the **Preparation Budget Period (October November 2017 – May 31, 2018)**
- **BP1 Progress Report 2:** This report is due no later than **March 31, 2019** and shall include the information detailed above for the period of **June 1, 2018 – December 31, 2018**
- **BP2 Progress Report 1:** This report is due no later than **August 31, 2019** and shall include the information detailed above for the period of **January 1 - June 30, 2019**
- **BP2 Progress Report 2:** This report is due no later than **March 31, 2020** and shall include the information detailed above for the period of **January 1 - December 31, 2019**

The content for CP or CSA Progress Reports 1 and 2 for a given Budget Period may differ, as Progress Report 2 provides detailed information about the entire Budget Period, whereas Progress Report 1 only covers the first half of the Budget Period.

5.5.2 Review and Approval of Semiannual Progress Reports

The State and the Independent Assessor will review the semiannual progress reports (see Section 6.2.2 for details). The State and the Independent Assessor will have a total of 45 calendar days to review and approve the report, or request additional information regarding the information reported. All approved semiannual progress reports will be sent to CMS.

5.5.3 Additional Reporting Requirements

ACOs, CPs, and CSAs must annually submit clinical quality data to the State for quality evaluation purposes. For example, as noted in Appendix D, the State has proposed three types of quality measures. The first type is solely based on claims or administrative data and will be calculated by the State with no further input (other than claims previously submitted) from the ACO/CP/CSA. The second type of quality measure is based on patient experience survey data, and will be collected by a state-procured survey vendor. The third type of quality measure will require both claims information and clinical (e.g. blood pressure) or administrative (e.g. completion of an assessment) information not available through claims. The State will produce the denominators for quality measures based on claims or other information and then submit the denominator to the ACO, CP, or CSA for completion of the numerator information. The State will then receive the numerator information from the ACOs, CPs, or CSAs and calculate performance. The State will conduct audits of the clinical quality data submitted by ACOs, CPs, and CSAs to ensure that the data are accurate.

Additionally, ACOs will need to submit their ACO revenue payer mix for safety net categorization purposes. CPs will need to submit to the State their roster of engaged members. All entities will also be responsible for ad hoc reporting as requested by the State.

Section 6. State Operations, Implementation, Governance, Oversight and Reporting

The State will utilize the small portion of DSRIP funding allocated to the State Operations and Implementation to support robust operations, implementation, governance and oversight of the DSRIP program. These state expenditures associated with implementation of the DSRIP program will be claimed as administrative costs on the CMS 64. Appendix C provides additional detail on anticipated personnel, fringe and contractual costs.

6.1 Internal Operations and Implementation

The State will use a robust internal implementation team to ensure the DSRIP program towards its goals at outlined in STC 57. The team will include, but not be limited to:

- ACO program and contract management team
- CP program and contract management team
- Statewide Investments program and contract management team
- MassHealth operations team

The State will develop an internal steering committee that will make recommendations to the Assistant Secretary for MassHealth on policy and programmatic decisions related to the DSRIP program. This steering committee will include representation from several MassHealth teams involved in the design and implementation of the DSRIP program.

Committee members will meet regularly and will solicit feedback from the DSRIP Advisory Committee on Quality and other stakeholders as needed. While the steering committee will provide timely information and consultation, ultimate decision-making power rests with the Assistant Secretary for MassHealth.

6.2 Advisory Functions

6.2.1 DSRIP Advisory Committee on Quality

The State will establish a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities as set forth in STC 71.[2] The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement, and clinical data used in performance improvement initiatives, quality and best practices. Final decision-making authority will be retained by the State and CMS, although all recommendations of the Committee will be considered by the State and CMS. The Committee will be made up of:

- Representatives from community health centers serving the Medicaid population
- Clinical experts in behavioral health, substance use disorder and long term services and supports. Clinical experts are physicians, physician assistants, nurse practitioners, licensed clinical social workers, licensed mental health counselors, psychologists, or registered nurses who satisfy two or more of the following criteria:
    - Five years of patient care in the relevant area of expertise
    - Experience managing clinical programs focused on the relevant patient populations

2 Note STC 71 called the Committee the "DSRIP Advisory Committee." State has decided to re-name it as the "DSRIP Advisory Committee on Quality" for clarification purposes.

    - Service on national or statewide advisory committees or panels for relevant topic areas
- Advocacy members: consumers or consumer representatives, including at least one representative for people with disabilities and, separately, at least one representative for people with complex medical conditions

At least 30% of members must have significant expertise in clinical quality measurement of hospitals, primary care providers, community health centers, clinics and managed care plans. Significant expertise is defined as not less than five years of recent full time employment in quality measurement in government service, at managed care plans, at health systems, or from companies providing quality measurement services to above listed provider types and managed care plans.

To minimize risk of conflicts of interest, no more than three members may be directly employed by Massachusetts hospitals, MassHealth ACOs, or Community Partners. To further minimize conflicts of interest, no CEO, CFO, COO, or CMO of a Massachusetts hospital, MassHealth ACO, or Community Partners will be appointed to the Committee. Additionally, any members whose affiliated organizations have financial interests in performance target setting for quality measures must recuse themselves when the Committee is discussing performance target setting. Finally, potential conflicts of interest will be considered when selecting Committee members to try to minimize such conflicts.

6.2.2 Independent Assessor

The State will identify an Independent Assessor with expertise in delivery system improvement to assist with DSRIP administration, oversight, and monitoring as set forth in STC 70. The Independent Assessor will provide an added, ongoing layer of review and monitoring. The State and the Independent Assessor will concurrently review ACOs', CPs', and CSAs' Full Participation Plans, Budgets, Budget Narratives, and Semi-Annual Progress Reports to ensure compliance with the STCs and DSRIP Protocol. Preliminary ACO and CP Participation Plans and the Budgets and Budget Narratives for the Preparation Budget Period will not be subject to review by the Independent Assessor. The Independent Assessor shall make recommendations to the State regarding approvals, denials or recommended changes to Participation Plans, Budgets, Budget Narratives, and Semi-Annual Progress Reports, but final decision-making authority regarding all approvals, denials or requests for modifications rests with the State. However, the State will carefully consider the Independent Assessor's recommendations. The State has the authority to change Independent Assessors at the State's discretion.

In contrast, the Independent Evaluator is charged with reviewing the DSRIP program as a whole (see Section 6.4). At the midpoint and conclusion of DSRIP, the Evaluator will undertake a midpoint assessment and summative evaluation, respectively, which will seek to determine the effectiveness of the DSRIP program in relationship to its goals. To accomplish such reviews, the Evaluator will use a quantitative and qualitative approach. These reviews may include evaluating the work of the Independent Assessor.

6.3 Stakeholder Engagement

6.3.1 Independent Consumer Support Program

The State will create Independent Consumer Support Program to assist beneficiaries in understanding their coverage models and in the resolution of problems regarding services, coverage, access, and rights. The Independent Consumer Support Program will assist beneficiaries to navigate and access covered services in accordance with STC 62.

6.3.2 State Public Outreach for ACO Program

The State aims to facilitate a seamless transition to the new care model for MCO and ACO enrollees and will do so through the State Public Outreach for ACO Program in accordance with STC 68.

6.3.3 State Reporting to External Stakeholders and Stakeholder Engagement

The State will compile public-facing annual reports of ACO, CP, and statewide investments performance. The report will provide relevant information on the State's progress under the DSRIP program, as determined by the State. Annual public meetings will be held to engage stakeholders on the DSRIP program at large, and allow for discussion, comments, and questions. MassHealth will also post information related to the DSRIP program online. The public will be encouraged to contact MassHealth to provide comments and feedback throughout the Demonstration through a dedicated e-mail address.

6.4 Evaluation of the Demonstration

The State will procure an Independent Evaluator to conduct a mid-point assessment and final evaluation of the DSRIP program per STCs 69 and 84. The State may utilize the same Independent Evaluator for the Demonstration under STC 84 as it does for the DSRIP program under STC 69.

6.4.1 Requirements for Midpoint Assessment of Performance and Interim Evaluation

The Independent Evaluator will conduct a midpoint assessment and an interim evaluation of the DSRIP program, in accordance with STCs 69(a) and 84. The midpoint assessment will evaluate the program to determine whether the investments made through the DSRIP program are contributing to achieving the demonstration goals as described in STC 57, and which areas need improvement (e.g., conduct rapid cycle evaluations). Specifically, the quantitative findings will be used to report on progress towards reaching goals, and qualitative findings will be used to understand additional implementation issues. The results from the midpoint assessment will help to develop an interim evaluation of the DSRIP program. The State may focus on issues identified in the assessment and interim evaluation report and may implement changes where necessary. For example, if the interim evaluation reveals that the administration of the flexible services program is too burdensome or not robust enough, then the State may identify potential adjustments to the program, and implement them accordingly with appropriate communication with ACOs and CPs.

Despite the schedule set forth in STC 69(a), the State has agreed to provide the midpoint assessment through December 2019 and to submit the interim evaluation to CMS by the end of June 2020. The State will provide the draft evaluation design of the overall waiver (including initial proposals for evaluation of the DSRIP program) to CMS in March 2017. The State will provide the proposed design for the interim DSRIP evaluation to CMS for review by June 30, 2018.

6.4.2 Final Evaluation

In contrast to the interim evaluation, the final evaluation will provide a summative overview of the DSRIP program over the five year demonstration period, and evaluate whether the investments made through the DSRIP program contributed to achieving the demonstration goals as described in STC 57. The Independent Evaluator will also be responsible for completing the final evaluation of the DSRIP program in accordance with STCs 69(b) and 84(f).

6.5 CMS Oversight

6.5.1 State Reporting to CMS

The State will compile quarterly and annual reports to submit to CMS consistent with sections IX and X of the approved STCs as part of the broader 1115 demonstration reports. These reports will include an account of all DSRIP payments made in the quarter or year, respectively and include insights and updates from the progress reports collected from ACOs, CPs, and CSAs. The State and CMS will agree upon a reporting template for quarterly and annual reports by the start of the demonstration for the quarterly report and by December 2017 for the annual report. The State and CMS will also use a portion of the Monthly Monitoring Calls for March, June, September, and December of each year for an update and

discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.

6.5.2 Process for Review, Approval, and Modification of Protocol

The State will work collaboratively with CMS for the review and approval of the DSRIP Protocol. As set forth in STC 58(c), the State may modify the DSRIP Protocol over time, with CMS approval. Reasons for modification may include but are not limited to:

- State decision to change programmatic features that are codified in the Protocol (e.g. change the structure of the outcomes-based payment funding stream for CPs)
- State decision to modify State Accountability Targets during the demonstration period, if the targets are no longer appropriate, or that targets were greatly exceeded or underachieved

State will submit the modification request to CMS, which will have 90 calendar days to review and approve. If CMS does not approve the Protocol, the State and CMS will work collaboratively together to align on appropriate modifications and a timeline for prompt approval.

Appendix A: Description of ACOs and CPs

Accountable Care Organizations

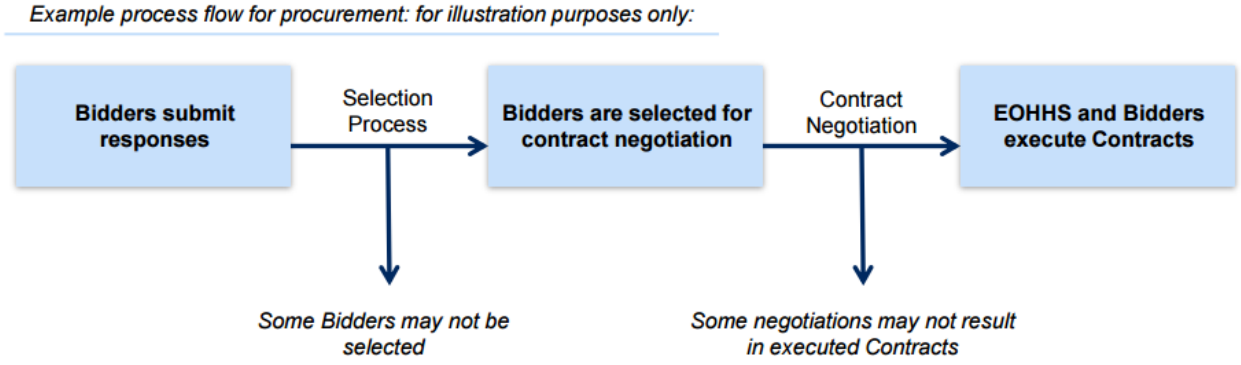
To achieve Massachusetts' DSRIP goals as described above, the State is transitioning a significant portion of the delivery system from a fragmented, fee-for-service model to one where providers come together in new partnerships to take financial accountability for the cost and quality of care for populations of members. Massachusetts is launching a new Accountable Care Organization program, has designed three ACO payment models that respond to the diversity of the state's delivery system, and intends to select ACOs across all three models through a competitive procurement.

ACO contracts will have an initial term of five-years and will include significant requirements for ACOs to ensure care delivery in line with the state's delivery system goals, including but not limited to requirements to screen members and connect them to appropriate settings of care; requirements to proactively identify at-risk members, complete comprehensive assessments, and provide them with appropriate care management activities; and requirements to work with Community Partners to integrate behavioral health, LTSS, and medical care. Massachusetts' three ACO models are described in Section 1.

Procurement Process

Massachusetts intends to select ACOs across all three ACO models as part of a single, competitive procurement. Bidders may bid on more than one model, but a bidder may be selected for, at maximum, one ACO model. The State may re-open the procurement at any time if, in the State's determination, the State has not received sufficient responses, or to otherwise meet the State's delivery system goals.

Bidders will submit responses to the State's procurement by the deadline, after which the responses will be evaluated by the State. The State will select successful ACO bidders to enter into contract negotiation. Through contract negotiation, the State intends to reach successful contract execution with a set of ACOs; although not all ACOs selected for negotiation may ultimately execute contracts with the State (e.g., if an ACO ultimately chooses not to accept final contract terms or rates). The graphic below shows an example process flow:



The State's current anticipated procurement timeline is as follows:

- Request for responses was posted in September 2016
- Bidders' responses are due mid-February 2017
- Target contract execution in August 2017

- Contracts will be effective the date they are executed, and will have an operational start date (i.e., the date on which members can enroll in ACOs) in December 2017

Further information on the ACO procurement can be found online at the State's public procurement website, www.commbuys.com.

Community Partners

Community Partners will support members with complex BH and LTSS needs, in coordination with ACOs and other managed care entities, as determined by the State. The focus populations of MassHealth members for the CP program may include, for example, (1) members with diagnoses of serious mental illness and/or substance use disorder who have significant utilization of acute services such as ER visits, inpatient stays, detoxification stays, medication assisted treatment for SUD or co-occurring chronic medical conditions; and/or (2) members with claims for MassHealth State Plan LTSS of more than $300 per month over at least 3 consecutive months.

MassHealth will selectively procure the following two types of CPs, BH CPs and LTSS CPs (see Sections 1 and 4.3 for additional descriptions of the CP Models).

- **BH CP Model overview**: MCOs and ACOs will delegate comprehensive care management responsibility to the BH CP for enrollees of the BH CP with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD). BH CPs will be required to coordinate care across the full healthcare continuum, including physical and behavioral health, LTSS and social service needs. Because BH CPs will be expected to have experience supporting members with LTSS needs, members with both complex BH and LTSS needs as assigned to a BH CP. BH CPs will be required to meet certain training obligations (e.g., training in person-centered planning, cultural competency, accessibility and accommodations, independent living and recovery principles, motivational interviewing, conflicts of interest and health and wellness principles) and coordination requirements (e.g., providing enrollees with at least two choices of LTSS service providers, assisting the member in navigating and accessing needed LTSS and LTSS-related services, identifying LTSS providers that serve or might serve the member, and coordinating and facilitate communication with LTSS providers) to ensure their capability to support members with both complex BH and LTSS needs.

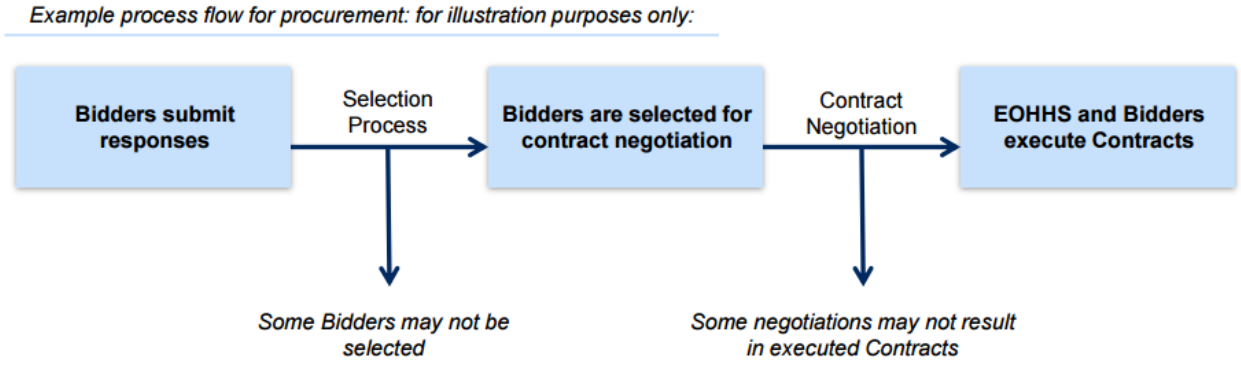
- **LTSS CP Model overview**: ACOs and MCOs will conduct comprehensive assessments, convene the care teams, and provide care planning and coordination for physical and behavioral health services to enrollees assigned to a LTSS CP. The LTSS CP will review the comprehensive assessment results with the LTSS CP assigned members as part of the person-centered LTSS care planning process and will inform the member about his or her options for specific LTSS services, programs and providers that may meet the member's identified LTSS needs. The LTSS CP is expected to be an integral part of the member's care team, as requested by the member. LTSS CPs may also have the opportunity to participate in an enhanced supports model (anticipated to begin in year 2), where responsibility for the comprehensive assessment and care management will be delegated by the ACO/MCO to the LTSS CP.

CPs will not be able to authorize services for members under either model.

Procurement Process

MassHealth intends to select BH and LTSS CPs across the State through a competitive procurement. ACOs (and other managed care entities as determined by the state) will be required to partner with CPs in all the regions or services areas in which the ACO operates.

Bidders will submit responses to the State's procurement by the deadline, after which the responses will be evaluated by the State. The State will consider any bid submitted by any entity that meets the minimum bidder qualifications of the procurement. The State will select successful CP bidders to enter into contract negotiation. Through contract negotiation, the State intends to reach successful contract execution with a set of CPs; although not all CPs selected for negotiation may ultimately execute contracts with the State (e.g., if an CP ultimately chooses not to accept final contract terms or rates). The graphic below shows an example process flow:



The State's current anticipated procurement timeline is as follows:

- Request for responses will be posted in February/March 2017
- CP responses are due end of May 2017
- Target contract execution in November 2017
- Contracting between CPs and ACOs & MCOs is targeted to be completed by January-February 2018
- CPs begin enrolling members in June 2018

Further information on the CP procurement can be found online at the State's public procurement website, www.commbuys.com.

Relationships between ACOs and CPs

Massachusetts has established a framework for ACOs and CPs to form and formalize their relationships. This framework is set forth in the model contracts for ACOs, and Massachusetts intends to similarly incorporate this framework in its model contracts for CPs. The framework delineates areas of delegated and shared responsibility between ACOs and CPs, as follows:

Delegated responsibility to BH CPs

ACOs must maintain agreements with BH CPs. These agreements will require the BH CP to support the ACO's care coordination and care management responsibilities, including:

- Working together to improve coordination and integration of BH services and expertise into care, including activities such as but not limited to:
    - Identifying BH providers that serve or might serve enrollees, and coordinating between the ACO and those providers
    - Assisting the ACO's members to navigate to and access BH and related services
    - Facilitating communication between members and providers
    - Coordinating with staff in state agencies that are involved in member care
    - Facilitating members' access to peer support services
- Working together to perform outreach and enrollment for members who are eligible for BH CPs
- Providing care management to BH CP-enrolled members, including designated care coordinators/clinical care managers, documented treatment plans, comprehensive transition management, health promotion, and other activities
- Collaborating and establishing mutual policies and procedures to ensure alignment, information sharing, appropriate sign-off, issue resolution, and communication
- Performance measurement and management, including the ACO and CP working together to evaluate performance on key process measures (e.g., outreach and enrollment) and outcome measures (e.g., the state's accountability score measures)

Delegated responsibility to LTSS CPs

ACOs must maintain agreements with LTSS CPs. These agreements will require the LTSS CP to support the ACO's care coordination and care management responsibilities, including:

- Working together to improve coordination and integration of LTSS and expertise into physical and behavioral health care, including activities such as but not limited to:
    - Identifying LTSS providers that serve or might serve enrollees, and coordinating between the ACO and those providers
    - Assisting the ACO's members to navigate to and access LTSS and related services
    - Facilitating communication between members and providers
    - Coordinating with staff in state agencies that are involved in member care
    - Providing support during transitions of care for the ACO's members
- Providing information and navigation to LTSS for the ACO's members
- Collaborating and establishing mutual policies and procedures to ensure alignment, information sharing, appropriate sign-off, issue resolution, and communication

- Performance measurement and management, including the ACO and CP working together to evaluate performance on key process measures (e.g., outreach and enrollment) and outcome measures (e.g., the state's accountability score measures)

Exhibit A1 below details the entities performing the comprehensive assessment, care planning and service authorization functions related to LTSS and the target populations for such functions.

Exhibit A1: LTSS Comprehensive Assessment, Care Planning and Service Authorization

Activity	Entity Performing Activity	Population
Care Needs Screening	ACO or MCO	ACO and MCO enrollees
Comprehensive Assessment	ACO or MCO	ACO and MCO enrollees assigned to a LTSS CP or with LTSS needs as specified by EOHHS
LTSS segment of Care Planning	ACO or MCO	ACO and MCO enrollees with LTSS needs as specified by EOHHS who are not assigned to LTSS CPs
	LTSS CP	ACO and MCO enrollees assigned to a LTSS CP
Service Authorization	*Before LTSS becomes covered services and included in TCOC:*	
	MassHealth	ACOs and MCOs enrollees, including LTSS CP engaged enrollees
	After LTSS become covered services and are included in TCOC (~year 3):	
	Accountable Care Partnership Plan	Accountable Care Partnership Plan enrollees, including LTSS CP engaged enrollees
	MCO	MCO-Administered ACO and MCO enrollees, including LTSS CP engaged enrollees
	MassHealth	Primary Care ACO enrollees, including LTSS CP engaged enrollees

Shared responsibility between ACOs and CPs
Agreements will codify responsibilities of ACOs and CPs and describe additional requirements, including:

- Member assignment to a CP (as applicable)
- Care team roles and participation
- Performance expectations and any associated financial arrangements (beyond DSRIP)
- Shared decision-making and governance
- IT systems and data exchange, including quality and cost reporting

Beyond delineation of roles and responsibilities, contracts between ACOs, CPs, and MCOs must include conflict resolution protocols to handle disputes between the relevant parties. As ACOs and MCOs will not be paying CPs for services provided, a substantial portion of disputes will likely center around member referrals and care plans. If the member believes that the care he or she is receiving is unacceptable, the member will have access to formal grievance processes through the ACO, MCO, and CP entities. Additionally, the member can contact MassHealth's Ombudsman Patient Protection Program, which is established to explicitly help members work through such issues. Throughout Year 1, the State will monitor disputes as they arise, and at year conclusion, will determine if further conflict resolution protocols are needed.

Appendix B: Description of Statewide Investments Initiatives

Student Loan Repayment

The student loan repayment program will repay a portion of a student's loan in exchange for at least a two year commitment (or equivalent in part time service) to work as a (1) primary care provider at a community health center or (2) behavioral health professional (e.g., Community Health Worker (CHW), Peer Specialist, Recovery Support Specialist, or Licensed Clinical social worker) in a community setting (e.g., community health center, community mental health center) and/or at an Emergency Service Program (ESP), and/or at any entity participating in a CP or CSA. This program hopes to reduce the shortage of providers and incentivize them to remain in the field long-term. Additionally, increased numbers of providers available to ESPs will help support diversionary strategies to reduce Emergency Department utilization and increase appropriate member placement in other settings.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the impact of the student loan repayment program on their practice and institutions. Awardees' accountability will be ensured through primary care providers' and behavioral health professionals' attestations that they have remained in the required placement for a minimum of two years or the equivalent in part time service. If a provider fails to fulfill the minimum requirement, the State will determine the appropriate recourse, which may include recoupment of funds paid by the State for student loans.

State Management

The State will select the recipients of the awards, and will conduct robust monitoring and assessment of the semi-annual progress reports including reviewing the awardees' progress, successes, and challenges.

Primary Care Integration Models and Retention

The State will implement a grant program that provides support for community health centers and community mental health centers, and/or any entity participating in a CP or CSA to allow their primary care and behavioral health providers to engage in one-year projects related to accountable care implementation, including improving care coordination and integrating primary care and behavioral health. These projects must support improvements in cost, quality and member experience through accountable care frameworks and will also serve as an opportunity to increase retention of providers. Community health centers, community mental health centers, and/or entities participating in a CP or CSA will be the primary applicant and will partner with primary care and behavioral health providers to apply for this funding.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select the recipients of this funding, and will conduct robust monitoring and assessment of the semiannual progress reports by reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or

renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Investment in Primary Care Residency Training

In order to increase the number of physicians receiving residency training in community health centers, the State will use DSRIP funding to help offset the costs of community health center and community mental health center residency slots for both community health centers, community mental health centers, and hospitals. Community health centers, community mental health centers, and hospitals will be eligible to apply for this funding.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the project's progress towards goals and pre-approved accountability measures (e.g., the number of providers remaining in the CHC for the length of the residency program), challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select the recipients of this award, and will conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures.

Workforce Development Grant Program

The State's payment reform initiatives will introduce new demands and shifting responsibilities for the healthcare workforce. The State will use DSRIP funding to support a wide spectrum of health care workforce development and training to allow for providers to more effectively operate in a new health care system. Entities participating in payment reform (ACOs, Community Partners, and CSAs), or entities in support of ACOs, CPs, and CSAs (e.g. training programs) are eligible to apply for funding.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

State will select the awardees, and will conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Technical Assistance

The State will procure vendors to provide technical assistance (TA) to ACOs, CPs and CSAs in a range of knowledge domains in order to help with the implementation of evidence-based interventions. TA may be provided in multiple forms, including but not limited to: individual consultation, learning collaboratives, tools and resources, and webinars. Providers participating in payment reform (ACOs, Community Partners, and CSAs) may be eligible to apply for funding.

Technical assistance may be available in areas such as, but not limited to:

(1) Education: Education on delivery system reform topics, such as governance requirements, shared savings and shared losses; network development; quality and financial management analytics; assistance with health care literacy; and other topics.

(2) **Actuarial and Financial:** Actuarial consulting to support participation in payment models. Baseline education and readiness assessments that address financial business process changes, patient attribution, budgeting, practice management systems, and other needs.

(3) **Care Coordination/Integration**: Technical assistance to support, establish, and improve care coordination/integration best practices, including best practices around incorporating community health workers and social workers into practice, among other areas

(4) **Performance Management:** Technical assistance to support program improvements, project management and provider performance management

(5) **Health Information Technology**: Consultations to provide insight into what HIT investments and workflow adjustments will be needed to achieve goals regarding data sharing and integration across the delivery system (e.g., establishing clinical or community linkages through an e-Referral system)

(6) **Accessible and Culturally Competent Care:** Training and support materials to promote best practices for accessibility and for culturally competent care for individuals with limited English proficiency; diverse cultural and ethnic backgrounds; physical, developmental, or mental disabilities; and regardless of gender, sexual orientation, or gender identity.

(7) **Chronic Conditions Management:** Training, support, and technical assistance on utilizing and implementing evidence-based interventions to manage chronic conditions, among other areas.

(8) **Behavioral Health Care Treatment and Management:** Training, support, data analytics, and technical assistance in caring for patients with behavioral health needs in the community, among other areas

(9) **Population Health and Data Analytics:** Training, support, and technical assistance in analyzing data (e.g. raw claims extracts from The State, clinical quality data from EHRs) to help providers make evidence-based decisions, among other items

Awardee's Obligations

ACOs, CPs, and CSAs will be eligible to apply for technical assistance. Interested ACOs, CPs, and CSAs will submit a comprehensive TA plan as part of their application, which will be subject to modification and approval by the State. Any TA resources to support the plan must not overlap with TA supported through other funding sources (e.g., federal, state, private sector). Awardees will be required to submit a semiannual progress report discussing the progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

Vendor's Obligations

Vendors will work in collaboration with the State, ACOs, CPs, and CSAs to provide TA in a way that optimizes allocated TA resources and supports sustainable TA infrastructure. Vendors will also be required to submit documentation covering the same topics discussed in the awardees' semiannual progress report.

State's Management

The State will procure qualified vendor(s) for each TA category. A vendor may be approved for multiple categories. To be considered a qualified vendor, the vendor must demonstrate expertise and capacity for the categories for which it is applying, as well as meet other eligibility criteria set by the State.

The State will conduct robust monitoring and assessment of progress reports submitted by the awardees and TA vendors, which will include reviewing progress, successes, challenges, and accountability measures. Awardee and TA vendor accountability will be based on meeting pre-determined accountability measures, which will focus on whether the awardee was able to meet its technical assistance goals, or whether the vendor provided appropriate TA. If the goals are not met, or performance is inadequate, the State, in consultation with the awardee and/or vendor, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Alternative Payment Methods (APM) Preparation Fund

The State will use DSRIP funding for an Alternative Payment Methods (APM) Preparation Fund, which will offer two years of support to providers that are not yet ready to participate in an APM, but want to take steps towards APM adoption. Funds can be used to develop, expand, or enhance shared governance structures and organizational integration strategies linking providers across the continuum of care. Massachusetts' providers seeking to move towards ACOs or APMs but that are not participating as a MassHealth ACO; and behavioral health providers, BH CPs, LTSS providers and LTSS CPs seeking to enter into APM arrangements with MassHealth managed care entities will be eligible to apply for funding. Funds may also be used to raise awareness about APM among providers not yet engaged in a MassHealth ACO, CP, or CSA.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select recipients of this funding, and conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Enhanced Diversionary Behavioral Health Activities

The State will use DSRIP funding to support investment in new or enhanced diversionary strategies or infrastructure to help place members with behavioral health needs in the least restrictive, clinically most appropriate settings and to reduce the incidence of members who are boarded in a hospital emergency

department waiting for admission into acute inpatient treatment or diversion to a community setting. Strategies for investment may include:

- Workforce Development
- Urgent care and intensive outpatient program (IOP)
- Community-Based Acute Treatment (CBAT) for adults
- ESP/Mobile Crisis Intervention (MCI) Teams with specific focus on placement in the EDs
- Crisis Stabilization Services (CSS)
- Telemedicine and Tele-psychiatry
- Peer Support models
- Discharge navigation services
- Web-based portal for navigation and data collection of ED boarding and available bed placement
- Care coordination software to better manage members who are boarded in the ED and to prevent such events

ACOs, CPs, CSAs, primary care providers, ESPs, community mental health centers, acute care hospitals, community health centers, psychiatric hospitals, advocacy organizations, provider organizations, vendors, and MCOs may be eligible to apply for funding. ACOs, CPs, or CSAs receiving funding must demonstrate that activities supported through this statewide investment are not duplicative with activities supported through other available funding.

Awardee's Obligations

Awardees will submit a semiannual progress report discussing the project's progress to date including activities and progress towards the reduction of ED boarding, goals and accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select recipients for this funding, and conduct robust monitoring and assessment of the semiannual progress and annual reports. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Improved accessibility for people with disabilities or for whom English is not a primary language

The State will use DSRIP funding to help providers offer necessary equipment and expertise at their facilities to meet the needs of persons with disabilities, or of those for whom English is not a primary language.

Funding would be available to help providers purchase items necessary to increase accessibility for members with disabilities, for accessible communication assistance, and for development of educational materials for providers regarding accessibility for members with disabilities. The State will tailor some of these materials specifically for providers treating members who are vision-impaired, deaf and hard of hearing, or for whom English is not a primary language. Applicants will be required to demonstrate that training is not duplicative of that received under the Technical Assistance statewide investments funding stream.

The State may also utilize this funding to support development of directories or other resources to assist MassHealth members find MassHealth providers by preferred accessibility preferences and to assist providers in identifying the accessibility preferences of their patients.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select funding recipients, and conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Appendix C: Example Calculation of State DSRIP Accountability Score by Accountability Domain for BP 4

The following example demonstrates how the State DSRIP Accountability Score will be calculated for Budget Period 4. There are five steps to calculate how much at-risk funding the State earns in a given BP:

- **Step 1:** Calculate the MassHealth ACO/APM Adoption Rate Score
- **Step 2:** Calculate the Reduction in Spending Growth Score
- **Step 3:** Calculate the Overall Statewide Quality and Utilization Performance Score
- **Step 4:** Using the three scores calculated in Steps 1 through 3 to calculate the State DSRIP Accountability Score
- **Step 5:** Use the State DSRIP Accountability Score to determine earned at-risk funds

Step 1: Calculate the MassHealth ACO/APM Adoption Rate Score for BP 4

For the ACO/APM Adoption Rate score, the State will earn a 100% score for a given Budget Period if the State meets or surpasses the target for that Budget Period. If the State does not meet the target, then it will earn a 0% score for that Budget Period.

For BP 4, the State must have at least 40% of MassHealth ACO-eligible members who are enrolled in or attributed to ACOs or who receive services from providers paid under APMs, as shown below:

EXHIBIT A2 – Target ACO/APM Adoption Rates, BP 4

Target ACO/APM Adoption Rates						
DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	**BP 4**	BP 5
% of MassHealth ACO-Eligible Lives Served by ACOs/ Covered by APMS	NA	25%	30%	35%	**40%**	45%

For the purpose of this example, assume that the State has a 42% ACO/APM adoption rate in BP 4. Therefore, the State receives an accountability domain score of **100%** in this category.

Step 2: Calculate the Reduction in Spending Growth Score for BP 4

In accordance with STC 67(g), the State will calculate its performance on reduction in state spending growth compared to the trended PMPM, and the domain score will be determined according to a gap-to-goal methodology for each budget period, as follows:

- If Actual Reduction < (50% * Reduction Target), then Measure Score = 0%
- If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
- If Actual Reduction ≥ (50% * Reduction Target) AND < (Reduction Target), then Measure Score is equal to: (Actual Reduction - (50% * Reduction Target)) / (Reduction Target - (50% * Reduction Target)) OR the simplified version,

$$\frac{Percent\ of\ reduction\ target\ achieved - 50\%}{100\% - 50\%}$$

For BP 4, the Reduction Target is 1.1% off of trended PMPM, as shown in below.

EXHIBIT A3 – Reduction Targets for ACO-Enrolled PMPMs, BP 4

Reduction Targets for ACO-Enrolled PMPMs						
DSRIP Budget Period	**Prep Budget**	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
% Reduction Target in ACO-enrolled PMPM vs. trended PMPM	NA	NA	NA	0.25% off of trended PMPM	**1.1% off of trended PMPM**	2.1% off of trended PMPM

For the purpose of this example, assume that the State's Actual Reduction is 0.9% in BP 4, which is roughly 82% of the Reduction Target, as show below:

$$Percent\ of\ reduction\ target\ achieved =$$
$$\frac{0.9\%}{1.1\%} \approx 82\%$$

Thus, to calculate this State accountability domain score:

$$\frac{82\% - 50\%}{100\% - 50\%} = 64\%$$

Therefore, the State receives an accountability domain score of **64%** in this category.

Step 3: Calculate the Overall Statewide Quality and Utilization Performance for BP 4

In accordance with STC 67(h), the State will annually calculate the State performance score for each quality and utilization domain by aggregating the performance scores of all ACOs on a member-month weighted basis. Weighting varies by Budget Period, as shown below:

EXHIBIT A4 – ACO Quality Domain Weights

ACO Quality Domain Weights			
Quality Domain		**Domain Weight: BP 1**	**Domain Weight: BP 2-5**
1	Prevention & Wellness	20%	10%
2	Chronic Disease Management	20%	15%
3	Behavioral Health / Substance Use	25%	15%
4	Long Term Services and Supports	10%	5%
5	Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	25%	20%
6	Avoidable Utilization	0%	20%
7	Member Care Experience	0%	15%

STEP 3(a): Scoring for all Domains Except Avoidable Utilization

For all domains except avoidable utilization, domain scores for BP4 are calculated using the following steps:

- Calculate the aggregate domain scores for BP 1-3
- Calculate the pooled aggregate domain scores across the three Budget Periods
- Calculate the aggregate domain scores for BP 4 (our example year) and run a weighted t-test to compare pooled aggregate domain scores from BP 1-3 against the BP 4 populations

Domain score calculations for other Budget Periods would follow a similar methodology.

1. Calculate the aggregate domain scores for BP 1-3

Assume there are two ACOs (ACO 1 and ACO 2) with 10,000 and 20,000 members, respectively, for all Budget Periods. Assuming ACO 1 receives a score of 30% and ACO 2 receives a score of 40% in the Prevention and Wellness domain for BP 1, the aggregate domain score for BP1 is:

$$\left(30\% \times \frac{10{,}000}{10{,}000 + 20{,}000}\right) + \left(40\% \times \frac{20{,}000}{10{,}000 + 20{,}000}\right) = 36.7\%$$

This step is repeated for all quality domains in BP 1-3 (see Exhibit 5 for detail).

2. Calculate the pooled aggregate domain scores for BP 1-3

The pooled aggregate domain score is then calculated by taking the weighted average of aggregate domain scores across a given range of budget periods. Using Prevention and Wellness again as the example, assume that the aggregate domain score for BP 1, BP 2 and BP 3 are 36.7%, 46.7% and 70%, respectively. The pooled aggregate domain score would be:

$$\left(Agg.\,Domain\,Score_{BP1} \times \frac{ACO\ Pop._{BP1}}{Total\ Pop._{BP1-3}}\right) + \left(Agg.\,Domain\,Score_{BP2} \times \frac{ACO\ Pop._{BP2}}{Total\ Pop._{BP1-3}}\right) + \left(Agg.\,Domain\,Score_{BP3} \times \frac{ACO\ Pop._{BP3}}{Total\ Pop._{BP1-3}}\right)$$

$$\left(36.7\% \times \frac{30{,}000}{90{,}000}\right) + \left(46.7\% \times \frac{30{,}000}{90{,}000}\right) + \left(70\% \times \frac{30{,}000}{90{,}000}\right) = 51.1\%$$

EXHIBIT A5 – ACO Aggregate and Pooled Aggregate Domain Scores, BP 1-3

Budget Period	BP 1			BP 2			BP 3			BP 1-3
	ACO 1	ACO 2	Total	ACO 1	ACO 2	Total	ACO 1	ACO 2	Total	Total (BP 1-3)
Number of members	10,000	20,000	30,000	10,000	20,000	30,000	10,000	20,000	30,000	**90,000**
DSRIP Quality Domains	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	Pooled Aggregate Domain Score (BP 1-3)
Prevention & Wellness	30	40	36.7	40	50	46.7	60	75	70.0	**51.1**
Chronic Disease Management	50	40	43.3	60	50	53.3	70	60	63.3	**53.3**
Behavioral Health / Substance Use	60	70	66.7	60	70	66.7	60	70	66.7	**66.7**
Long Term Services and Supports	60	60	60.0	50	60	56.7	60	70	66.7	**61.1**
Integration (PH, BH, LTSS, SS)	40	50	46.7	50	60	56.7	60	70	66.7	**56.7**
Member Care Experience	40	40	40.0	50	60	56.7	60	70	66.7	**54.4**

3. Calculate the aggregate domain scores for BP 4 and run weighted t-test

After calculating the BP 4 aggregate domain scores using the same method utilized to calculate BP 1-3 domain scores (see above), the State will run a stratified Wilcoxon test (i.e. the van Elteren test) to compare each aggregate domain score from BP 4 against its related pooled aggregate domain score from BP 1-3. The p-value from this test will indicate whether each BP 4 quality domain score is statistically better (receives 100% score), statistically worse (receives 0% score) or not statistically different (receives 100% score) from previous years.

EXHIBIT A6 – Stratified Wilcoxon test of BP 4 Aggregate Scores and BP 1-3 Aggregate Pooled Scores

Budget Period	BP 1-3	BP 4			Stratified Wilcoxon test *Testing BP 4 aggregate domain scores against BP 1-3 pooled aggregate domain scores*		
	Total (BP 1-3)	ACO 1	ACO 2	Total (BP 4)			
Number of members	90,000	10,000	20,000	30,000			
DSRIP Quality Domains	Pooled Domain Score (BP 1-3)	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	Result	DSRIP Domain Score	Weight
Prevention & Wellness	**51.1**	60	75	**70.0**	Statistically BETTER	100%	10%
Chronic Disease Management	**53.3**	70	60	**63.3**	Statistically BETTER	100%	15%
Behavioral Health / Substance Use	**66.7**	60	70	**66.7**	NOT statistically significant	100%	15%
Long Term Services and Supports	**61.1**	40	60	**53.3**	Statistically WORSE	0%	5%
Integration (PH, BH, LTSS, SS)	**56.7**	60	70	**66.7**	Statistically BETTER	100%	20%
Member Care Experience	**54.4**	60	70	**66.7**	Statistically BETTER	100%	15%

STEP 3(b): Scoring for Avoidable Utilization

In accordance with STC 67(j), the State's performance on avoidable hospital utilization will be evaluated on two measures:

- Potentially preventable admissions (3M's PPA measure)

- Hospital all-cause readmissions (NQF #1789)

These measures will be calculated using the following methodology:

- If Actual Reduction < (50% * Reduction Target), then Measure Score = 0%
- If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
- If Actual Reduction ≥ (50% * Reduction Target) AND < (Reduction Target), then Measure Score is equal to: (Actual Reduction - (50% * Reduction Target)) / (Reduction Target - (50% * Reduction Target)) OR the simplified version,

$$\frac{Percent\ of\ reduction\ target\ achieved - 50\%}{100\% - 50\%}$$

Reduction Targets vary by budget period, as shown below:

EXHIBIT A7 – Avoidable Utilization Reduction Targets

Avoidable Utilization Reduction Targets						
DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
PPA Reduction Targets	Reporting Only	Reporting Only	3%	7%	12%	15%
Readmissions Reduction Targets	Reporting Only	Reporting Only	3%	9%	15%	20%

For the purpose of this example, assume that the State achieves a 12% PPA Reduction in BP 4, which gives the State a PPA Reduction score of 100%.

Also assume that the State achieves a 13% Readmissions reduction BP 2, which is roughly 87% of the Reduction Target, as show below:

$$Percent\ of\ reduction\ target\ achieved =$$

$$\frac{13\%}{15\%} \approx 87\%$$

Thus, the Readmissions Reduction Score is:

$$\frac{87\% - 50\%}{100\% - 50\%} = 74\%$$

The average of the PPA Reduction Score and the Admissions Reduction Score yields the overall Utilization score:

$$\frac{100\% + 74\%}{100\% + 100\%} = 87\%$$

Therefore, the State receives an accountability domain score of **87%** in this category.

STEP 3(c): Calculating the Overall Statewide Quality and Utilization Performance

To calculate the overall Statewide Quality and Utilization performance, we multiply the domain scores from BP 4 and the weights from BP 4 and obtain the sum:

EXHIBIT A8 – Calculating the Statewide Quality and Utilization Score for BP 4

DSRIP Quality Domains	Domain Score	BP 4 Weight	Weighted Domain Score
Prevention & Wellness	100%	10%	10%
Chronic Disease Management	100%	15%	15%
Behavioral Health / Substance Use	100%	15%	15%
Long Term Services and Supports	0%	5%	0%
Integration (PH, BH, LTSS, SS)	100%	20%	20%
Member Care Experience	100%	15%	15%
Avoidable Utilization	87%	20%	17%
Statewide Quality and Utilization Score for BP 4 =			**92%**

Step 4: Calculate the Overall State DSRIP Accountability Score for BP 4

The State will calculate the State DSRIP Accountability Score by multiplying the Score for each State DSRIP Accountability domain by the associated weight and then summing the totals together.

For this example, the State achieved the following domain scores in BP 4:

- MassHealth ACO/APM Adoption Rate: **100%**
- Reduction in State Spending Growth: **64%**
- ACO Quality and Utilization Performance: **92%**

Thus, the State DSRIP Accountability Score for BP 4 is **86.6%**, as demonstrated in the table below:

EXHIBIT A9 – Calculating the Overall State DSRIP Accountability Score

Example Calculation of State DSRIP Accountability Score for BP 4				
DSRIP Accountability Domain	**Domain Weight**	**State Domain Score**	**State Accountability Calculations**	**DSRIP Score**
MassHealth ACO/APM Adoption Rate	20%	100%	20% x 100% =	20%
Reduction in State Spending Growth	25%	64%	25% x 64% =	16%
ACO Quality and Utilization Performance	55%	92%	55% x 92% =	50.6%
State DSRIP Accountability Score =				**86.6%**

Step 5: Determine At-Risk Funds Lost and Earned for BP 4

As noted above, the amount of at-risk State expenditure authority varies by Budget Period. For Budget Period 4, the amount at-risk is $41.25M.

EXHIBIT A10 – Percent of State DSRIP Expenditure Authority At-Risk, BP 4

Percent of State DSRIP Expenditure Authority At-Risk					
DSRIP Budget Period	**Prep BP and BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
DSRIP Expenditure Authority	$637.5M	$412.5M	$362.5M	$275M	$112.5M
% of Expenditure Authority At-Risk	0%	5%	10%	15%	20%
Actual Expenditure Authority At-Risk*	$0M	$20.625M	$36.25M	**$41.25M**	$22.5M

To calculate how much at-risk funding the State has earned for BP 4:

$$BP\ 4\ amount\ at\text{-}risk\ \times BP\ 4\ State\ DSRIP\ Accountability\ Score$$

$$\$41.25M\ \times 86.6\% = \$35.7M$$

To calculate how much at-risk funding the State has lost for BP 4:

$$BP\ 4\ amount\ at\text{-}risk - BP\ 4\ at\text{-}risk\ funding\ earned$$

$$\$41.25M - \$35.7M = \$5.55M$$

Therefore, the State earned **$35.7M** and lost **$5.55M** of the $41.25M at-risk in Budget Period 4.

Appendix D: Measure Tables

ACO Measure Slate

#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1	PY2	PY3	PY4	PY5
								(CY2018)	(CY2019)	(CY2020)	(CY2021)	(CY2022)
	Prevention & Wellness											
1	Well child visits in first 15 months of life	Percentage of ACO attributed members who turned 15 months old during the measurement period and who had 6 or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life.	H	NCQA – Health Plan	1392	NCQA Quality Compass	Yearly	R	P	P	P	P
2	Well child visits 3-6 yrs	Percentage of ACO attributed members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	H	NCQA – Health Plan	1516	NCQA Quality Compass	Yearly	R	P	P	P	P
3	Adolescent well-care visit	Percentage of ACO attributed members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetricianand gynecology (OB/GYN) practitioner during the measurement period.	H	NCQA – Health Plan	N/A	NCQA Quality Compass	Yearly	R	P	P	P	P
4	Weight Assessment / Nutrition Counseling and Physical Activity for Children/Adolescents	Percentage of ACO attributed members 3 to 17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement period: (1) body mass index (BMI) percentile documentation, (2) counseling for nutrition, and (3) counseling for physical activity.	H	NCQA - ACO	24	NCQA Quality Compass	Yearly	R	P	P	P	P
5	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to ACO attributed members (up to age 65) between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of attribution to the ACO.	H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
6	Postpartum Care	Postpartum Care: The percentage of deliveries of live births to ACO attributed members (up to age 65) between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.	H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
7	Oral Evaluation, Dental Services	Percentage of ACO attributed members under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	American Dental Association on behalf of the Dental Quality Alliance	2517	EOHHS benchmarks derived fromnationally and state/locally available data	Quarterly	R	R	P	P	P
8	Tobacco Use: Screening and Cessation Intervention	Percentage of ACO attributed members ages 18 to 64 who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	H	American Medical Association on behalf of the Physician Consortium for Performance	28	EOHHS benchmarks derived from nationally and state/locally available data	Yearly	R	R	P	P	P
9	Adult BMI Assessment	Percentage of ACO attributed members ages 18 to 64 who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement period	H	NCQA - ACO	N/A	NCQA Quality Compass	Yearly	R	P	P	P	P

10	Immunization for Adolescents	Percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday. The measure will calculate a combination rate using Combo-1. [2017 HEDIS Spec will be updated Oct 2016 to include HPV vaccine.]	H	NCQA - ACO	1407	NCQA Quality Compass	Yearly	R	P	P	P	P
	Chronic Disease Management											
11	Controlling High Blood Pressure	Percentage of ACO attributed members 18 to 64 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement period, based on age/condition-specific criteria	H	NCQA - ACO	18	NCQA Quality Compass	Yearly	R	P	P	P	P
12	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 to 64, for ACO attributed members with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
13	Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA – Health Plan	1800	NCQA Quality Compass	Quarterly	R	P	P	P	P
14	Comprehensive Diabetes Care: A1c Poor Control	The percentage of patients 18 to 64 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	H	NCQA – Health Plan	59	NCQA Quality Compass	Yearly	R	P	P	P	P
15	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 ACO attributed member months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272	NCQA Quality Compass	Quarterly	R	P	P	P	P
	Behavioral Health / Substance Abuse											
16	Developmental Screening for behavioral health needs: Under Age 21	Percentage of ACO attributed members under age 21 screened for behavioral health needs using an age appropriate EOHHS approved developmental screen	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
17	Screening for clinical depression and documentation of follow-up plan: Age 12+	Percentage of ACO attributed members age 12 to 64 screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	H	CMS	418	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
18	Depression Remission at 12 months	Percentage of ACO attributed members age 18-64 with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months (Defined as PHQ-9 score less than 5). Or a response to treatment at 12 months (+/- 30 days) after diagnosis or initiating treatment. (Patient Health Questionnaire-9 (PHQ-9) score decreased by 50% from initial score at 12 months (+/- 30 days).	H	Minnesota Community Measurement (also adapted by CMS and NCQA)	710	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

19	Initiation and Engagement of AOD Treatment (Initiation)	Percentage of ACO attributed members ages 13 to 64 diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	C	NCQA - ACO	4	NCQA Quality Compass	Quarterly	R	P	P	P	P
20	Initiation and Engagement of AOD Treatment (Engagement)	Percentage of ACO attributed members ages 13 to 64 diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	C	NCQA - ACO	4	NCQA Quality Compass	Quarterly	R	P	P	P	P
21	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for ACO attributed members ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA - ACO	576	NCQA Quality Compass	Quarterly	R	P	P	P	P
22	Follow-up care for children prescribed ADHD medication - Initiation Phase	Percentage of ACO attributed members 6 to 12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	C	NCQA - ACO	108	NCQA Quality Compass	Quarterly	R	P	P	P	P
23	Follow-up care for children prescribed ADHD medication - Continuation Phase	Percentage of ACO attributed members 6 to 12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	C	NCQA - ACO	108	NCQA Quality Compass	Quarterly	R	P	P	P	P
24	Opioid Addiction Counseling	Percentage of ACO attributed members ages 18 to 64 with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
	Long Term Services and Supports											
25	Assessment for LTSS	Percentage of ACO attributed members (up to age 65) with an identified LTSS need with documentation of an age appropriate EOHHS-approved assessment.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
	Integration											
26	Utilization of Behavioral Health Community Partner Care Coordination Services	Percentage of ACO attributed, BH CP-eligible members (up to age 65) who had at least one Behavioral Health Community Partner care coordination support during the measurement period.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
27	Utilization of Outpatient BH Services	Percentage of ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R

28	Hospital Admissions for SMI/SUD Population	Risk-adjusted percentage of ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD who were hospitalized for treatment of selected mental illness diagnoses or substance use disorder (regardless of primary or secondary diagnosis)	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
29	Emergency Department Utilization for SMI/SUD Population	Risk-adjusted ratio of observed to expected ED visits during the measurement period, for ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD for a selected mental illness or substance use disorder that is either the primary or secondary diagnosis	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
30	Emergency Department Care Coordination of ED Boarding Population	Percentage of patients boarding in the ED for whom a referral was made by the ED to the PCP or Community Partner (CP) upon discharge. Boarding defined as ≥ 48 hours in the ED.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
31	Utilization of LTSS Community Partners	Percentage of ACO-attributed, LTSS CP-eligible members (up to age 65) who received at least one LTSS CP support during the measurement period	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
32	All Cause Readmission among LTSS CP eligible	Percentage of ACO attributed, LTSS CP eligible members (up to age 65) who were hospitalized and subsequently readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
33	Social Service Screening	Percentage of ACO attributed members (up to age 65) who were screened for social service needs.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
34	Utilization of Flexible Services	Percentage of ACO-attributed members (up to age 65) recommended by their care team to receive flexible services support that received flexible services support.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
35	Care Plan Collaboration Across PC, BH, LTSS, and SS, Providers	Percentage of ACO attributed members (up to age 65) identified for care management/care coordination with documentation of a care plan that: - is developed by/shared with primary care, behavioral health, LTSS, and social service providers, as applicable - addresses needs identified in relevant assessments/screenings - is approved by member (or caregiver, as appropriate).	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

36	Community Tenure	Measure will assess ACO's ability to support and retain member placement in the community. Measure under development: Potential examples include: 1. Percentage of ACO attributed members who transitioned to the community from an LTC facility and did not return to a facility during the subsequent 12 months period. 2. Percentage of Days in Community for members with at least one index discharge from a LTC facility: (Total Eligible Days – Total Institutional Care Days)/Total Eligible Days 3. Average or median days of community tenure for ACO attributed members with an index discharge (during the measurement year) from a long term stay institution to a community setting who were admitted to a long term stay institution within 180 day period following the index discharge. Note: Community setting definition should follow CMS HCBS Final Rule 2249-F and 2296-F.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
	Avoidable Utilization											
37	Potentially Preventable Admissions	Risk-adjusted ratio of observed to expected ACO attributed members who were hospitalized for a condition identified as "ambulatory care sensitive"	C	3M	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	P	P	P	P
38	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO attributed members (up to age 65) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	CMS*	1789*	EOHHS benchmarks derived from baseline data	Quarterly	R	P	P	P	P
39	Potentially Preventable Emergency Department Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO attributed members ages 18 to 64 per 1,000 member months.	C	3M	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
Member Experience			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P

* CMS specifications as documented in NQF #1789 will be utilized with changes to the age range (up to age 64 rather than 65 and above) and the insured population (Medicaid rather than Medicare)

BH CP Quality Measure Slate. ***Measures will be calculated for those CP eligible members engaged with the CP***

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to ACO/MCO/health plan enrollees (any age) between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of assignment to the BH CP.	C	NCQA	1517	NCQA Quality Compass	Quarterly	R	R	P	P	P
2	Annual primary care visit	Percent of CP-engaged members who had an annual primary care visit in the last 15 months	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Chronic Disease Management												
3	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO/MCO/health plan enrollees with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
4	Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA	1800	NCQA Quality Compass	Quarterly	R	R	P	P	P
5	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 ACO/MCO/health plan member months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272	NCQA Quality Compass	Quarterly	R	R	P	P	P
III. Behavioral Health / Substance Use Disorder												
6	Initiation and Engagement of AOD Treatment (Initiation)	The percentage of ACO/MCO/health plan adolescent and adult members with a new episode of AOD who received the following: Initiation of AOD Treatment	C	NCQA	4	NCQA Quality Compass	Quarterly	R	R	P	P	P
7	Initiation and Engagement of AOD Treatment (Engagement)	The percentage of ACO/MCO/health plan attributed adolescent and adult members with a new episode of AOD who received the following: Engagement of AOD Treatment	C	NCQA	4	NCQA Quality Compass	Quarterly	R	R	P	P	P
8	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for ACO/MCO/health plan enrollees ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576	NCQA Quality Compass	Quarterly	R	R	P	P	P
9	Follow-up After Hospitalization for Mental Illness (3-day) by BH CP	Percentage of discharges for BH CP-enrolled members ages 21 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had a face-to-face encounter with a BH CP within 3 days of discharge	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
IV. Member Experience												
A. Access			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Participation in Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Quality and Appropriateness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
E. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
F. Social Connectedness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
G. Self Determination			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
H. Functioning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
Self Reported Outcomes			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
J. General Satisfaction			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
V. Integration												
12	Social Service Screening	Percentage of CP-engaged members who were screened for social service needs	H	EOHHS	N/A		Quarterly	R	R	P	P	P
13	Utilization of Flexible Services	Percentage of ACO-enrolled, CP-engaged members (up to age 64) recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	P	P	P
14	Utilization of Outpatient BH Services	Percentage of ACO/MCO/health plan enrollees that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A		Quarterly	R	R	P	P	P
VI. Avoidable Utilization												
15	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO/MCO/health plan enrollees CP CP-engaged (up to age 64) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
16	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO/MCO/health plan enrollees CP-engaged ages 18 to 64 per 1,000 member months.	C	3M	N/A		Quarterly	R	R	P	P	P
VII. Engagement												
17	BH Comprehensive Assessment /Care Plan in 90 Days	Percentage of ACO/MCO/health plan-enrolled, BH CP assigned members with documentation of a comprehensive assessment and approval of a care plan by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to BH CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
11	Rate of Care Plan Completion	Percentage of ACO/MCO/health plan-enrolled, BH CP assigned member who had a completed care plan during the measurement period	H	EOHHS	N/A		Quarterly	R	R	P	P	P

LTSS CP Quality Measure Slate. ***Measures will be calculated for those CP eligible members engaged with the CP***

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Well child visits 3-6 yrs	Percentage of ACO/MCO enrollees 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	C	NCQA	1516	NCQA Quality Compass	Quarterly	R	R	P	P	P
2	Adolescent well-care visit	Percentage of ACO/MCO enrollees 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A	NCQA Quality Compass	Quarterly	R	R	P	P	P
3	Oral Evaluation, Dental Services	Percentage of ACO/MCO enrollees under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Member Experience												
A. Service Delivery			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Choice and Control/Consumer Voice			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Effectiveness/Quality of Care			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
III. Integration												
6	Utilization of Flexible Services	Percentage of ACO-enrolled, CP-engaged members (up to age 64) recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	P	P	P
7	Social Service Screening	Percentage of CP-engaged members who were screened for social service needs	H	EOHHS	N/A		Yearly	R	R	P	P	P
8	Annual primary care visit	Percent of CP-engaged members who had an annual primary care visit in the last 15 months	C	EOHHS	N/A		Quarterly	R	R	P	P	P
IV. Avoidable Utilization												
9	All Cause Readmission	Risk-adjusted ratio of observed to expected ACO/MCO enrolled, CP-engaged members (up to age 64) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
10	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO/MCO enrolled, CP-engaged members ages 18 to 64 per 1,000 member months.	C	3M	N/A		Quarterly	R	R	P	P	P
V. Engagement												
11	LTSS Care Plan in 90 days	Percentage of ACO/MCO enrolled, LTSS CP assigned members with documentation of a LTSS care plan that is approved by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to LTSS CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
5	Rate of Care Plan Completion	Percentage of ACO/MCO -enrolled, LTSS CP assigned member who had a completed care plan during the measurement period	H	EOHHS	N/A		Yearly	R	R	P	P	P

CSA Quality Measure Slate

#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Well child visits 3-6 yrs	Percentage of CSA members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	C	NCQA	1516	NCQA Quality Compass	Yearly	R	R	P	P	P
2	Adolescent well-care visit	Percentage of CSA members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A	NCQA Quality Compass	Quarterly	R	R	P	P	P
3	Oral Evaluation, Dental Services	Percentage of CSA members under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Behavioral Health												
4	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for CSA members ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576	NCQA Quality Compass	Quarterly	R	R	P	P	P
III. Member Experience: Wraparound Fidelity Index Short Form (WFI-EZ) - Caregiver Form												
A. Your Experiences around Wraparound			Form	TBD	N/A			R	R	P	P	P
B. Satisfaction			Form	TBD	N/A			R	R	P	P	P
C. Outcomes			Form	TBD	N/A			R	R	P	P	P
IV. Avoidable Utilization												
6	Hospital Admissions for SMI/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI and/or SUD who were hospitalized for treatment of selected mental illness diagnoses or substance use disorder (regardless of primary or secondary diagnosis)	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
7	Emergency Department Utilization for SMI/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI and/or SUD who utilized the emergency department for a selected mental illness or substance use disorder that is either the primary or secondary diagnosis	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
V. Engagement												
8	CSA Comprehensive Care Plan in 90 Days	Percentage of CSA members with documentation of a care plan and approval of care plan by primary care clinician or designee and member or legal authorized representative as appropriate . Expected attainment = 70% or above	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P

MassHealth 1115 Demonstration
Attachment N
Safety Net Provider Payment Eligibility and Allocation

Hospitals that meet the eligibility criteria to receive a Safety Net Provider Payment pursuant to STC 53 and their corresponding payments are listed in Table 1 below.

Safety Net Provider Payment allocation methodology:

Hospitals that are eligible to receive Safety Net Provider Payments must demonstrate an uncompensated care shortfall on their 2014 UCCR or 403 cost reports (if UCCR is unavailable) based on their Medicaid and Uninsured payments and costs. Further detail related to hospital eligibility for Safety Net Provider Payments can be found in STC 53.

Eligible hospitals are split into two groups based on these criteria:

Group 1: Group 1 includes any hospital that received Delivery System Transformation Initiative (DSTI) payments in the SFY 2015-2017 demonstration period.

Group 2: Group 2 includes any eligible hospital that did not receive DSTI payments in the SFY 2015-2017 demonstration period.

SFY 2022 payments are determined as follows:

- Group 1 hospitals will receive payments equal to 72% of the payments received in SFY 2017.
- Group 2 hospitals will receive a share of remaining available funding for Safety Net Provider Payments based on each hospital's relative Medicaid Gross Patient Service Revenue (GPSR) reported in the latest available hospital cost report as of August 2016.

Note that the initial allocation of DSTI payments among the eligible hospitals for the SFY 2012-2014 and SFY 2015-2017 demonstration periods was similarly determined based on relative Medicaid and Low Income Public Payer GPSR.

An increasing portion of these payments are at risk for each individual hospital in each year of the demonstration extension period, subject to accountability and performance requirements as specified in STC 53. As such, provider payment amounts are classified as "potential payments" as reflected in Table 1 below

Table 1. Safety Net Provider Potential Payments by Eligible Hospital Provider

Hospital Provider	SFY18 ($M)	SFY19 ($M)	SFY20 ($M)	SFY21 ($M)	SFY22 ($M)
Group 1					
Boston Medical Center*	$107.70	$106.30	$106.30	$106.30	$105.21
Holyoke Medical Center	$6.49	$6.49	$6.49	$6.49	$6.49
Lawrence General Hospital	$13.20	$12.90	$12.50	$12.20	$11.47
Mercy Medical Center	$13.00	$12.60	$12.20	$12.12	$12.04
Signature Healthcare Brockton Hospital	$14.70	$14.00	$13.50	$13.30	$13.27
Steward Carney Hospital	$5.12	$5.12	$5.12	$5.12	$5.12
Group 2					
Baystate Medical Center	$5.61	$5.61	$5.61	$5.61	$5.61
North Shore Medical Center	$3.37	$3.37	$3.37	$3.37	$3.37
Southcoast Hospital Group	$4.07	$4.07	$4.07	$4.07	$4.07
Tufts Medical Center	$3.40	$3.40	$3.40	$3.40	$3.40
Morton Hospital	$0.50	$0.50	$0.50	$0.50	$0.50
Franklin Medical Center	$0.47	$0.47	$0.47	$0.47	$0.47
Berkshire Medical Center	$1.63	$1.63	$1.63	$1.63	$1.63
Good Samaritan Hospital	$0.95	$0.95	$0.95	$0.95	$0.95

In addition, note that for Boston Medical Center, the 72 percent Group 1 target payment amount for SFY 2022 takes into account SFY 2017 DSTI payment authority, plus $32 million in Public Service Hospital Safety Net Care payment authority that does not continue in the new demonstration extension period.

MassHealth 1115 Demonstration
Attachment O
-Pricing methodology for ACOs and MCOs

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

1. Unified approach to setting TCOC Benchmarks for Primary Care ACOs and MCO-Administered ACOs, and setting prospective Capitation Rates for MCOs and Partnership Plans

Massachusetts will set total cost of care (TCOC) Benchmarks using a uniform methodology that aligns with the methodology for setting prospective Capitation Rates for MCOs and Accountable Care Partnership Plans. As described in STC 41, Accountable Care Partnership Plans will be paid prospectively rated capitation payments, which are subject to annual rate certification. Primary Care ACOs will share savings and losses with the Commonwealth based on comparison between their TCOC Performance and TCOC Benchmark (i.e., their performance on managing the costs of their attributed or enrolled population). Primary Care ACOs may also be paid under a prospective pre-payment methodology as described in STC 41. Similarly, MCO-administered ACOs will share savings and losses with their contracting MCOs based on the same comparison. EOHHS intends to establish an aligned methodology for setting TCOC benchmarks for Primary Care ACOs and MCO-Administered ACOs, as further described below; EOHHS will require MCOs to share savings and losses with their contracted MCO-Administered ACOs using this methodology and based on the risk-tracks and schedule set by the state. Such requirement is broadly consistent with 42 CFR 438.6.

The TCOC benchmark (for Primary Care ACOs or MCO-Administered ACOs) or prospective Capitation Rate (for MCOs or Accountable Care Partnership Plans) will be developed as follows:

1. A benchmark or rate will be developed for each individual rate cell, where a rate cell is defined as a specific region and rating category (e.g., Rating Category I – Adults in Greater Boston Region).
2. All such benchmarks and rates will be based on a unified base dataset, which will be constructed as follows:
    a) Claims and encounter experience for all Managed Care-eligible lives, including members enrolled in the MCO, PCC, and ACO programs, will be aggregated for a baseline period established annually by the Commonwealth (e.g., one to three years of the most recent available history).
    b) Only services covered under the list of MCO Covered Services, the list of ACO Covered Services, or the list of TCOC Included Services will be included in the base data. These three lists of services will align, as ACOs will be financially accountable for the same services as MCOs. EOHHS will finalize and publish these lists in advance of finalizing the benchmarks/rates.
    c) Actual prices paid for covered services during the baseline period will be re-priced to reflect average market prices paid for those services. The methodology used to

re-price services delivered during the base period will be developed by the Commonwealth and shared with CMS for approval before the Operational Start Date of the ACO and MCO programs.

3. For each rate cell, actuarial methods will be applied to the base dataset to estimate the average per-member per-month total cost of care ("market-rate TCOC"). Actuarial adjustments could account for factors such as, but not limited to, the following:
   a) Changes in member risk and enrollment
   b) Completion for incurred but not reported encounters in the base data
   c) Anticipated program changes between the base period and the performance period
   d) Cost and utilization trends from the base period to the performance period
   e) Other adjustments as appropriate
4. This market-rate TCOC will be consistent across all ACOs and MCOs within each rate cell, and will be incorporated into the final benchmarks and rates, along with the Network Efficiency factor as described in the following section.

2. Development and incorporation of the Network Efficiency Factor in TCOC Benchmarks and prospective Capitation Rates

The Commonwealth will incorporate an ACO-specific Network Efficiency Factor into the TCOC Benchmarks for Primary Care ACOs and MCO-Administered ACOs, and into the prospective Capitation Rates for Partnership Plans.

The Commonwealth will calculate and apply the Network Efficiency Factor for each ACO, for each Performance Year, as follows:

1. The Network Efficiency Factor will equal the ACO's Historic TCOC divided by the ACO's market-rate TCOC, after applying adjustments for each ACO's member mix across rate cells and member acuity.
   a) For each ACO, using a similar methodology and adjustments to those used to calculate the market-rate TCOC, the Commonwealth will develop for each rate cell an ACO's Historic TCOC based on the cost experience in the base period for the Managed Care eligible members attributed to primary care providers participating in the ACO.
   b) The Network Efficiency Factor represents the variance between an ACO's Historic TCOC and the ACO's market-rate TCOC that cannot be explained by variation in price or member risk
2. The Commonwealth will multiply each ACO's market-rate TCOC (after applying adjustments for each ACO's member mix across rate cells and member acuity) by the ACO's Network Efficiency Factor. The Commonwealth will calculate and apply the Network Efficiency Factor each year, but intends to place a decreasing weight on the Network Efficiency Factor over time. For example, in the first rating period under the demonstration, a 90 percent weight may be placed on the Network Efficiency Factor; that is, an ACO with a Network Efficiency Factor of 1.10 would have a TCOC benchmark that is 9.0% higher than its market-rate TCOC, while an ACO with a Network Efficiency Factor of 0.95 would have a TCOC benchmark that is 4.5% below its market-rate TCOC.

3. Additional detail on TCOC reconciliation

The Commonwealth may incorporate a number of further policies into the TCOC benchmark-setting methodology described above, subject to CMS approval. Such decisions may include, but are not limited to:

1. Excluding certain high-cost services (e.g., therapies for treating Hepatitis C) from the list of covered services, and therefore the base dataset
2. Applying stop-loss thresholds in the base period and performance period TCOC benchmark
3. Setting TCOC Benchmarks on a preliminary basis, and refining them during reconciliation to produce final TCOC Benchmarks that incorporate certain retrospective adjustments for unforeseen effects, to ensure ACOs are appropriately held accountable for their performance rather than exogenous factors

The Commonwealth may decide to apply such policies for some types of ACOs but not others, subject to CMS approval. For instance, the Commonwealth may decide to exclude certain high- cost drugs from the benchmark for Primary Care ACOs and MCO-administered ACOs, but not Accountable Care Partnership Plans. Should such a policy be applied differently between ACO model types, the benchmark-setting methodology for each model type would fully reflect the difference.

For each Primary Care ACO and MCO-Administered ACO, total savings or losses will be calculated as the difference between actual TCOC performance during the performance period and the ACO's TCOC benchmark, in aggregate across all rate cells in which the ACO participates. The portion of savings and losses shared, as well as the mechanism by which savings and losses are shared, will differ by ACO model type. The share of savings and losses may be symmetric or asymmetric, and may include shares of savings and losses up to 100%. ACO risk sharing arrangements will include requirements for financial stability (e.g., including reinsurance requirements) and in some cases will include maximum caps on gains and losses. The Commonwealth intends to generally increase the share of savings and losses over time in ACO risk tracks, and to move towards symmetric rather than asymmetric arrangements; however, the Commonwealth will continue to evaluate ACOs' performance and ability to bear risk in setting risk track policy. The Commonwealth will submit details of these risk arrangements to CMS for approval prior to the Operational Start Date of the ACO and MCO programs.

For each ACO model type, the final calculation of shared savings and losses is subject to the ACO's quality performance. In the event that an ACO is determined to have earned savings, poor quality performance can reduce the share of savings retained by Accountable Care Partnership Plans or paid to Primary Care ACOs and MCO-administered ACOs. In the event that an ACO is determined to have incurred losses, strong quality performance can reduce the share of losses retained by Accountable Care Partnership Plans or the share of losses owed by Primary Care ACOs and MCO-administered ACOs.

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

The MassHealth demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types and benefit levels. The demonstration was initially implemented in July 1997, and expanded Medicaid income eligibility categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility was also expanded to certain non-categorically eligible populations, including unemployed adults and non-disabled persons living with Human Immunodeficiency Virus (HIV). Finally, the demonstration also authorized the Insurance Partnership program, which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings. However, the Commonwealth's preferred mechanism for achieving coverage has consistently been employer-sponsored insurance, whenever available and cost-effective.

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

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

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

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

At this time, there was also an eligibility expansion in the Commonwealth's separate title XXI

program for optional targeted low-income children between 200 percent and 300 percent of the FPL, which enabled parallel coverage for children in households where adults are covered by Commonwealth Care. This expansion ensured that coverage is equally available to all members of low-income families.

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

Three amendments were approved in 2010 and 2011 to allow for additional flexibility in the Demonstration. On September 30, 2010, CMS approved an amendment to allow Massachusetts to (1) increase the MassHealth pharmacy co-payment from $2 to $3 for generic prescription drugs; (2) provide relief payments to Cambridge Health Alliance totaling approximately $216 million; and (3) provide relief payments to private acute hospitals in the Commonwealth totaling approximately $270 million.

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

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

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

e) Support a Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children with high-risk asthma;
f) Offer early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community- based services waiver because the child has not been determined to meet institutional level of care requirements;
g) Utilize Express Lane eligibility methodologies to conduct renewals for parents and caretakers to coincide with the Commonwealth's intent to utilize Express Lane

eligibility for children; and

h) Further, expand the SNCP to provide incentive payments to participating hospitals for Delivery System Transformation Initiatives focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

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

i) Maintain near-universal health care coverage for all eligible residents of the Commonwealth and reduce barriers to coverage;

j) Continue the redirection of spending from uncompensated care to insurance coverage;

k) Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and

l) Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

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

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

i. Extend the demonstration for a five-year period based upon the authority under Section 1915(h)(2) of the Social Security Act which authorizes five-year renewal terms for states that provide medical services for dual eligible individuals through their demonstration. The five-year renewal period supported the Commonwealth's dual eligibles demonstration as some of the authorities for the duals demonstration are contained in the in the section 1115(a) demonstration.

ii. Continue authority for the Pediatric Asthma Pilot Program focused on

improving health outcomes and reducing associated Medicaid costs for children ages 2-18 with high-risk asthma;

iii. Continue authority to offer intensive early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;

iv. Continue Health Connector Subsidies to provide premium assistance to individuals receiving Qualified Health Plan (QHP) coverage through the Marketplace withincomes at or below 300 percent of the FPL;

v. Continue and expand the authority for the Commonwealth to conduct streamlined eligibility redeterminations using Supplemental Nutrition Assistance Program (SNAP) verified income data;

vi. Provide for payment of the cost of the monthly Medicare Part A and Part B premiums and the cost of deductibles and coinsurance under Part A and Part B for Medicare-eligible individuals who have incomes up to 133 percent of the FPL, and pay the costs of the Medicare Part B premium only for CommonHealth members with incomes between 133 and 135 percent FPL; and

vii. Through June 30, 2017, provide incentive payments to participating hospitals for Delivery System Transformation Initiatives and the Public Hospital Transformation and Incentive Initiatives, and provide support for Infrastructure and Capacity Building investments focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

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

viii. Maintain near universal coverage for all residents of the Commonwealth and reduce barriers tocoverage;

ix. Continue the redirection of spending from uncompensated care to insurance coverage;

x. Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successfulcare transitions, integration of services, and measurable health outcome improvements; and

xi. Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

In the 2016 amendment to the demonstration, the Commonwealth and CMS agreed to implement new demonstration components to support a value-based restructuring of MassHealth's health care delivery and payment system, including a new Pilot Accountable Care Organization program, building toward a transition to fuller accountable care models in the future. In addition, behavioral health services authorized under the demonstration have been expanded to strengthen

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

Massachusetts' system of recovery-oriented Substance Use Disorder treatments and supports, in large part with the goal of addressing the opioid addiction epidemic.

The amendment also made other changes, including expanding CommonHealth eligibility for working adults over age 65; authorizing MassHealth to require enrollment in Student Health Insurance Plans (SHIP) when deemed cost effective and to provide for continuous eligibility for the duration of the SHIP year; and expanding the availability of Health Connector subsidies to include cost sharing subsidies for Health Connector enrollees with incomes at or below 300 percent of the FPL, in addition to premium subsidies for this population that were previously authorized.

MassHealth 1115 Demonstration
Attachment Q:
Medicaid Managed Care Entity/ACO Performance-Based Incentive Payment Mechanisms

1. Overview

As delivery system reforms are implemented, the Commonwealth and CMS seek to shift payments to risk-based alternative payment models focused on accountability for quality, integration and total cost of care. Consistent with this goal, within the five-year demonstration term, the Commonwealth will direct Medicaid Managed Care Entities/Accountable Care organizations (MMCE/ACO), to administer performance-based quality incentive programs for hospitals as described below ("MMCE/ACO payment mechanism"). In addition to being critical to the delivery system reform goals shared by the Commonwealth and CMS, these performance-based quality incentive programs are integral to the Commonwealth's overall financing of activities authorized under the demonstration, and are considered payments that are broadly compliant with requirements for payments made under 42 CFR 438.6(c)(1)(ii).

2. General Requirements

The four MMCE/ACO payment mechanisms described below, which the Commonwealth agrees to establish, shall be implemented through MMCE/ACO contracts consistent with this Attachment in order to meet the requirements of 42 CFR 438.6.

3. Description of the Payment Mechanisms

The Commonwealth intends to direct MMCE/ACOs to administer the following four MMCE/ACO performance-based quality incentive programs:

a. **Disability Access Incentive (DY21/SFY2018 – DY25/SFY2022):** The Commonwealth will direct MMCE/ACOs to make payments to all contracted acute hospitals based on reporting and performance related to disabled members' access to medical and diagnostic equipment.

b. **Hospital Quality Incentive (DY21/SFY2018 – DY25/SFY2022):** The Commonwealth will direct MMCE/ACOs to make payments to Essential MassHealth hospitals (Cambridge Health Alliance and UMass Memorial Health Care, Inc. Hospitals) based on hospital quality performance.

c. **Integrated Care Incentive (DY22/SFY 2019 – DY25/SFY 2022):** In the event that primary care providers employed by or affiliated with Cambridge Health Alliance participate in the Commonwealth's Accountable Care Partnership Plan model, the Commonwealth will direct that MMCE/ACO to make payments to non-federal, non-state, public hospitals based on the accountable care performance of such hospitals' owned or affiliated primary care providers.

d. **Behavioral Health Quality Incentive (DY23/SFY 2020 – DY25/SFY 2022):** The Commonwealth will direct the Commonwealth's single Prepaid Inpatient Health Plan (PIHP) to make payments to non-federal, non-state, public hospitals in its network based on behavioral health quality performance.

4. General Methodology Linking Payment Mechanisms to Utilization/Delivery of Services

The Commonwealth shall include in its MMCE/ACO contracts payment mechanisms consistent with the following approach:

a. The Commonwealth will specify the maximum allowable payment amount that it will direct each MMCE/ACO to pay to one or more designated classes of hospitals during the MMCE/ACO contract year.
b. The maximum payment amount earned by a specific hospital (i.e., the amount earned if a hospital attains a quality score of 100 percent) will be equal to the total amount directed to the designated class multiplied by the proportion of the class's total managed and non-managed Medicaid Gross Patient Service Revenue ("Medicaid GPSR") or other measure of utilization and delivered of services, for which the specific hospital's Medicaid GPSR, or other measure of delivered services, accounts during the MMCE/ACO contract year.
c. The Commonwealth will calculate periodic lump sum payments that MMCE/ACOs will be directed to pay to specific hospitals. The periodic lump sum payments will be calculated based on:
    i. The Commonwealth's projection of each hospital's Medicaid GPSR, or other measure of utilization and delivered services, during the MMCE/ACO contract year;
    ii. Each hospital's expected performance (based on prior year or other data);
    iii. A target for the MMCE/ACO to pay 90% of each hospital's expected earned payments in advance of a final reconciliation after the MMCE/ACO contract year.
d. Within seven days prior to each scheduled lump sum payment described above, the Commonwealth shall make a payment to each MMCE/ACO that is directed to make an incentive payment to hospitals. The Commonwealth's payment to each MMCE/ACO shall be equal to the sum of all payments that the MMCE/ACO is directed to make. The Commonwealth may use any permissible source, including intergovernmental transfers, as the source of the non-federal share for MMCE/ACO payments.
e. Following the MMCE/ACO contract year, actual Medicaid GPSR, or other measure of utilization and delivered services, for each hospital and performance under each contract will be determined and the actual payment amount earned by hospitals will be calculated.
f. Final reconciliation: Based on the difference between the periodic lump sum amounts paid to hospitals during the MMCE/ACO contract year and the actual amount earned, MMCE/ACOs will be directed to make a final reconciliation payment to hospitals. In the event that the lump sum payments made by the MMCE/ACO to a hospital during the MMCE/ACO contract year exceeded the total actual amount earned, the hospital will remit the excess payment to the MMCE/ACO as part of the final reconciliation. Any amount remitted by a hospital to a MMCE/ACO as part of the reconciliation shall in turn be remitted by the MMCE/ACO to the Commonwealth.

5. Performance Measures and Evaluation Plan

As required under 42 CFR 438.6(c)(2)(i)(D), the Commonwealth shall have a plan to evaluate the extent to which the payment mechanisms and performance measure incentives achieve the goals and objectives identified in the managed care quality strategy. The Commonwealth may use performance measures based upon the following domains, or other domains not listed below, for the incentive programs. The Commonwealth may include process, improvement, outcomes, system transformation, and innovative measures and indicators that are consistent with the Commonwealth's delivery system reforms and quality strategy. For the Hospital Quality, Integrated Care, and Behavioral Health Quality Incentives, the Commonwealth will designate two types of performance measure domains. Type I domains will have 80% or more of the measures drawn from nationally vetted and endorsed measure sets (e.g. National Quality Forum, National Committee for Quality Assurance, the Joint Commission, etc.) or measures in wide use across Medicare and Medicaid quality initiatives (e.g. the Medicaid Child and Adult Core Set Measures, CMS Core Quality Measures Collaborative measure sets, Health Home measure sets, Behavioral Health Clinic measure sets, and Merit-based Incentive Payment System and Alternative Payment Model measures, etc.). Type II domains will not have a lower limit on the percentage of measures drawn from nationally validated measure sets. As a matter of general principle, where practicable, specific performance measures for each incentive payment mechanism will be drawn from the nationally recognized measure sets.

The Commonwealth will submit the evaluation plan and performance measures to CMS for approval, consistent with the process set forth at 438.6.

Any changes made to the specific domains listed below would not require an amendment to the Demonstration:

a. **Disability Access Incentive Payment** - Hospital performance expectations shall increase every year from the beginning of the incentive program, beginning with two years of reporting and three years of performance as measured by disability access to MDE:
   i. Year 1 of incentive program (October 1, 2016 to September 30, 2017): Hospitals required to report:
      A. The Provider's capacity to provide accessible MDE to individuals with disabilities
      B. A detailed list of the Provider's accessible MDE
      C. The Provider's plan to improve its provision of accessible medical and diagnostic equipment
      D. The name and contact information for the Provider's single point of contact for those seeking or having questions about access for individuals with disabilities (i.e. a Disability Access Key Contact)
   ii. Year 2: Hospitals shall be required to report:
      A. Year 1 metrics
      B. Measures related to patient experience. The measures may include, and are not limited to:
         - Average wait times for disabled patients for specified MDE
         - Ratio of accessible MDE to the number of local disabled individuals
         - Results of disabled patient experience surveys regarding access to MDE
   iii. Years 3-5

A. Continued reporting requirements as in Years 1 and 2
B. Hospital performance will be measured on the basis of how a disabled member's experience of accessing MDE compares to the experience of a non-disabled member. The metrics upon which the two populations' experience would be compared may include, and are not limited to:
    - Average wait times for disabled patients for specified MDE
    - Ratio of accessible MDE to the number of local disabled individuals
    - Results of disabled patient experience surveys regarding access to MDE

b. Hospital Quality Incentive Payment - Performance for this payment mechanism will be based on the following:

i. Type I domains include measures related to:
    A. Inpatient care and other hospital system quality (e.g., appropriate care for key conditions)
    B. Transitions of care (e.g., follow-up after discharge, reconciled medication list at discharge)
    C. Avoidable utilization and patient safety (e.g., rates of hospital-acquired infections)
ii. Type II domains include measures related to:
    A. System transformation
iii. EOHHS may include other domains beyond those listed here

c. Integrated Care Incentive Payment - Performance for this payment mechanism will be based on the following:

i. Type I domains include measures related to:
    A. Care coordination – transitions of care
    B. Avoidable / appropriate utilization (e.g., admission from emergency department to inpatient setting and readmissions rates)
    C. Patient quality scores
ii. Type II domains include measures related to:
    D. Care coordination measures aside from transitions of care
    E. Member engagement
    F. Care integration, system transformation, multi-disciplinary team-based care
iii. EOHHS may include other domains beyond those listed here

d. Behavioral Health Quality Incentive Payment - Performance for this payment will be based on the following:

i. Type I domains include measures related to:
    A. Behavioral health-specific quality of care
ii. Type II domains include measures related to:
    A. Behavioral health-specific care coordination
    B. System transformation
iii. EOHHS may include other domains beyond those listed here

iv. Many of the proposed measures will be the same measures for which non-federal, non-state, public hospitals are accountable in the PHTII program under this demonstration.

Each participating hospital's performance, under each performance-based incentive payment mechanism, shall be measured against approved benchmarks and a score for each measure or group of measures will be calculated according to a methodology to be defined by EOHHS and approved by CMS. Benchmarks for any individual performance measure may be set either on the basis of absolute performance standards or improvement targets for individual hospitals. Scores will be summed, with or without weighting, across all measures or groups of measures in order to calculate an overall performance score between 0 and 100 percent. Under the MMCE/ACO payment mechanism, each hospital's performance score shall be multiplied by that hospital's maximum incentive payment amount in order to calculate the actual payment earned by the hospital.

To the extent practicable and feasible, the specific performance measures for each incentive payment mechanisms should be aligned with comparable national standards and other process, improvement, outcomes, system transformation, and innovative metrics that are consistent with the Commonwealth's delivery system reforms and quality strategy.

6. Funding Sources and Anticipated Incentive Program Amounts

The scheduled maximum dollar amounts directed to designated classes of providers under each of the four MMCE/ACO incentive payments mechanisms are:

#	Incentive Title	MMCE/ACO vehicle	Hospital class	Maximum MCO incentive payment to designated hospital class, by SFY ($ millions)				
				SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
1	Disability access incentive	MMCOs	All in-network acute hospitals	265	265	265	265	265
2	Hospital Quality incentive	MMCOs	Essential MassHealth hospitals in network	157	315	316	315	315
3	Integrated care incentive	Accountable care partnership plans affiliated with Cambridge Health Alliance	Non-federal, non-state, public hospitals in network	0	28	39	39	39
4	Behavioral health quality incentive	Commonwealth's single Prepaid Inpatient Health Plan (PIHP)	Non-federal, non-state, public hospitals in network	0	0	141	138	135

The Commonwealth may propose an increase or decrease of 20 percent of the maximum payment amounts listed in the Table. The incentive payments will be incorporated as a component of the MMCE/ACO capitation amounts, and are therefore subject to CMS approval under the review and approval process described in the next section.

Because of the expectation that these payments will transition out of the demonstration, these amounts are not reflected in Attachment E for the respective years noted above.

7. CMS Review and Approval

No later than November 15, 2016, as part of the template described below, the Commonwealth shall submit to CMS a detailed framework for measuring and scoring performance under the Hospital Quality, Integrated Care, and Behavioral Health Quality incentive payments described in this attachment. The Commonwealth and CMS shall work toward applicable approvals by January 15, 2017.

The Commonwealth shall submit to CMS for approval any payment mechanisms that direct payments as described in 42 CFR 438.6(c) at least 120 days prior to implementation, in a format and template to be specified by CMS. Such submission shall include the incentive payment amounts and the performance measures and scoring benchmarks. In addition, the Commonwealth shall clearly identify the specific goals and objectives described in the Commonwealth's managed care quality strategy that the incentive payment mechanism is designed to achieve. Materials submitted for approval shall be consistent with this Attachment in order to meet the requirements of 42 CFR 438.6 and may be submitted for approval prior to the contract and rate certification submission under 42 CFR 438.3 and 42 CFR 438.7. CMS will provide initial written feedback within 45 calendar days of the Commonwealth's submission, and shall render a final decision on the proposal no more than 90 days after the Commonwealth's initial submission. Pursuant to 42 CFR 438.6(c)(2)(1), the Commonwealth must obtain annual prior written approval from CMS for each performance-based quality incentive program.

This Attachment is intended to describe a common understanding between the Commonwealth and CMS on a framework for implementing incentive payments. The attachment does not prohibit the Commonwealth from modifying the payment amounts or the performance measures to best meet its needs and submitting such revisions through the CMS review and approval process; such changes shall not require an amendment to the demonstration.

CMS and the State recognize that this performance framework is a new, significant shift toward a performance-based structure for hospital supplemental payments. Therefore, at the end of the second year of this demonstration, CMS and the State shall jointly evaluate and review the performance measures described in Section 5 of this Attachment.