

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

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

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

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning on the date of the approval letter, through June 30, 2022, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

All previously approved waivers for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

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

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

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

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

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

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

3. **Eligibility Procedures and Standards** **Section 1902(a)(10)(A),**

**Section 1902(a)(10)(C)(i)-(iii),
and Section 1902(a)(17)**

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

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

To exempt Massachusetts from making DSH payments to hospitals which qualify as a Disproportionate Share Hospital in any fiscal year or part of a fiscal year in which Massachusetts is authorized to make provider payments from the Safety Net Care Pool (the amount of any DSH payments made during a partial fiscal year must be prorated if necessary so that DSH payments will not exceed the percentage of the DSH allotment corresponding to the percentage of the federal fiscal year for which payment of DSH payments is required).

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

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

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

To enable Massachusetts to restrict freedom of choice of provider for individuals in the demonstration, including to require managed care enrollment for certain populations exempt from mandatory managed care under section 1932(a)(2) Freedom of choice of family planning provider will not be restricted.

To limit primary care clinician plan (PCC) plan and Primary Care ACO enrollees to a single Prepaid Insurance Health Plan (PIHP) for behavioral health services, to limit enrollees who are clients of the Departments of Children and Families or Youth Services and who do not choose a managed care option to the single PIHP for behavioral health services, and to permit the state to limit the number of providers who provide Anti Hemophilia Factor drugs.

To permit the state to mandate that Medicaid eligibles with access to student health

plans enroll into the plan, to the extent that it is determined to be cost effective, as a condition of eligibility as outlined in section IV and Table E. No waiver of freedom of choice is authorized for family planning providers. This state's ability to apply this authority is subject to the approval of the state's modification to the state plan to implement a premium assistance program to purchase health insurance through the individual market. This demonstration authority will end should the state not obtain a freedom of choice waiver as described within the SHIP SPA by December 31, 2017.

7. Payment for Care and Services **Section 1902(a)(30)(A)**

To permit the state to pay providers using rates that vary from those set forth under the approved state plan to the extent that the payment varies based on shared savings or shared losses in an incentive arrangement.

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

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

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

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

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

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

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

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

AWARDEE: Massachusetts Executive Office of Health and Human

Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Massachusetts for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension (date of the approval letter through June 30, 2022), unless otherwise specified, be regarded as expenditures under the State's title XIX plan. All previously approved expenditure authorities for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

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

This demonstration will test whether the expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Expenditure authorities 11, 13, 14, 15, and 18 increase efficiency and quality of care for eligible individual through initiatives to transform service delivery networks.
- Expenditure authorities 1, 2, 3, 4, 5, 6, 7, 8, 9, 16, 18, 19, 21, 22, and 23 increase overall coverage of low-income individuals in the state.
- Expenditure authorities 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23 improve health outcomes for Medicaid and other low-income populations in the state.
- Expenditure authorities 18, 19, 20, and 21 increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state

I. Demonstration Population Expenditures

CommonHealth Adults. Expenditures for health care-related costs for:

- a. Adults aged 19 through 64 who are totally and permanently disabled, not eligible for comprehensive coverage under the Massachusetts state plan.
- b. Adults aged 65 and over who are not eligible for comprehensive coverage under the Massachusetts state plan, with disabilities that would meet the

federal definition of “permanent and total disability” if these adults were under the age of 65.

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

during the period.

8. **Provisional Coverage Beneficiaries.** Expenditures for MassHealth Coverage for individuals who self-attest to any eligibility factor, except disability, immigration and citizenship.
9. **Presumptively Eligible Beneficiaries.** Expenditures for individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration by qualified hospitals that elect to do so.

II. Service-Related Expenditures

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

Expenditures to cover the costs of monthly Medicare Part B premiums for CommonHealth members who are also eligible for Medicare with gross income between 133 and 135 percent FPL (without applying an asset test).

16. **Continuous Eligibility Period for Individuals enrolled in Student Health Insurance Plans.** Expenditures for health care costs, including insurance premiums and cost sharing for individuals who are enrolled while Medicaid eligible in cost-effective student health insurance as determined by the state for

periods in which such individuals are no longer Medicaid eligible during a continuous eligibility period. This state's ability to draw down these expenditures is subject to the approval of the state's modification to the state plan to implement a premium assistance program to purchase health insurance through the individual market. This authority will end should the state not obtain a freedom of choice waiver as described the SHIP SPA by December 31, 2017.

III. Delivery System-Related Expenditures

17. **PCCM Entities and Pilot ACOs:** Expenditures for shared savings payments to participating ACOs and Pilot ACOs that include risk-based (upside and downside) payments to these ACOs, and that may allow or require ACOs to distribute some portion of shared savings to or collect shared losses from select direct service providers, that are outside of the ranges for Integrated Care Models (ICMs) provisions and/or are not otherwise authorized under 42 CFR §438.
 - a. **Safety Net Care Pool (SNCP).** Expenditures for the following categories of expenditures, subject to overall SNCP limits and category-specific limits set forth in the STCs.
18. **Incentive-Based Pools.** As described in Attachment E and effective July 1, 2017, expenditures for Delivery System Reform Payments (DSRIP) and continued expenditures for Public Hospital Transformation and Incentive Initiatives.
 1. **DSRIP and Related Initiatives.** Expenditures for incentive payments and state infrastructure payments for the DSRIP program specified in Section VIII of the STCs, and for flexible services provided to ACO enrolled beneficiaries, to the extent not otherwise available under the Medicaid state plan, under other state or federal programs, or under this demonstration.
 2. **Public Hospital Transformation and Incentive Initiatives (PHTII).** Expenditures for incentive payments that support Cambridge Health Alliance's transformation work through its Public Hospital Transformation and Incentive Initiatives program.
19. **Disproportionate Share Hospital-like (DSH-like) Pool.** As described in Attachment E, limited to the extent set forth under the SNCP limits, expenditures for payments to providers, including: acute hospitals and health systems, non- acute hospitals, and other providers of medical services to support uncompensated care for Medicaid eligible individuals , and low-income uninsured individuals, in accordance with the Massachusetts' Uncompensated Cost Limit Protocol approved December 17, 2013, and expenditures for payments for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).
20. **Uncompensated Care Pool.** As described in Attachment E, expenditures for supplemental payments to hospitals to reflect uncompensated charity care costs beyond

the expenditure limits of the DSH Pool. Specifically, expenditures for additional Health Safety Net payments to hospitals that reflect care provided to certain low-income, uninsured patients; and Department of Public Health (DPH) and Department of Mental Health (DMH) hospital expenditures for care provided to uninsured patients.

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

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

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

- b. **Health Connector Gap Coverage.** Expenditures for individuals who are determined eligible QHP coverage, for up to 100 days while they select, pay and enroll into a health plan.

b. Streamlined Redeterminations

21. **Streamlined Redeterminations for Adult Populations.** Expenditures for parents, caretaker relatives, and childless adults who would not be eligible under either the state plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.
22. **Streamlined Redeterminations for Children’s Population.** Expenditures for children who would not be eligible under the Title XIX state plan, Title XXI state child health plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.

All requirements of the Medicaid program expressed in law, regulation, and policy statements that are explicitly waived under the Waiver List herein shall similarly not apply to any other

expenditures made by the state pursuant to its Expenditure Authority hereunder. In addition, none of the Medicaid program requirements as listed and described below shall apply to such other expenditures. All other requirements of the Medicaid program expressed in law, regulation, and policy statements shall apply to such other expenditures.

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

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

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

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

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

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

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

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

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

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

28. **Mandatory Services** **Section 1902(a)(10)(A) insofar as it incorporates Section 1905(a)**

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

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

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

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

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

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

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts MassHealth section 1115(a) Medicaid demonstration (hereinafter “Demonstration”). The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (which is the single state agency that oversees the MassHealth program), (State/Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the Commonwealth’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the State’s expenditures relating to dates of service during this demonstration extension, unless otherwise specified. The demonstration is set to expire on June 30, 2022.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Demonstration Programs and Benefits
- VI. Delivery System
- VII. Cost Sharing
- VIII. The Safety Net Care Pool
- IX. General Reporting Requirements
- X. Monitoring
- XI. Close Out Reporting
- XII. General Financial Requirements under Title XIX
- XIII. Monitoring Budget Neutrality for the Demonstration
- XIV. Schedule of Deliverables for the Demonstration Extension Period

Attachment A.	Overview of Children’s Eligibility in MassHealth
Attachment B.	Cost Sharing
Attachment C.	Quarterly Operational Report Content and Format
Attachment D.	MassHealth Historical Per Member/Per Month Limits
Attachment E.	Safety Net Care Pool Payments
Attachment F.	Pediatric Asthma Pilot Program Protocols
Attachment H.	Safety Net Care Pool Uncompensated Care Cost Limit Protocol
Attachment K.	Cambridge Health Alliance Public Hospital Transformation and Incentive Initiatives (PHTII) Protocol
Attachment L.	Pilot Accountable Care Organization (ACO) Payment Methodology
Attachment M	Reserved for Delivery System Reform Incentive Payment (DSRIP) Program Protocol
Attachment N.	Safety Net Provider Payment Eligibility and Allocation
Attachment O.	Pricing methodology for ACOs and MCOs
Attachment P.	Historical Background regarding Demonstration
Attachment Q.	Managed Care Organization Incentives
Attachment R.	Reserved for Flexible Services

II. PROGRAM DESCRIPTION AND OBJECTIVES

In this extension of the demonstration, the Commonwealth and CMS have agreed to implement major new demonstration components to support a value-based restructuring of MassHealth’s health care delivery and payment system, including a new Accountable Care Organization (ACO) initiative and Delivery System Reform Incentive Program (DSRIP) to transition the Massachusetts delivery system into accountable care models. The Safety Net Care Pool (SNCP) has been redesigned to align SNCP funding with MassHealth’s broader accountable care strategies and expectations and to establish a more sustainable structure for necessary and ongoing funding support to safety net providers.

During the new extension period approved for state fiscal year (SFY) 2018-2022, the goals of the demonstration are:

- (1) Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care;
- (2) Improve integration of physical, behavioral and long term services;
- (3) Maintain near-universal coverage;
- (4) Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals; and
- (5) Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children’s Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - A. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such a change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - B. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day, such state legislation becomes effective, or on the last day, such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the

demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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

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

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

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

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

- C. **Phase-out Procedures:** The state must comply with all notice requirements found in 42

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

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

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

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. The CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
14. **Adequacy of Infrastructure.** The Commonwealth will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section

5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements at outlined in the state's approved state plan, when any program changes to the demonstration including (but not limited to) those referenced in STC 5, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state must to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 C.F.R. section 447.205 for changes in statewide methods and standards for setting payment rates.

16. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.
17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The State shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter. CMS expects the state to implement both an interim and long-term plan to collect, validate and report managed care encounter data, per required T-MSIS reporting and 1115 evaluation. The interim plan must be submitted to CMS by January 31, 2017. The long-term plan must be submitted to CMS no later than June 30, 2017. The system costs associated with this work are eligible for enhanced match. Failure to achieve this condition may result in a reduction in systems FFP for the costs associated with operations of the State's current data warehouse solution.

IV. ELIGIBILITY AND ENROLLMENT

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

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

MassHealth defines the age of a dependent child for purposes of the parent/caretaker relative coverage type as a child who is younger than age 19. A caretaker relative is eligible under this provision only if the parent is not living in the household.

19. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance to STC 48 Table E.
20. **Calculation of Financial Eligibility.** Financial eligibility for demonstration programs is determined by comparing the family's Modified Adjusted Gross Income (MAGI) with the applicable income standard for the specific coverage type, with the exception of adults aged 19 and above who are determined eligible on the basis of disability and whose financial eligibility is determined as described below. MAGI income counting methodologies will also be applied to disabled adults in determining eligibility for MassHealth Standard and CommonHealth; however, household composition for

disabled adults will always be determined using non-tax filer rules, regardless of whether the individual files income taxes or is claimed as a dependent on another person's income taxes. In determining eligibility for MassHealth Standard and CommonHealth for disabled adults, the Commonwealth will apply the five percent income disregard that is also applied to non-disabled adults.

21. **Streamlined Redeterminations.** Under the streamlined renewal process, enrollees are not required to return an annual eligibility review form if they are asked to attest whether they have any changes in circumstances (including household size and income) and do not have any changes in circumstances reported to MassHealth. The process applies to the following populations:

- A. Families with children under the age of 19 who have gross income as verified by MassHealth at or below 150 percent FPL and who are receiving SNAP benefits with SNAP verified income at or below 180 percent FPL.
- B. Families with children up to age 21 whose SNAP verified income is at or below 180 percent FPL, effective to the extent that the state uses an Express Lane eligibility process under its state plan for children up to the age of 21.
- C. Childless adults whose SNAP verified income is at or below 163 percent FPL.

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

22. **TANF and EAEDC Recipients.** The Medicaid agency shall extend MassHealth eligibility to individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. MassHealth eligibility for individuals in this demonstration population does not involve an income determination, but is based on receipt of TANF/EAEDC benefits. Individuals in this demonstration population would not be described in the new adult group, because that is a group defined by an income determination. Therefore, the enhanced match for individuals in the new adult group is not available for this population. If an individual loses his/her TANF/EAEDC eligibility then he/she must apply for MassHealth benefits and receive an income eligibility determination in order to receive MassHealth benefits.

23. **Hospital-Determined Presumptive Eligibility for Additional Eligibility Groups.** Qualified hospitals that elect to do so may make presumptive eligibility determinations for individuals who appear eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan.

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

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

for a 90-day “provisional eligibility period,” during which MassHealth will require further verifications from the applicant.

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

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

Benefits for all other individuals who have been determined provisionally eligible begin on the date that MassHealth sends the notice of the provisional eligibility determination. If all required verifications are received before the end of the provisional eligibility period, retroactive coverage is provided for the verified coverage type in accordance with Table E. The Commonwealth must not provide retroactive coverage for individuals age 21 and over or for non-pregnant adults until eligibility has been verified through federal and state data hubs or, if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, until MassHealth has obtained further verifications from the applicant verifying eligibility during the retroactive period. For individuals eligible for the New Adult Group, the Commonwealth may not claim the expansion state Federal Medical Assistance Percentage (FMAP) for individuals whose eligibility has not been verified within the provisional eligibility period, but may claim the regular FMAP for those individuals for no longer than a 90 day plus a five-day notice period of benefits (unless the individual can demonstrate that he or she did not receive the notice within five days, in which case benefits would be extended).

The reasonable opportunity period for immigration, citizenship and identity verification will be aligned with the provisional eligibility period. An individual may receive provisional eligibility no more than once within a twelve-month period, starting with the effective date of the initial provisional eligibility determination, unless the individual is transitioning from a Qualified Health Plan (QHP) with an Advanced Premium Tax Credit (APTC), or if the individual self-attests pregnancy. In those cases, an individual may receive provisional eligibility before such 12-month period has passed.

25. Verification of Breast or Cervical Cancer or Human Immunodeficiency Virus (HIV).

For individuals who indicate on the application that they have breast or cervical cancer or HIV, a determination of eligibility will be made in accordance with the procedures described in STC 24. Persons who have not submitted verification of breast cancer, cervical cancer, or HIV diagnosis

within 90 days of the eligibility determination will subsequently have their eligibility redetermined as if they did not have breast cancer, cervical cancer, or HIV.

26. **Eligibility Exclusions.** Notwithstanding the criteria outlined in this section or in Table A, the following individuals are excluded from this demonstration. Payments or expenditures related to uncompensated care for such individuals as defined in STC 51 (b), and for DSHP as described in STC 54, however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP). In addition, SUD services described in STC 40 provided to MassHealth eligible individuals age 65 and over may be included as an allowable expenditure under the demonstration.

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

27. **Enrollment Caps.** The Commonwealth is authorized to impose enrollment caps on populations made eligible solely through the demonstration, except that enrollment caps may not be imposed for the demonstration expansion population groups listed as “Hypotheticals” in Table A. Setting and implementing specific caps are considered amendments to the demonstration and must be made consistent with section III, STC 7.

28. **Twelve Month Continuous Eligibility for Student Health Insurance Program Population.**

Individuals who are enrolled in a cost-effective Student Health Insurance Program will be continuously eligible for a period of up to 12 months while enrolled in the SHIP plan, until the end of the policy year date. The policy year will end on either July 31 or August 31 of each year. The Commonwealth will determine the individual’s eligibility at the completion of each policy year to ensure that the individual remains eligible.

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

Table A. MassHealth State Plan Base Populations¹ (See STC 89 for terminology)

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

<p>AFDC-Poverty Level Children and Independent Foster Care Adolescents</p>	<ul style="list-style-type: none"> • Age 1 - 5: 0 through 133% • Age 6 - 17: 0 through 114% • Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets • Former Foster Care Adolescents until the age of 26 without regard to income or assets (effective January 1, 2014) 	<p>Title XIX</p>	<p><u>Base Families</u></p>	<p>Standard</p>	
<p>AFDC-Poverty Level Children Medicaid Expansion Children I</p>	<ul style="list-style-type: none"> • Age 6 - 17: 114.1% through 133% • Age 18: 0 through 133% 	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted 	<p><u>Base Families</u> <u>Base Families XXI RO</u></p>	<p>Standard</p>	

¹ Massachusetts includes in the MassHealth demonstration almost all the mandatory and optional populations aged under 65 eligible under the state plan. All Standard and CommonHealth members who have access to qualifying private insurance may receive premium assistance plus wrap-around benefits. The Massachusetts state plan outlines all covered populations not specifically indicated here.

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

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	<ul style="list-style-type: none"> Title XIX if insured at the time of application Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted 	<u>1902(r)(2) Children</u> <u>1902(r)(2) XXI RO</u>	Standard	
Medicaid Expansion Children II (effective January 1, 2014)	Ages 19 and 20: 133.1 through 150%	Title XIX	<u>1902(r)(2) Children</u>	Standard	
CHIP Unborn Children	0 through 200%	Title XXI	<u>n/a</u>	Standard	
Pregnant women	0 through 185%	Title XIX	<u>Base Families</u>	Standard	
Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance	0 through 133%	Title XIX	<u>Base Families</u>	Standard	
Disabled children under age 19	0 through 150%	Title XIX	<u>Base Disabled</u>	Standard	
Disabled adults ages 19 through 64	0 through 114%	Title XIX	<u>Base Disabled</u>	Standard	
Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	<u>Base Disabled</u>	CommonHealth	Must spend-down to medically needy income standard to become eligible as medically needy
Pregnant women	185.1 through 200%	Title XIX	<u>1902(r)(2) Children</u>	Standard	

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

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

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

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

Table A. MassHealth Demonstration Expansion Populations *

Groups with a Categorical Link Made Eligible through the Demonstration (“Hypotheticals”)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Higher income children with disabilities	<ul style="list-style-type: none"> · < Age 1: 200.1 through 300% · Ages 1 - 18: 150.1 through 300% 	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI via the separate XXI program (Funded through title XIX if title XXI is exhausted) 	<p align="center"><u>CommonHealth</u> <u>CommonHealth XXI</u></p>	CommonHealth	The CommonHealth program existed prior to the separate XXI Children’s Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI state plan and as authorized under this 1115 demonstration. Certain children derive eligibility from both the authority granted under this demonstration <u>and</u> the separate XXI program.
Higher income children with disabilities ages 0 through 18	Above 300%	Title XIX	<u>CommonHealth</u>	CommonHealth	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL
Higher income adults with disabilities ages 19 through 64.	Above 133% Above 150% for 19- and 20-year olds)	Title XIX	<u>CommonHealth</u>	CommonHealth (“working”)	Such individuals are subject to a one-time only deductible except that there is no deductible for individuals who work 40 hours or more per month. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

<p>Higher income adults with disabilities who are 65 and older.</p>	<p>Net income above 100% FPL and/or Assets > \$2,000</p>	<p>Title XIX</p>	<p><u>CommonHealth</u></p>	<p>CommonHealth (65+)</p>	<p>Such individuals are subject to a deductible and asset test under the State Plan except there is no deductible or asset test for individuals who have paid employment for 40 hours or more per month. Individuals who met the deductible and asset test under the State plan receive MassHealth Standard.</p> <p>Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.</p>
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Table A. MassHealth Demonstration Expansion Populations (See STC 89 for terminology)

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

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

Populations Made Eligible through the Demonstration	Federal Poverty Level (FPL) and other qualifying criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	Massachusetts Demonstration Program	Additional comments
Individuals with HIV not otherwise eligible for medical assistance with income above 133% through 200% FPL.	Above 133 to 200%	Title XIX	<u>e-HIV/FA</u>	Family Assistance	Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.
Individuals who receive Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children	N/A	Title XIX	<u>TANF/EAEDC</u>	MassHealth	Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not an income determination.
Provisional Eligibility	Self-Attested income level to qualify for other group, pending verification	Title XIX	<u>Provisional Eligibility</u>	MassHealth	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority in accordance with STC 24.
End of Month Coverage Beneficiaries determined eligible for subsidized Qualified Health Plan (QHP) coverage through the Massachusetts Health Connector but not enrolled in a QHP	Ineligible for MassHealth and Eligible for QHP up to 400% FPL	Title XIX	<u>End of Month Coverage</u>	N/A	Effective January 1, 2014, expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP, during the period specified in STC 29.

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

V. DEMONSTRATION PROGRAMS AND BENEFITS

29. **End of Month Coverage for Members Eligible for Subsidized Coverage through the Massachusetts Health Connector.** When a MassHealth member's enrollment is being terminated due to a change in circumstance that makes the member ineligible for MassHealth but eligible for subsidized coverage through the Health Connector, MassHealth will extend the member's last day of coverage to the end of the month before Health Connector coverage may feasibly become effective. If the termination otherwise would have been effective on or before the 15th of a given month, then MassHealth coverage will be extended to the end of that month. If the termination otherwise would have been effective on or after the 16th of a given month, then MassHealth coverage will be extended to the end of the following month.
30. **Demonstration Program Benefits.** Massachusetts provides health care benefits through the following specific benefit programs. The benefit program for which an individual is eligible is based on the criteria outlined in Table A of Section IV of the STCs. Table B in STC 38, provides a side-by-side analysis of the benefits offered through these MassHealth programs.
31. **MassHealth Standard.** Individuals enrolled in MassHealth Standard receive state plan services including for individuals under age 21, Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. In addition, individuals enrolled in Standard receive additional demonstration benefits specifically authorized in demonstration expenditure authorities.

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

MassHealth Standard benefits will be provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished as described in STC 46 and 47.

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

32. **MassHealth CarePlus.** MassHealth's CarePlus ABP is for individuals in the New Adult Group ages 21-64 who are not otherwise eligible for MassHealth Standard ABP. CarePlus provides medical and behavioral health services, including diversionary behavioral health service and non-emergency medical transportation, but does not include long term services and supports. Benefits are provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished as described in STC 46 and 47.

33. **MassHealth Breast and Cervical Cancer Demonstration Program (BCCDP).** The BCCDP is a health benefits program for individuals in need of treatment for breast or cervical cancer. This program offers MassHealth Standard benefits to individuals under 65 who do not otherwise qualify for MassHealth.
34. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under Standard; individuals under age 21 receive EPSDT services as well. In addition, individuals enrolled in CommonHealth receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished as described in STC 46 and 47. In addition, for CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth will also pay the cost of the monthly Medicare Part B premium. These benefits shall begin on the first day of the month following the date of the MassHealth eligibility determination. The Commonwealth may establish eligibility for this coverage without applying an asset test.
35. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under Standard. Among other things, individuals enrolled in Family Assistance receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. The Commonwealth may waive its requirement for children with access to ESI to enroll in ESI if the Commonwealth determines it is more cost effective to provide benefits under direct Family Assistance coverage than to provide premium assistance. For individuals who derive their Family Assistance benefits via the 1115 demonstration and who are on Direct Coverage, premium assistance will be furnished in coordination with STC 46. There are two separate categories of eligibility under Family Assistance:
- A. Family Assistance-HIV/AIDS.** As referenced in Table A above, for persons with HIV/AIDS whose income is above 133 percent less than or equal to 200 percent of the FPL would be eligible for the New Adult Group (MassHealth CarePlus) but for the income limit. Unlike other coverage types, persons with HIV who have access to ESI do not have to enroll in available ESI; however, if they choose to receive premium assistance, the Commonwealth will provide covered services that are not available from the ESI plan on a fee-for-service (FFS) basis.
- B. Family Assistance-Children.** As referenced in table A above, children can be enrolled in Family Assistance if their family's income is above 150 percent and less than or equal to 300 percent FPL. Benefits are provided either through direct coverage or cost effective premium assistance. Direct coverage Family Assistance under the title XXI program is provided through an MCO, ACO, or the PCC plan for children without access to ESI. Premium Assistance benefits are limited to premium assistance for ESI, to the extent that ESI is available to these children that is cost-effective, meets a basic benefit level (BBL), and for which the employer contributes at least 50 percent of the premium cost. Premium assistance may exceed the cost of child-only coverage and

include family coverage if cost effective based on the child’s coverage. Direct coverage is provided for children with access to cost effective ESI that meets the BBL only during the provisional eligibility period and the time span while the Commonwealth is investigating availability of and enrolling the child in ESI.

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

37. **MassHealth Limited.** Individuals are enrolled in Limited if they are federally non-qualified non-citizens, whose immigration status makes them ineligible for other MassHealth programs under the state plan. These individuals receive emergency medical services only as described in 42 C.F.R. 440.255.

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

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

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

Chapter 766 Home Assessment***	X	X	X	
Chiropractic Care	X	X	X	
Chronic Disease and Rehabilitation on Hospital Inpatient	X	X	X	X
Chronic Disease and Rehabilitation Hospital Outpatient	X	X	X	X
Community Health Center (includes FQHC and RHC services)	X	X	X	X
Day Habilitation****	X	X		
Dental Services	X	X	X	X
Diversionsary Behavioral Health Services	X	X	X	X
Durable Medical Equipment and Supplies	X	X	X	X
Early Intervention	X	X	X	
Family Planning	X	X	X	X
Group Adult Foster Care	X	X		
Hearing Aids	X	X	X	X
Home Health	X	X	X	X
Hospice	X	X	X	X
Laboratory/X-ray/Imaging	X	X	X	X
Medically Necessary Non-emergency	X	X		X

Transport				
Nurse Midwife Services	X	X	X	X
Nurse Practitioner Services	X	X	X	X
Orthotic Services	X	X	X	X
Outpatient Hospital	X	X	X	X
Outpatient Surgery	X	X	X	X
Oxygen and Respiratory Therapy Equipment	X	X	X	X
Personal Care	X	X		
Pharmacy	X	X	X	X
Physician	X	X	X	X
Podiatry	X	X	X	X
Private Duty Nursing	X	X		
Prosthetics	X	X	X	X
Rehabilitation	X	X	X	X
Renal Dialysis Services	X	X	X	X
Skilled Nursing Facility	X	X	Limited	Limited
Speech and Hearing Services	X	X	X	X
Targeted Case Management	X	X		
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X
Vision Care	X	X	X	X

Chart Notes

****Adult Foster Care Services** – These services are state plan services and the definition of these services

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

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

****** Day Habilitation Services** – These services are state plan services and the definition of these services may vary contingent upon the approved state plan. In general, the services are assistance with skill acquisition in the following developmental need areas: self-help, sensorimotor, communication, independent living, affective, behavior, socialization and adaptive skills. Services are provided in non-residential settings or Skilled Nursing Facilities when recommended through the PASRR process. Services include nursing, therapy and developmental skills training in environments designed to foster skill acquisition and greater independence. A day habilitation plan sets forth measurable goals and objectives, and prescribes an integrated program of developmental skills training and therapies necessary to reach the stated goals and objectives.

39. **Diversionsary Behavioral Health Services.** Diversionsary 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. Diversionsary services are also provided to support an individual's return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionsary services, those provided in a 24-hour facility, and those which are provided on an outpatient basis in a non-24-hour setting or facility. Generally, 24-hour and non-24 hour diversionsary behavioral health services are provided by free-standing (community-based) or hospital-based programs licensed by the Department of Mental Health or the Department of Public Health. Some of the 24 hour service providers of Diversionsary Behavioral Health Services meet the definition of an Institution for Mental Diseases (IMD). Diversionsary services are offered to provide interventions and stabilization to persons experiencing mental health or substance abuse crises in order to divert from acute inpatient hospitalization or to stabilize after discharge. These services do not include residential programs involving long-term residential stays. Any MassHealth member under the demonstration who is enrolled in managed care may be eligible to receive diversionsary services. Managed care entities and the Prepaid Inpatient Health Plan (PIHP) for behavioral health services identify appropriate individuals to receive diversionsary services. Managed care entities maintain a network of diversionsary services and arrange, coordinate, and oversee the provision of medically necessary diversionsary services, as described in Table C.

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

<u>Diversionary Behavioral Health</u>	<u>Setting</u>	<u>Definition of Service</u>
Community Crisis Stabilization	24-hour facility	Services provided as an alternative to hospitalization, including short- term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.
Community Support Program (CSP)	Non-24-hour facility	An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services
<u>Diversionary Behavioral Health</u>	<u>Setting</u>	<u>Definition of Service</u>
		to Covered Individuals with a long-standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.

<p>Partial Hospitalization*</p>	<p>Non-24-hour facility</p>	<p>An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.</p>
<p>Acute Treatment Services for Substance Abuse</p>	<p>24-hour facility, Including IMDs</p>	<p>24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co- occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs</p>

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

Intensive Outpatient Program	Non-24-hour	A clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.
<u>Diversionary Behavioral Health</u>	<u>Setting</u>	<u>Definition of Service</u>
Structured Outpatient Addiction Program	Non-24-hour facility	Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.

<p>Program of Assertive Community Treatment</p>	<p>Non-24-hour facility</p>	<p>A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community.</p> <p>Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.</p>
<p>Emergency Services Program*</p>	<p>Non-24-hour facility</p>	<p>Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.</p>

Community Based Acute Treatment for Children and Adolescents	24-hour facility	Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (which is defined as one- on-one therapeutic monitoring as needed for individuals who may be at immediate risk for suicide or other self-harming behavior); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.
<i>Chart Notes:</i>		
* This service is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment.		
** In this context, “therapeutic milieu” refers to a structured, sub-acute setting, in which clinical services (therapies) are provided at both the individual and group level, and in which the common social/interpersonal interactions between each patient, and all others who are present in the setting, are incorporated into the treatment approach.		

40. Substance Use Disorder Services

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

As is currently the case, MassHealth anticipates that the Department of Public Health, Bureau of Substance Abuse Services (BSAS), which is the single state authority on SUD services, continue to fund primary prevention efforts, including education campaigns and community prevention coalitions. Intervention and initial treatment will be available to MassHealth members, as described below, in a number of different settings (as set forth herein) and allow for a bio-psycho-social clinical assessment, based on the ASAM principles, to gain an understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability and other issues.

Table D. Additional SUD Authorized Services

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

Services and 24-hour community-based family SUD treatment services	in MassHealth Limited		individual, while providing active treatment and reassessment. Through this service MassHealth will provide ASAM Level 3.1 services to adults, families, and adolescents. Residential Rehabilitation Services includes day programming and individual and group services.
Recovery support navigator services	All MassHealth members, except those in MassHealth Limited		Under this service, a Recovery Support Navigator develops and monitors a recovery plan in conjunction with the member, coordinates all clinical and non-clinical services, participates in discharge planning from acute treatment programs, works with the member to ensure adherence to the discharge plan, and assists the member in pursuing his or her health management goals.
Recovery coach services	Available to MassHealth members who receive care through an ACO/MCO		Under this service, a Recovery Coach (a person with SUD lived experience) will serve as a recovery guide and role model. Recovery Coaches provide nonjudgmental problem solving and advocacy to help members meet their recovery goals.

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

VI. DELIVERY SYSTEM

The MassHealth section 1115 demonstration provides benefits through multiple delivery systems and programs. A fundamental philosophy of MassHealth is that the Commonwealth will enable beneficiaries to take advantage of available and qualified employer-sponsored (ESI) or student health (SHIP) insurance if cost effective. These circumstances include the availability of ESI, the employer's contribution level meeting a state-specified minimum, and its cost-effectiveness. MassHealth pays for medical benefits directly (direct coverage) only if no other source of payment is available and cost-effective. Beneficiaries are required, as a condition of eligibility under some coverage types, to obtain or maintain private health insurance if MassHealth determines it is cost effective to do so, with the premium assistance necessary to make it affordable for the beneficiary. All demonstration programs except MassHealth Limited have a premium assistance component.

41. Direct Coverage and Eligibility for Managed Care

MassHealth benefits provided through direct coverage are delivered through the following delivery systems under the demonstration, grouped into four categories:

- a) Fee for service (“FFS”);
- b) A behavioral health contractor (which is a PIHP);
- c) Two primary care case management (PCCM) delivery systems: the PCC Plan; and Primary Care ACOs (which are PCCM entities); and
- d) Two MCO-based delivery systems: the MassHealth MCOs; and Accountable Care Partnership Plans

Together, all of these delivery systems except for FFS (i.e., the PCC Plan, the Behavioral Health PIHP, Primary Care ACOs, MassHealth MCOs, and Accountable Care Partnership Plans) are referred to as “Managed Care.” Additional detail on these Managed Care delivery systems is provided in STC 43-45. MassHealth may require beneficiaries eligible for direct coverage under any of the following categories to enroll in one of the Managed Care options described above: Standard, Standard ABP, Family Assistance, CarePlus, or CommonHealth members with no third party liability.

In addition, children who are clients of the Departments of Children and Families (DCF) or Youth Services (DYS) who do not choose to enroll in Managed Care may instead choose to receive medical services through FFS, but are nonetheless required to enroll with the behavioral health contractor for behavioral health services.

Children eligible under TEFRA section 134 (Kaileigh Mulligan) and children receiving title IV-E adoption assistance may opt to enroll in Managed Care, or may choose instead to receive health services through FFS. Children who choose fee-for-service will be passively enrolled with the behavioral health contractor for behavioral health services, but have the ability to opt-out and receive behavioral health services through the fee-for-service provider network.

See Table E below for additional details on Managed Care eligibility and enrollment rules.

42. Exclusions from Managed Care Enrollment. The following individuals may be excluded from enrollment in Managed Care:

- A.** Any individual for whom MassHealth is a secondary payer (i.e., a member with other health insurance). For purposes of exclusion from Managed Care, “other health insurance” is defined as any medical coverage plan available to the member, including, but not limited to Medicare, CHAMPUS, or a private health plan. However, MassHealth requires children eligible for MassHealth Standard/Standard ABP and CommonHealth, for whom MassHealth is a secondary payer, to enroll with the behavioral health contractor for behavioral health services;
- B.** Any individual receiving benefits during the hospital-determined presumptive eligibility period or the time-limited period while MassHealth investigates and verifies access to qualified and cost-effective private health insurance or the time-limited period

while the member is enrolling in such insurance;

- C. Any individual receiving Limited coverage;
- D. Any individual receiving hospice care, or who is terminally ill as documented with a medical prognosis of a life expectancy of 6 months or less; and
- E. Any participant in a Home and Community-Based Services Waiver who is not eligible for SSI and for whom MassHealth is not a secondary payer.

MassHealth may permit such individuals to enroll in Managed Care, including the option to enroll with the behavioral health contractor for behavioral health services and receive their medical services through FFS.

43. Managed Care Delivery Systems

MassHealth’s Managed Care delivery systems include two categories as described above: (1) PCCM delivery systems (which includes the PCC Plan and Primary Care ACOs); and (2) MCO-based delivery systems (which includes the MassHealth MCOs and Partnership Plans). Table E below provides an overview of these delivery systems.

Table E. Overview of Managed Care Delivery Systems

Managed Care					
PCCM delivery systems			MCO-based delivery systems		
PCC Plan		Primary Care ACOs (previously “Model B ACOs”)	MassHealth MCOs		Partnership Plans (previously “Model A ACOs”)
<i>Non-Pilot</i>	<i>ACO Pilot</i>			<i>Non-ACO</i>	

44. PCCM delivery systems:

- A. **The PCC Plan.** The PCC Plan is a managed care option operated by MassHealth. Members enrolled in the PCC Plan are also enrolled in a single Behavioral Health Program (BHP) contractor, which is a Prepaid Inpatient Health Plan (PIHP), for behavioral health coverage. Members enrolled in the PCC Plan access other services from MassHealth’s FFS network, subject to PCC referral and other utilization management requirements. Each member enrolled in the PCC Plan is assigned to a designated primary care provider (a “Primary Care Clinician,” or “PCC”) from among the PCC Plan’s available PCCs, who provides primary care case management. A member’s PCC provides most primary and preventive care and is responsible for providing referrals for most specialty services and for otherwise coordinating the member’s services. PCC Plan members may receive family planning services from

any provider without consulting their PCC or obtaining prior approval from MassHealth. Members enrolled in the PCC Plan do not experience fixed enrollment, and may enroll in another Managed Care delivery system (i.e., a Primary Care ACO, a MassHealth MCO, or a Partnership Plan) at any time.

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

- B. Primary Care ACOs.** Primary Care ACOs are managed care options operated by MassHealth using PCCM contractors (“Primary Care ACOs”). MassHealth contracts with Primary Care ACOs to serve as PCCM entities. Primary Care ACOs are not paid directly to provide services. Members enrolled in Primary Care ACOs are also enrolled in MassHealth’s Behavioral Health PIHP for behavioral health coverage and access other services from MassHealth’s FFS network, subject to primary care referral and other utilization management requirements. Each member enrolled in a Primary Care

ACO is assigned to a primary care provider from among the Primary Care ACO's participating primary care providers.. Primary Care ACO enrollees may receive family planning services from any provider without consulting their primary care provider or their Primary Care ACO, or obtaining prior approval from MassHealth.

- i. The State may limit disenrollment for Primary Care ACO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
- ii. MassHealth may establish Referral Circles for Primary Care ACOs; Referral Circles are groups of providers within MassHealth's FFS network, for which MassHealth will eliminate the need for otherwise-required primary care referrals for Primary Care ACO enrollees, in order to facilitate increased access and coordinated care.
- iii. MassHealth will hold Primary Care ACOs financially accountable for cost and quality of care through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses). See Attachment O for additional detail on pricing for Primary Care ACOs.
- iv. Similar to the Center for Medicare and Medicaid Innovation (CMMI) "Next Gen" ACO program and its option for population-based payment, MassHealth may also prospectively pre-pay a Primary Care ACO, at the request of both the Primary Care ACO and the providers. Providers and Primary Care ACOs may choose such arrangements to support greater control of service revenue funds within a coordinated system, to increase accountability for total cost of care, to support up-front investments in infrastructure that supports integrated care delivery, or for other purposes in service of MassHealth's delivery system goals. Under such a payment mechanism, MassHealth would continue to maintain the FFS network and receive claims from network providers for payments for services, but would reconcile those claims to prepayments for such services. The Commonwealth will submit a proposal for any such payment mechanism to CMS for approval prior to implementation.
- v. Primary Care ACOs may be required to implement payment arrangements in their contracts with their participating primary care providers that may include minimum levels and/or frequency of risk sharing. Such arrangements will be consistent with 42 CFR 438.6.
- vi. MassHealth will contract with Primary Care ACOs selectively. Primary Care ACOs are PCCM entities under 42 CFR 438.

C. Other features of MassHealth's PCCM delivery systems. MassHealth will maintain responsibility for requirements of the delivery systems not specifically delegated to the PCCMs or PCCM entities (e.g., member communications about the delivery system).

45. MCO-based delivery systems:

- A. MassHealth MCOs.** MassHealth contracts selectively with Managed Care Organizations (MCOs) that provide comprehensive health coverage, including behavioral health services, to enrollees. Some Direct Coverage services are not provided by the MCOs but are instead

covered directly by MassHealth for members enrolled in MCOs. Over the course of the Demonstration, MassHealth anticipates that enrollees will begin to receive certain of these Direct Coverage services from the MCOs. For example, Long Term Services and Supports (LTSS) are anticipated to be phased into MCO covered services during the Demonstration extension period. Members enrolled in MCOs may receive family planning services from any provider without consulting their PCP or MCO and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in a member's MCO network, MassHealth reimburses the provider on a fee-for-service basis and recoups the funds from the MCO. See Attachment O for additional detail on pricing for MassHealth MCOs. MassHealth MCOs are MCOs under 42 CFR 438.

- A. The State may limit disenrollment for MCO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
- B. MCO contracts will include requirements to use alternative payment methodologies and other arrangements described in STC 43 and Attachment G, to increase accountability for cost and quality of care through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses).

C. **MCO-Contracted ACOs.** MassHealth will select certain qualified ACOs through a competitive selection process, for accountability for services furnished through MassHealth ACOs. These "MCO-Contracting ACOs" will be provider-led entities such as health systems or groups of health care providers that contract with MCOs to provide care coordination and management and to take financial accountability for cost and quality of care for certain attributed MCO enrollees. They are not managed care entities under 42 CFR 438 and there will not be a separate delivery system or enrollment option for MCO enrollees attributed to MCO-contracting ACOs; such individuals will receive services from the MCO service delivery system. MCO enrollees who receive primary care from primary care providers who participate in MCO-contracting ACOs are considered attributed to those ACOs for the purposes of this cost and quality accountability. MassHealth MCO contracts will include requirements for MCOs to contract with MCO-Administered ACOs using a MassHealth-approved alternative payment contract framework that includes risk tracks and schedules set by the state, which will be broadly consistent with 42 CFR 438.6(c). This alternative payment contract framework will hold MCO-Contracted ACOs financially accountable through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses). As with MCO enrollees not attributed to ACOs, these MCO enrollees may experience fixed enrollment to their MCO, and receive services from their MCO's provider network (except for certain Direct Coverage services provided directly by MassHealth, as described above) subject to their MCO's rules for referral, prior authorization, and primary care provider assignment. See Attachment O for additional detail on pricing for MCO-Administered ACOs.

- B. **Accountable Care Partnership Plans ("Partnership Plans").** MassHealth will contract selectively with Partnership Plans that provide comprehensive health coverage, including behavioral health services, to enrollees. Some Direct Coverage services are not provided by

the Partnership Plans but are instead covered directly by MassHealth for members enrolled in Partnership Plans. Over the course of the Demonstration, MassHealth anticipates that enrollees will begin to receive certain of these Direct Coverage services from the Partnership Plans. For example, Long Term Services and Supports (LTSS) are anticipated to be phased into Partnership Plan covered services during the Demonstration extension period. Members enrolled in Partnership Plans may receive family planning services from any provider without consulting their PCP or Partnership Plan and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in a member's Partnership Plan network, MassHealth reimburses the provider on a fee-for-service basis and recoups the funds from the Partnership Plan. See Attachment O for additional detail on pricing for Partnership Plans.

- i. The state may limit disenrollment for Partnership Plan enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
- ii. Partnership Plans may have certain additional requirements such as requirements to partner with an ACO-based provider network to deliver services and coordinate care for enrollees, and to hold such ACO and providers financially accountable for the cost and quality of care under a MassHealth-approved framework that may include minimum levels and/or frequency of risk sharing. Such arrangements will be consistent with 438.6.
- iii. MassHealth will contract with Partnership Plans selectively. Partnership Plans are MCOs under 42 CFR 438.

44. **Primary Care Exclusivity.** MassHealth will establish rules to require the exclusivity of primary care providers for certain Managed Care delivery systems, in order to ensure that accountability for cost and quality can accurately be assigned, and to facilitate members' choice among delivery systems options if members wish to choose based on their preferred primary care provider. Specifically, MassHealth will require all Pilot ACOs, Primary Care ACOs, Partnership Plans, and MCO-Administered ACOs (all of which are financially accountable for the cost and quality of attributed members) to each ensure that their participating primary care providers do not simultaneously participate in any other delivery system option, as follows:

- a) A primary care provider participating with a Pilot ACO may not simultaneously participate with another Pilot ACO
- b) A primary care provider participating with a Primary Care ACO may not simultaneously participate with another Primary Care ACO, with a Partnership Plan, or with an MCO-Administered ACO. This primary care provider also may not serve as a PCC in the PCC Plan or a network PCP in the network of a MassHealth MCO. This primary care provider will exclusively serve as a primary care provider for enrollees in the Primary Care ACO.
- c) A primary care provider participating with a Partnership Plan may not simultaneously participate with a Primary Care ACO, with another Partnership Plan, or with an MCO-Administered ACO. This primary care provider also may not serve as a PCC in the PCC Plan or a network PCP in the network of a MassHealth MCO. This primary care provider will exclusively serve as a primary care provider for enrollees in the Partnership Plan.
- d) A primary care provider participating with an MCO-Contracted ACO may not simultaneously participate with a Primary Care ACO, with a Partnership Plan, or with

another MCO-Contracted ACO. This primary care provider also may not serve as a PCC in the PCC Plan. This primary care provider may not serve as a network PCP in the network of a MassHealth MCO, except as part of the MCO-Administered ACO (i.e., the MCO must have a MassHealth-approved ACO contract with the MCO-Administered ACO). This primary care provider will exclusively serve as a primary care provider for MassHealth MCO enrollees who are attributed to the MCO-Administered ACO.

Where this exclusivity applies, it applies only for MassHealth members eligible for Managed Care. Primary care providers may be in MassHealth's FFS network and provide services to non-Managed Care enrolled MassHealth members (e.g., dually eligible FFS members).

45. **Contracts.**

a) Managed Care Contracts. All contracts and modifications of existing contracts between the Commonwealth and MCOs or between the Commonwealth and Partnership Plans must be prior approved by CMS. The Commonwealth will provide CMS with a minimum of 90 calendar days to review and approve changes.

i. MassHealth may make periodic payments of the types described below to managed care entities (MCE), including MCOs, Partnership Plans and PIHPs, and direct that these payments be made to hospitals in the MCEs' networks:

For example, starting in MCO Rate Year 2017 (October 1, 2016-September 30, 2017), MassHealth will direct its contracted MCOs to make payments to hospitals in their networks as an incentive for hospitals to report on and subsequently improve access to appropriate medical and diagnostic equipment for members with disabilities. MassHealth will calculate the payments for which each hospital is eligible based on current year Medicaid Gross Patient Service Revenue and will direct the MCOs to make payments accordingly, contingent on the hospitals meeting requirements set forth by MassHealth. While this program will not be renewed automatically, it will be a multi-year initiative in which the first two years will require reporting by hospitals on access to medical and diagnostic equipment, and future years will include related performance requirements for hospitals. In future years this program may also be administered by Accountable Care Partnership Plans, in accordance with Attachment Q and I.

b) Public Contracts. Contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index), unless the contractual payment rate is set at the same rate for both public and private providers. This requirement does not apply to contracts under the SNCP as outlined in STC 51.

c) Selective Contracting. Procurement processes and the subsequent final contracts developed to implement selective contracting by the Commonwealth with any provider group shall be

subject to CMS approval prior to implementation, except for contracts authorized pursuant to 42 C.F.R. section 431.54(d).

- d) Capitation Rate Development. Capitation rates for MCOs and Partnership Plans shall comply with the rate development and certification standards in 42 CFR §438. The Commonwealth shall develop its capitation rates in a manner consistent with Attachment O

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

If available and cost effective, the Commonwealth will provide premium assistance on behalf of individuals eligible for Standard (including ABP 1), CarePlus or CommonHealth coverage, to assist them in the purchase of private health insurance coverage. The state will also provide coverage for additional services required to ensure that such individuals are receiving no less than the benefits they would receive through direct coverage under the state plan. This coverage will be furnished, at the state option, on either a FFS basis or through managed care arrangements. These individuals are not required to contribute more towards the cost of their private health insurance than they would otherwise pay for MassHealth Standard (including ABP 1), CarePlus or CommonHealth coverage. Cooperation with the Commonwealth to obtain or maintain available health insurance will be treated as a condition of eligibility for all of those in the family group, except those who are under the age of 21, or pregnant.

47. **Student Health Insurance (SHIP) Plans.** For individuals with access to SHIP plans, the Commonwealth may require enrollment in such plan as a condition of receiving benefits. Once the individual enrolls in the SHIP Plan, premium and cost sharing assistance will be provided for the entire plan year or the duration of the SHIP plan enrollment, if less than one year. The state will also ensure individuals receive comparable benefits to those offered in Medicaid programs the individual is eligible for receiving, for the duration of the individual's enrollment in SHIP. In addition, for those individuals enrolled in SHIP plans with premium assistance, the Commonwealth will provide continuous eligibility that will coincide with the SHIP plan year, or the duration of the SHIP plan enrollment, if less than one year, for which premium assistance is provided.

48. **Overview of Delivery System and Coverage for MassHealth Administered Programs.** The following chart provides further detail on the delivery system utilized for the MassHealth administered programs and the related start date for coverage:

Table E. Delivery System and Coverage for MassHealth Demonstration Programs

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
<u>Standard/Standard ABP</u>					
Individuals with no third party liability (TPL)	Managed Care (PCC Plan, MCO, or Accountable Care)	x			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS		x		10 days prior to date of application
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application

<p>Kaileigh Mulligan eligible children and children receiving title IV-E adoption assistance</p>	<p>Behavioral health is typically provided via BHP PIHP, although a FFS alternative must be available; all other services are offered via Managed Care or FFS.</p>		<p>x</p>		<p>Kaileigh Mulligan - may be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided.”</p> <p>Title IV-E adoption assistance - start date of adoption</p>
<p>Medically complex children in the care/custody of the DCF</p>	<p>Special Kids Special Care MCO</p>		<p>x</p>		<p>Start date of state custody</p>
<p>Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF</p>	<p>All services are offered via Managed Care or FFS, with the exception of behavioral health which is provided via mandatory enrollment in BHP PIHP unless the child enrolls in an MCO or Accountable Care Partnership Plan</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>Start date of state custody</p>

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
	in which case, behavioral health is provided through the MCO or Accountable Care Partnership Plan				
Provisionally eligible pregnant women and children, for an up to 90-day period, before self-attested family income is verified	FFS			x	10 days prior to date of application if citizenship/immigration status is verified
Individuals in the Breast and Cervical Cancer Treatment Program	Managed Care	X			10 days prior to date of application
<u>CommonHealth*</u>					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for HIV/AIDS*</u>					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for Children***</u>					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>CarePlus</u>					
Individuals with no TPL	Managed Care	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			X	10 days prior to date of application

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

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
*TPL wrap could include premium payments					
** FFS until member selects or is auto-assigned to MCO, ACO or PCC Plan					
***Presumptive and time-limited during health insurance investigation					
**** All retroactive eligibility is made on a FFS basis.					

VII. COST SHARING

49. **Overview.** Cost-sharing imposed upon individuals enrolled in the demonstration and eligible under the state plan or in a “hypothetical” eligibility group is consistent with the provisions of the approved state plan except where expressly made not applicable in the demonstration expenditure authorities. Cost sharing for individuals eligible only through the demonstration may vary across delivery systems, demonstration programs and by FPL, except that no co-payments are charged for any benefits rendered to children under age 21 or pregnant women. Additionally, no premium payments are required for any individual enrolled in the demonstration whose gross income is less than 150 percent FPL. Please see Attachment B for a full description of cost-sharing under the demonstration for MassHealth-administered programs. The Commonwealth has the authority to change cost-sharing for the Small Business Employee Premium Assistance programs without amendment. Updates to the cost-sharing will be provided upon request and in the annual reports,

- a. **State Differential Cost Sharing and Network Adequacy.** The Commonwealth’s ability to implement premiums and copayments cost sharing that vary by eligibility group, income level, delivery system and service as described in Attachment B through June 30, 2020 may be extended with approval from CMS, based on findings of an evaluation of aggregate provider networks in the ACO and MCO programs relative to the PCC Plan, as further described in Section XII (language below in Evaluation section), using metrics created by the state. If the findings are satisfactory to CMS then the waiver authority and the waiver is extended, such renewal shall not require that the state submit an amendment request to the demonstration.

VIII. THE SAFETY NET CARE POOL (SNCP)

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

expenditures, both aimed at improving health care delivery systems and thereby improving access to effective, quality care. During the current extension period, the SNCP has been restructured to include the following expenditure categories:

- i. Payments that offset Medicaid FFS and managed care underpayment, and uncompensated care for uninsured and underinsured (DSH – shortfall and uninsured).
- ii. Uncompensated care pool restricted to charity care for uninsured and underinsured, aligned with CMS uncompensated care pool policy as applied in other states (UCC – uninsured care). CMS will only make changes to the base methodology during the negotiation of another demonstration extension with the Commonwealth.
- iii. Time-limited incentive based pools, that phase down over the course the five year extension period; and
- iv. Expenditures for Health Connector subsidies.

51. **Expenditures Authorized under the SNCP.** The Commonwealth is authorized to claim as allowable expenditures under the demonstration, to the extent permitted under the SNCP limits under STC 52, for the following categories of payments and expenditures. The Commonwealth must identify the provider and the source of non-federal share for each component of the SNCP. Federally-approved payments and expenditures within these categories are specified in Attachment E. The Commonwealth must only claim expenditures at the regular FMAP for these programs.

a) **Payments for Uncompensated Care**

- i. **Disproportionate Share Hospital-like (DSH-like) Pool.** As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the demonstration, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, and low-income uninsured individuals consistent with the definition of uncompensated care in 42 CFR 447.299, except that DSRIP and PHTII incentive payments will not be included as patient care revenues for this purpose. The Commonwealth may also claim as allowable expenditures payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease. Payments are limited to uncompensated care costs incurred by providers and verified in cost reports or other cost records, in serving individuals who are eligible for Medicaid, or have no health care insurance for the service. These payments are subject to the SNCP limits under STC 52. The DSH Pool may include expenditures for:
 1. Public Service Hospital Safety Net Care payments to hospitals for care provided to eligible low income uninsured and underinsured patients;
 2. Health Safety Net Trust Fund payments to hospitals and community health centers for care provided to eligible low income uninsured and underinsured patients;
 3. Payments to Institutions for Mental Disease (IMDs) for care provided to MassHealth Members, to the extent these expenditures are not claimed under the SUD authority described in STC 40;
 4. Certified public expenditures for uncompensated care provided by Department of Public Health (DPH) and Department of Mental Health (DMH) hospitals; and
 5. Safety Net Provider Payments to qualifying hospitals, as described in (2) below.

- ii. **Safety Net Provider Payments.** The Commonwealth may make Safety Net Provider Payments to eligible hospitals, in recognition of safety net providers in the Commonwealth that serve a large proportion of Medicaid and uninsured individuals and have a demonstrated need for support to address uncompensated care costs consistent with the definition of 42 CFR 447.299. These payments are intended to provide ongoing and necessary operational support; as such, they are not specifically for the purposes of delivery system reform and are not time limited.

The Commonwealth will determine, based on the eligibility criteria listed below, the hospitals that are eligible to receive the Safety Net Provider Payments. The eligibility criteria below use hospitals' fiscal year 2014 Uncompensated Care Cost Report (UCCR) and, if a UCCR is unavailable, Massachusetts 403 hospital cost reports for these calculations:

To be eligible, the hospital must meet the following three criteria:

1. Medicaid and Uninsured payer mix by charges of at least 20.00%;
2. Commercial payer mix by charges of less than 50.00%;
3. Is not a MassHealth Essential hospital as defined in Massachusetts' approved State Plan.

Once meeting the above eligibility criteria, a hospital may only receive a Safety Net Provider payment if its FY14 UCCR or, if an FY14 UCCR is unavailable, its FY14 403 cost report demonstrates that it experienced a shortfall for the combination of its Medicaid FFS, managed care, and Uninsured payments versus costs for Medicaid and Uninsured patients, excluding Safety Net Care Pool payments other than Health Safety Net Trust Fund payments. Hospitals that qualify for Safety Net Provider payments because they meet these eligibility criteria and have a demonstrated Medicaid and Uninsured shortfall are listed in Attachment N. Safety Net Provider Payments to any provider may not exceed the amount of documented uncompensated care indicated on these reports.

Safety Net Provider Payments will have accountability requirements, aligned with the Commonwealth's overall delivery system and payment reform goals. In each year of the demonstration extension period, hospitals that receive Safety Net Provider Payments must participate in one of MassHealth's ACO models. In addition, an increasing portion of Safety Net Provider Payments each year of the demonstration extension period will be tied to ACO performance measures as defined in the approved DSRIP Protocol. The benchmarks for ACO performance and methodology for calculating the ACO Accountability Score and associated payment will be the same as the benchmarks and methodology used in the DSRIP program and specified in the approved DSRIP Protocol. The risk levels for each year are specified below:

The portion of the Safety Net Provider Payments that is at-risk will follow the same at-risk Budget Period structure as for the ACOs. The Budget Period is January 1 through December 31. Funds for the 6 month Preparation Budget Period (July 1, 2017 to December 31, 2017) for each safety net provider will be equal to half of the provider's Safety Net

Provider Payments in Demonstration Year 1. Budget Period 1 funds for each safety net provider will be equal to the sum of half of the provider's Safety Net Provider Payments in Demonstration Year 1, and half of the Payments in Demonstration Year 2. Budget Periods 2 through 4 for each safety net provider will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds for each safety net provider will be equal to half of the provider's Safety Net Provider Payments in Demonstration Year 5.

The risk levels for each Budget Period are specified below:

1. 6 month Preparation Budget Period: 5% of each provider's total Safety Net Provider Payments / – hospitals that participate in a MassHealth ACO model will have met the accountability requirement for the 6 month Preparation Budget Period
2. Budget Period 1: 5% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
3. Budget Period 2: 5% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
4. Budget Period 3: 10% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
5. Budget Period 4: 15% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
6. Budget Period 5: 20% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures

iii. **Uncompensated Care (UC) Pool**

1. As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the demonstration, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for non-Medicaid-eligible, uninsured individuals. Payments to an individual provider cannot exceed uncompensated care expenditures documented in cost reports or other records, except that DSRIP and PHTII incentive payments will not be included as hospital patient care revenues for this purpose. Consistent with the Cost Limit Protocol, incentive payments, including DSRIP and PHTII, will not be included as hospital patient care revenues for this purpose. Expenditures provided under the UCC Pool are not subject to the Provider Cap for the DSH Pool described in STC 52. The UCC Pool will include expenditures for:
 - a. Health Safety Net payments to hospitals specifically for costs incurred by the hospital in providing care to Health-Safety Net qualified low income, uninsured patients;
 - b. Certified public expenditures for DPH and DMH hospital expenditures for care provided to uninsured patients, when the source of the non-federal share of such expenditures is not derived from federally-supported funds.
2. Massachusetts will only claim expenditures under the UC Pool to the extent that such expenditures for a particular hospital, when added to amounts paid through the DSH

- Pool, do not exceed the hospital's documented uncompensated care (except as specified below, for critical access hospitals). The methodology used by the state to determine UC payments will ensure that payments to hospitals are in no way subject to any manifest partiality based on sources of nonfederal share or other funding considerations.
3. Prior to the initiation of the Uncompensated Care Pool and at any time in which there is a material change in the pool's distribution methodology, the Commonwealth shall submit a Uncompensated Care Pool Distribution Methodology Report that describes the specific allocation methodology of the pool and demonstrates compliance with the above STCs.

52. Expenditure Limits under the SNCP.

- a) Aggregate SNCP Cap. For SFYs 2018-2022 (July 1, 2017 through June 30, 2022) (SNCP extension period), the SNCP will be subject to an aggregate cap of up to \$4.451 billion added to the provider cap for the DSH-like pool described in STC 52. b) below, as well as the overall budget neutrality limit established in section XI of the STCs, provided, however, that allowable expenditures for Health Connector subsidies will not be subject to the aggregate SNCP cap. Because the aggregate SNCP cap is based, in part, on an amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate SNCP cap, and a corresponding change to the provider cap as described in subparagraph (b). Such a change shall be reflected in this STC 52(b), and shall not require a demonstration amendment.
- b) Provider Cap for the DSH-like Pool. The Commonwealth may expend an amount for purposes specified in STC 51(b) equal to no more than the cumulative amount of the Commonwealth's annual DSH allotments for the SNCP extension period. Any change in the Commonwealth's federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate amount available for the DSH-like pool. Such change shall not require a demonstration amendment. The DSH-like Pool funding is based on the amount equal to the state's entire DSH allotment as set forth in section 1923(f) of the Act, ("DSH"). In order to align DSH amounts with each SFY, the state's DSH allotment for the federal fiscal year will be pro-rated. In any year to which reductions to Massachusetts' DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to the SNCP in a given DY shall be reduced consistent with CMS guidelines. The funding limit does not apply to expenditures under the UC Pool, though the Commonwealth may only claim expenditures under the UC Pool to the extent that the DSH Pool has been fully expended.
- c) Uncompensated Care Pool Cap. The Commonwealth may expend up to \$212 million (total computable) for SFY 2018 and up to \$100.4 million (total computable) annually in SFYs 2019-2022 for allowable UC Pool expenditures, as further described in Attachment E. Any unused expenditure authority in SFY 2018 can be expended in SFY 2019, subject to any applicable approval processes described in STC 76.

d) **Budget Neutrality Reconciliation.** The Commonwealth is bound by the budget neutrality agreement described in section XIII of the STCs. The Commonwealth agrees to reduce spending in the SNCP to comply with budget neutrality in the event that expenditures under the demonstration exceed the budget neutrality ceiling outlined in section XIII, STC 106.

53. **Cost for Uncompensated Care.** The SNCP payments pursuant to STC 51(b) support providers for furnishing uncompensated care. This protocol ensures that all provider payments for uncompensated care pursuant to STC 50(b) will be limited on a provider-specific basis to the cost of providing Medicaid state plan services and any other additional allowable uncompensated costs of care provided to Medicaid eligible individuals and uninsured individuals, less payment received by or on behalf of such individuals for such services. DSRIP and PHTII revenues will not be considered to be patient care revenues for this purpose along with other revenues as described in Massachusetts' Cost Limit Protocol approved by CMS in December 2013. Notwithstanding the generality of the foregoing, Critical Access Hospitals may receive 101% of the cost of providing Medicaid services, and 100% of uncompensated care costs as specified by the provisions of Section 1923(g) of the Act as implemented by 447.295(d).

54. **Transition of Specified Safety Net Provider Payments and Public Hospital Transformation and Incentive Initiatives into Medicaid Managed Care/ACO Incentive Payment Mechanisms.** As the 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. These payments are described in Attachment Q, MassHealth MCO Incentives.

55. **Designated State Health Programs.** The Commonwealth may claim as allowable expenditures under the demonstration Health Connector subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for individuals with incomes at or below 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; and (2) whose income is at or below 300 percent of the FPL through 300 percent of the FPL. The state may also claim as allowable expenditures under the demonstration the payments made through its state-funded Health Safety Net (HSN) program to provide gap coverage subsidies for individuals eligible for coverage through the Health Connector with incomes at or below 300% FPL. HSN-Health Connector gap coverage subsidies are provided to eligible individuals during the time designated to select and enroll in a plan through the Marketplace.

Federal financial participation for the premium assistance, gap coverage, and cost-sharing portions of Health Connector subsidies for citizens and eligible qualified non-citizens will be provided through the Designated State Health Programs authority under the SNCP pursuant to this STC. Allowable expenditures for Health Connector subsidies will not be subject to the aggregate SNCP limit described in STC 52 or other SNCP sub-caps.

56. **Cambridge Health Alliance (CHA) Public Hospital Transformation and Incentive Initiatives (PHTII).** CHA is the Commonwealth's only non-state, non-federal public acute hospital and has

among the highest concentration of patients participating in MassHealth demonstration programs of any acute hospital in the Commonwealth.

The PHTII program, which was established in the previous demonstration extension period, will evolve to focus on two areas that align with the Commonwealth's plans for a restructured MassHealth delivery system centered around ACOs and emphasizing the integration of care across physical and behavioral health care, long term services and supports, and health related social services. The two areas of focus for PHTII are:

- a) Participation in an ACO model and demonstrating success on the corresponding ACO performance measures, utilizing the same performance measures as specified for the DSRIP initiative; because CHA relies on PHTII as an important component of its overall MassHealth funding structure, enhancing the level of incentive funding tied to these critical measures will ensure alignment across payment streams and enable CHA to devote attention and resources to improving these outcomes;
- b) Continuation and strengthening of initiatives approved through PHTII from the prior demonstration period, including but not limited to initiatives focusing on access to behavioral health services and integration of behavioral health care with physical health care, given CHA's role as a major provider of behavioral health services. These PHTII initiatives will build on work done during the 2014-2017 period and will include a strengthened set of outcome and improvement measure slates that reflect the potential for greater measurable impact over time.

Attachment E specifies the total potential funding available for CHA's Public Hospital Transformation and Incentive Initiatives. An increasing proportion of PHTII funding will be at-risk based on ACO performance, outcome and improvement measures over the course of the demonstration period. For example, the proportion of total PHTII funding tied to CHA's performance on MassHealth DSRIP accountability measures as part of an ACO increases from 5% to 20% over the course of the demonstration period. In addition, 10 percent of total PHTII funding each year will be tied to performance on outcomes and improvement measures associated with continuing PHTII initiatives from the prior demonstration period. The remainder of PHTII incentive funding is contingent on CHA's successful completion of initiative activities and reporting. Further details regarding the Metrics and Evaluation of the initiatives are outlined in Attachment K.

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

To the extent that CHA fails to meet PHTII accountability measures and does not receive PHTII payments, the expenditure authority for PHTII will be reduced by the amount not payable.

Intended Funding Source: The non-federal share of PHTII payments will be provided through permissible intergovernmental transfer provided by CHA (from funds that are not federal funds or are

federal funds authorized by federal law to be used to match other federal funds in accordance with 1903(w) of the Act and implementing regulations).

57. **Delivery System Reform Incentive Program (DSRIP).** The state may claim, as authorized expenditures under the demonstration, up to \$1.8 billion (total computable) for five years, performance-based incentive payments to providers that support change in how care is provided to Medicaid beneficiaries through payment and delivery system reforms. DSRIP payments are an incentive for successfully meeting associated metrics and outcomes rather than payment of claims for the provision of medical care. For this reason, DSRIP payments shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the Safety Net Care Pool Uncompensated Care Cost Limit Protocol under demonstration authority. DSRIP will be a time limited program, and Massachusetts' efforts undertaken through DSRIP will be sustainable after the demonstration period concludes.

Specifically, the Commonwealth may claim as allowable expenditures under the demonstration, payments to Accountable Care Organizations (ACOs), certified Community Partners (CPs), social service organizations, providers, sister agencies, full-time staff, and contracted vendors for activities that will likely increase the success of the payment and care delivery reform efforts and the overall goals as outlined above and in the 1115 demonstration. Such activities include: (1) start up and ongoing support for ACO development, infrastructure, and new care delivery models; (2) support for ACOs to pay for traditionally non-reimbursed flexible services to address health-related social needs; (3) transitional funding for certain safety net hospitals to support the transition to ACO models and to smooth the shift to a lower level of ongoing Safety Net Provider funding; (4) support to Community Partners for care management, care coordination, assessments, counseling, and navigational services; (5) support to Community Partners for infrastructure and capacity building; and (6) initiatives to scale up statewide infrastructure and workforce capacity to support successful reform implementation. DSRIP funds must be subject to limitations that prevent their use as the non-federal share of claimed Medicaid expenditures.

Massachusetts may also claim as allowable expenditures under the demonstration payments for state implementation and robust oversight of the DSRIP program as described below in STC 98.

DSRIP payments are incentive payments and are therefore not subject to the Safety Net Care Pool Uncompensated Care Cost Limit Protocol

- a. **Objective and Goals.** The objective of the DSRIP program is to further key goals of the 1115 demonstration, including: (1) enacting 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) improving integration among physical health, behavioral health, long-term services and supports, and health-related social services; and (3) sustainably supporting safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals.

The goal of the DSRIP program is to provide a time-limited investment into the provider community that will facilitate transition away from a fee-for service payment model to one that moves toward alternative payment models. These models assure that health care services

are member-driven, integrated, and coordinated and that begins to address social determinants of health while moderating the cost trend.

- b. **Accomplishment of Goals.** Massachusetts seeks to accomplish its goals through the creation of three ACO models, certification of and investment in Community Partners, and investments in statewide infrastructure and workforce development. Minimal funds will be used for state implementation and oversight.
- c. **Funding Sources.** MassHealth must use a permissible source of non-federal share to support the DSRIP program. FFP is only available for DSRIP payments to Participant ACOs and CPs that comply with the DSRIP Protocol and Participation Plans; or to other entities that receive funding through the DSRIP statewide investments or DSRIP-supported state operations and implementation funding streams. The Commonwealth may claim FFP for up to two years after the calendar quarter in which the State made DSRIP payments to eligible entities. MassHealth's DSRIP expenditures are subject to availability of funds.
- d. **Expenditure Limits.** The Commonwealth may claim FFP for up to \$1.8 billion in DSRIP expenditures.
 - i. An increasing amount of state DSRIP expenditure authority will be at-risk over the five-year period (See STC 67).
 - ii. If the Commonwealth, or a provider participating in a DSRIP project on an at risk basis, loses any of its at-risk expenditure authority based on the State's DSRIP Accountability Score or the DSRIP accountability applicable to the provider's DSRIP project, the State's expenditure authority will be reduced. MassHealth will reduce DSRIP payments in proportion to the reduced expenditure authority.
 - iii. **Enrollment Adjustments.** Given that a significant portion of DSRIP expenditure authority will be disbursed on a PMPM bases, 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. The state may only carry forward funds from one DSRIP year to the next for reasons related to member participation fluctuations. If the carry forward amount from any given year to the next is more than 15%, the state must obtain CMS approval. The state must ensure that carry over does not result in the amount of DSRIP for DY 25 being greater than the amount for DY 24.
- e. **Funding Allocation and Methodologies.** The funding table below shows anticipated amounts of funding per DSRIP funding stream by waiver demonstration year. The State and CMS recognize that these funding amounts may vary due to a variety of reasons, including fluctuations in the number of members enrolled in ACOs, and the number of members who require BH and LTSS CPs services. As such, the state may reallocate funding amounts between funding streams at its discretion. If the actual funding amounts per DSRIP funding stream vary by more than 15% from the amounts provided in the table below, the state must notify CMS 60 calendar days prior to the

effective reallocation of funds. CMS reserves the right to disapprove any such reallocations.

Table F. DSRIP Funding Allocation Total Computable (In Millions)

Funding Stream	DY 21	DY 22	DY 23	DY 24	DY 25	Total
ACO Funding	\$329.2M	\$289.9M	\$229.4M	\$152.0M	\$65.1M	\$1,065.6M
Community Partners	\$57.0M	\$95.9M	\$132.2M	\$133.6M	\$128.0M	\$546.6M
Statewide Investments	\$24.2M	\$24.6M	\$23.8M	\$24.8M	\$17.4M	\$114.8M
State Operations and Implementation	\$14.6M	\$14.6M	\$14.6M	\$14.6M	\$14.6M	\$73.0M
Total:	\$425.0	\$425.0	\$400.0	\$325.0	\$225.0	\$1,800.0

58. **DSRIP Protocol.** The State must develop and submit to CMS for approval a DSRIP Protocol, and work collaboratively with CMS towards an approval date of December 15, 2016. Once approved by CMS, this document will be incorporated as Attachment M of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. The Protocol lays out the permissible uses of DSRIP specific funding for ACO and CP, as well as state implementation and oversight of the DSRIP program. Changes to the Protocol will apply prospectively, unless otherwise indicated in the Protocols. DSRIP payments for each participating entity or organization are contingent on fully meeting requirements as specified in the DSRIP Protocol. In order to receive incentive funding the entity must submit all required reporting, as outlined in the DSRIP Protocol.
- a) **Protocol Purpose:** The Commonwealth may only claim FFP for DSRIP expenditures in accordance with the DSRIP Protocol. The DSRIP Protocol:
- i. Outlines the context, goals, and outcomes that the Commonwealth seeks to achieve through payment reform;
 - ii. Specifies the allowed uses for DSRIP funding, and the methodologies/process by which the Commonwealth will determine how to distribute DSRIP funding and ensure robust oversight of said funds;
 - iii. Specifies requirements for the DSRIP Participation Plans and Budgets that ACOs and CPs are required to submit and have approved by the Commonwealth;
 - iv. Specifies requirements for how the Commonwealth will procure and oversee any statewide investments in support of the key goals of the demonstration.
- b) **DSRIP Protocol Requirements:** At a minimum the DSRIP protocol must contain the following information:
- i. Specify a State review process and criteria to evaluate and monitor each ACOs and Community Partners individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;

- ii. Specify a review process and timeline to evaluate DSRIP progress, in which first the State and then CMS must certify that a targets were met as a condition for FFP for the continued release of associated DSRIP funds;
 - iii. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating entity may be eligible to receive during the implementation of the DSRIP project, and a formula for determining the incentive payment amounts, quality incentive payments, any other outcomes- or performance-based payments, etc.;
 - iv. Specify that an entity's failure to fully meet performance targets under its DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
 - v. Include a process that allows for potential modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which potential protocol modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and
 - vi. Include a State process of developing an evaluation of DSRIP as a component of the evaluation design as required by STC 84. When developing the DSRIP Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating entities should use similar metrics for similar projects to enhance evaluation and learning experience. To facilitate evaluation, the DSRIP Protocol must identify a core set performance targets that all participating entities and/or the State must be required to report.
- c) **Review and Approval of Modifications to DSRIP Protocol:** Massachusetts has the right to modify the DSRIP Protocol over time with CMS approval, taking into account evidence and learnings from experience; unforeseen circumstances; or other good cause.
- i. CMS and Massachusetts agree to a targeted approval date of 60 business days after submission of the DSRIP Protocol modification.
 - ii. If CMS determines that the DSRIP Protocol modifications are not ready for approval by the target date, CMS will notify Massachusetts of its determination, and CMS and Massachusetts will then work collaboratively together to address the reasons provided by CMS for not granting approval.

59. **ACO & CP Participation Plans:** In order to receive DSRIP funding, ACOs must submit their Participation Plan, Budget, and Budget Narratives to MassHealth, and receive MassHealth approval. The Participation Plans must describe how the ACO will use DSRIP funding to support the transition to the new MassHealth ACO models.
- a. At a minimum, the Participation Plans must include the following sections: executive summary, patient and community population, partnerships, narrative, timeline, milestones and metrics, and sustainability.
 - b. The Budget is a line item budget for the ACO's proposed DSRIP-funded investments and programs; the accompanying Budget Narrative explains uses of the funds. See DSRIP Protocol for more details about the Participation Plans and Budgets.
 - c. **MassHealth Review and Approval:** MassHealth must review the ACO Participation Plans, Budgets, and Budget Narratives and notify ACOs of approval.
 - d. **Participation Plan, Budget, and Budget Narrative Modification Process.** An ACO or CP may request modifications to its Participation Plan, Budget, and Budget Narrative by submitting a request for modification to MassHealth in writing.
 - e. MassHealth will provide CMS with approved Participation Plans upon request.

DSRIP Investment Domains

60. **Accountable Care Organizations.** The Commonwealth will provide DSRIP investment funds to its contracted ACOs, which are generally provider-led health systems or organizations that focus on integration of physical health, Behavioral Health, Long Term Services and Supports, and social service needs; ACOs will be financially accountable for the cost and quality of their members' care. MassHealth's ACO models are described in STC 43 above.
- a) **Eligibility:** ACO entities that are eligible to receive DSRIP payments from MassHealth are entities that have signed contracts to be MassHealth ACOs (i.e., Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs).
 - b) **Funding Use:** MassHealth may pay ACOs under the DSRIP expenditure authority for the following:
 - i. ACO startup/ongoing support
 - ii. Support for flexible services. These services will be delineated in the post-approval Flexible Services Protocol. The Commonwealth will submit the protocol for CMS review and approval by May 2017. The protocol will include eligibility criteria and service definitions, payment methodologies, specific interventions, a description of the methodology used to identify the target population(s) including data analyses and a needs assessment of the target population, the nature of the individualized determination that would need to be made to determine potential for institutional placement and description of services that will be made available to beneficiaries including medical, behavioral, social and non-medical services. Flexible services include:
 1. Transition services for individuals transitioning from institutional settings into community settings consistent with the guidance provided on the provision of

- transition services as a home and community based service.
2. Home and Community-Based Services to divert individuals from institutional placements.
 3. Services to maintain a safe and healthy living environment.
 4. Physical activity and nutrition.
 5. Experience of violence support.
 6. Other individual goods and services.
 - a) Address medical needs and provide direct benefit and support specific outcomes that are identified in the individual waiver participant's care plan; and
 - b) Promote the delivery of covered services in community settings;
 - c) Decrease the need for other Medicaid services;
 - d) Reduce the reliance on paid support; or
 - e) Are directly related to the health and safety of the member in his/her home or community; or
 - f) Satisfy the other criteria listed below
- iii. These flexible services must satisfy the following criteria:
1. Must be health-related
 2. Not covered benefits under the MassHealth State Plan, the 1115 demonstration Expenditure Authority, or a home and community based waiver the member is enrolled in.
 3. Must be consistent with and documented in member's care plan
 4. Determined to be cost effective services that are informed by evidence that the service is related to health outcomes.
 5. May include, but are not limited to, classes, programs, equipment, appliances or special clothing or footwear likely to improve health outcomes, prevent or delay health deterioration.
 6. Other criteria established by MassHealth. And approved by CMS
- c) Limitations on FFP for Flexible Services: The state must provide detailed information, as part of its quarterly report, on the exact flexible service, number and dollar amounts provided by each ACO and CP during the quarter. If during the course of the demonstration CMS finds that flexible services provided by an ACO or CP are outside of the scope of the STCs or other CMS federal policy guidance, CMS reserves the right to modify and/or terminate the expenditure authority for flexible services only.
- d) Additional Limitations on Flexible Services. Flexible service dollars may not be used to fund or pay for the following: (Section 5.1 of MassHealth Proposal for *Integration of Social Needs and MassHealth Reform and Flexible Services Funding*)
- i. State Plan, 1115 demonstration services, or services available through a Home and Community Based waiver in which the member is enrolled
 - ii. Services that a member is eligible to receive from another state agency
 - iii. Services that a member is eligible for, *and able to*, receive from a publically funded program (recognizing that certain public programs, periodically run out of funds)
 - iv. Services that are duplicative of services a member is already receiving

- v. Services where other funding sources are available.
 - vi. Alternative medicine services (e.g., reiki)
 - vii. Medical marijuana
 - viii. Copayments
 - ix. Premiums
 - x. Ongoing rent or mortgage payments
 - xi. Room and board, including capital and operational expenses of housing
 - xii. Ongoing utility payments
 - xiii. Cable/television bill payments
 - xiv. Gift cards or other cash equivalents
 - xv. Student loan payments
 - xvi. Credit card payments
 - xvii. Memberships not associated with one of the allowable domains
 - xviii. Licenses (drivers, professional, or vocational)
 - xix. Services outside of the allowable domains. For example:
 - xx. Educational supports
 - xxi. Vocational training
 - xxii. Child care not used to support attendance of medical or other health-related appointments
 - xxiii. Social activities not related to the health of an individual
 - xxiv. Hobbies (materials or courses)
 - xxv. Clothing (beyond specialized clothing necessary for fitness)
 - xxvi. Auto repairs not related to accessibility
- e) Transitional “glide path” funding for DSTI safety net hospitals: This funding will only be available to ACOs that include a DSTI safety net hospital, and is allocated according to a MassHealth-determined schedule that was developed based on negotiations with CMS regarding the overall funding glide path for DSTI hospitals, inclusive of other funding streams.
- f) At-Risk DSRIP Funding: A portion of DSRIP ACO startup/ongoing funds and glide path funding will be at-risk. An ACO’s DSRIP Accountability Score will determine the amount of at-risk funding that is earned (STC 67).
- g) Funding Methodology: The amount of DSRIP payments MassHealth provides to an ACO will be the summed amount of the three funding streams described in these STCs. An ACO’s DSRIP funding allocation for startup/ongoing support and for flexible services will be determined by multiplying the number of lives attributed to the ACO by a per member per month (PMPM) rate. DSTI Glide Path funding will be based on a schedule determined by MassHealth for each specific DSTI hospital.
- h) Startup/ongoing support: The PMPM amount for startup/ongoing funds decreases over the five year period, and will vary for each ACO, depending on the ACO’s payer revenue mix and the ACO model and risk track selected, as determined by MassHealth.
- i) Flexible services support: The PMPM amount for flexible services decreases over the DSRIP period, and is the same for every ACO.

- j) **Sustainability.** The base PMPMs used to calculate payment amounts will decrease over the five years so as to avoid a funding cliff at the end of the DSRIP program. At that point, ACOs will be required to absorb incremental costs associated with new care expectations under TCOC management.

61. **Assessments and Person-Centered Planning for LTSS.** Consistent with the requirements at 42 CFR 438.208(b), the state will develop methods to identify members enrolled in MCO-based delivery systems and Primary Care ACOs who have LTSS needs. The state will establish policies for the scope of services MassHealth MCOs, Partnership Plans, and Primary Care ACOs must include in assessments and person-centered care plans to reflect the phasing in of LTSS accountability over the duration of the Demonstration. Where MassHealth MCOs, Partnership Plans, and Primary Care ACOs are accountable for members' LTSS needs, or as otherwise defined by the state, enrollees with LTSS needs in these delivery systems will have comprehensive assessments and person-centered care plans.

- a) **Assessments.** The state will develop policies and procedures to ensure comprehensive assessments are completed for members enrolled in MCO-based delivery systems and Primary Care ACOs with identified LTSS needs. MassHealth MCOs, Partnership Plans, and Primary Care ACOs will be responsible for comprehensively assessing each enrollee with LTSS needs, consistent with the requirements at 42 CFR 438.208(c)(2). MassHealth will develop and set standards to ensure assessments of LTSS needs are independent, as described in STC 61(c) below.
- b) **Person-Centered Planning.** MassHealth MCO, Partnership Plan, and Primary Care ACO enrollees with identified LTSS needs will have a person-centered care plan maintained at the MassHealth MCO, Partnership Plan, or Primary Care ACO, consistent with the requirements at 42 CFR 438.208(c)(3). Person-centered planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level and support systems. The person-centered plan will be developed by a person trained in person-centered planning using a person-centered process and plan with the enrollee, the assistance of the enrollee's providers, and those individuals the enrollee chooses to include. The plan will include the services and supports that the enrollee needs. The plan will be reviewed and revised upon reassessment of functional need, at least every 12 months, if the enrollee's needs change significantly, or at the request of the enrollee. Person-centered plans will be developed in accordance with 42 CFR 441.301(c)(4)(F)(1) through (8).
- c) **Avoiding Conflict of Interest for LTSS.** EOHHS will establish policies and procedures to ensure that individuals with LTSS needs enrolled in MassHealth MCOs, Partnership Plans, and Primary Care ACOs receive independent LTSS assessments.

Providers of facility- or community-based LTSS may not conduct LTSS needs assessments, except as explicitly permitted and monitored by the state (e.g. because a provider has select expertise, or is the only qualified and willing entity available). In such circumstances, the state will require that the provider entity establish a firewall or other appropriate controls in order to mitigate conflict of interest. An organization providing only evaluation, assessment, coordination, skills training, peer supports, and Fiscal Intermediary services will not be

considered a provider of LTSS.

62. **Independent Consumer Support Program.** To support the beneficiary's experience receiving services in an MCO or ACO environment, the state shall create and maintain a permanent independent consumer support program to assist those beneficiaries in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.
- a) **Organizational Structure.** The Independent Consumer Support Program shall operate independently from any MCO or ACO. Additionally, to the extent possible, the program shall also operate independently of the state Medicaid agency.
 - b) **Accessibility.** The services of the Independent Consumer Support Program shall be available to all Medicaid beneficiaries enrolled in an MCO or an ACO and must be accessible through multiple entryways (e.g., phone, internet, office) and also provide outreach in the same manner as appropriate.
 - c) **Functions.** The Independent Consumer Support Program shall assist beneficiaries to navigate and access covered services, including the following activities:
 - i. Offer beneficiaries support in the pre-enrollment state, such as unbiased health plan choice counseling and general program-related information.
 - ii. Serve as an access point for complaints and concerns about health plan enrollment, access to services and other related matters.
 - iii. Help enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level, and assist them through the process if needed/requested.
 - iv. Conduct trainings with MCO and ACO providers on community-based resources and supports that can be linked with covered plan benefits.
 - d) **Staffing.** The Independent Consumer Support Program must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs.
 - e) **Data Collection and Reporting.** The Independent Consumer Support Program shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly.
 - f) **Geographic expansion of ACO.** In any geographic location where the state is operating an ACO or where ACO may enroll into an ACO, the state must have the Independent Consumer Support Program in place at least 30 days prior to enrollment procedures for that geographic location.

63. **Community Partners.** Certified Community Partners (CPs) are community-based organizations that offer members linkages and support to community resources that facilitate a coordinated, holistic approach to care.

Behavioral Health (BH) CPs are responsible for providing services for members (adults and children) with serious mental illness (SMI), serious emotional disturbance (SED), and/or serious and persistent substance use disorder (SUD).

Long Term Services and Supports (LTSS) CPs are responsible for providing services to support members with LTSS needs including physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD).

- a. Eligibility: Entities that are eligible to receive DSRIP funding are entities that have been certified by MassHealth and have signed contracts to be MassHealth BH CPs or MassHealth LTSS CPs and have executed contracts with ACOs or MCOs.
- b. Funding Use: Community Partners DSRIP funding uses depends on whether the organization is a BH CP or LTSS CP
 - i. A BH CP may utilize DSRIP funding for the following purposes. The CP may not bill Mass Health, MCOs or ACOs for services funded through DSRIP:
 - ii. Provision of person-centered care management, assessments, care coordination and care planning, including but not limited to:
 1. Screening to identify current or unmet BH needs
 2. Review of members' existing assessments and services
 3. Assessment for BH related functional and clinical needs
 4. Care planning
 5. Care management
 6. Care coordination
 7. Managing transitions of care
 8. Member engagement outside of existing care provision (e.g., adherence, navigation)
 9. Member and family support
 10. Health promotion
 11. Navigation to and engagement with community resources and social services providers
 12. Other activities to help promote integration across physical health, behavioral health, LTSS and health-related social needs for BH CP members, as agreed upon by the care team
 - iii. The CP may not bill Mass Health, MCOs or ACOs for services funded through DSRIP. An LTSS CP may utilize DSRIP funding for the following purposes, including but not limited to:
 1. LTSS assessments and counseling on available options
 2. Support for person-centered care management, care plan support and care coordination activities, including but not limited to:

3. Screening to identify current or unmet LTSS needs
4. Review of members' existing LTSS assessment and current LTSS services
5. Independent assessment for LTSS functional and clinical needs
6. Choice counseling including navigation on LTSS service options and member education on range of LTSS providers
7. Care transition assistance
8. Provide LTSS-specific input to the member care plan and care team
9. Coordination (e.g., scheduling) across multiple LTSS providers; coordination of LTSS with medical and BH providers/services as appropriate
10. Member engagement regarding LTSS
11. Health promotion
12. Other activities to help promote integration across physical health, behavioral health, LTSS and health-related social needs for LTSS CP members, as agreed upon by the care team

iv. Infrastructure and capacity building

- c. At-Risk DSRIP Funding: A portion of DSRIP Community Partners funding will be at-risk. A CP's DSRIP Accountability Score will determine the amount of at-risk funding that is earned (see Section 7.vii).
- d. Funding Methodology: The amount of MassHealth's DSRIP payment any CP receives will be based on the total number of members that the CP serves each DSRIP year, as well as other funding methodologies, such as a needs-based grant program for infrastructure and capacity building support. DSRIP payments will be adjusted for at-risk performance.
- e. Sustainability. MassHealth will evaluate the Community Partners program to assess whether the program should be continued after the DSRIP period concludes. If MassHealth determines that the CP program should continue, then it will work to identify other funding sources to support the CP program, such as contributions from the budgets of ACOs/MCOs.

64. **ACO & CP Reporting Requirements.** ACOs and CPs must submit semiannual progress reports, including expenditures for the semiannual periods upon which the semiannual progress reports are based

- a) ACOs must also annually submit clinical quality data to the Commonwealth for quality evaluation purposes; and their ACO revenue payer mix, for safety net categorization purposes
- b) CPs must also annually submit clinical quality data to the Commonwealth for quality evaluation purposes
- c) State Reporting to CMS. The State must compile ACO and CP quarterly operational reports to submit to CMS as part of the broader 1115 demonstration quarterly reports.
- d) State Reporting to External Stakeholders and Stakeholder Engagement. The State must compile public-facing annual reports of ACO and CP performance.
 - i. The State must give stakeholders an opportunity to provide feedback on reports
 - ii. The State must allow for stakeholder engagement through meetings, access to web resources, and opportunities to provide feedback.

65. ACO Accountability to the State.

- a) ACO DSRIP Accountability Score: The amount of at-risk funding earned by an ACO will be determined by an ACO's DSRIP accountability score, which is based on performance in the following two domains:
 - i. ACO Total Cost of Care (TCOC) Performance
 - ii. ACO Quality and Utilization Performance
- b) Additional Accountability Considerations.
 - i. If an ACO performs below a MassHealth-determined performance threshold for two consecutive years, MassHealth may increase the proportion of DSRIP funds at risk for that ACO in the following year.
 - 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.
- c) CP DSRIP Accountability Score: The amount of at-risk funding earned by a CP will be determined by a CP's DSRIP accountability score, which will be based on performance in the following domains: CP quality and member experience measures; progress towards integration across physical health, LTSS and behavioral health; and efficiency measures. See DSRIP Protocol for information about CP Accountability to the State

66. Statewide Investments: Statewide investments allow the Commonwealth to efficiently scale up statewide infrastructure and workforce capacity. These Statewide investments are limited to those provided for by the DSRIP funding pool, and specified in the DSRIP protocol.

- a.) Massachusetts will make eight different statewide investments to efficiently scale up statewide infrastructure and workforce capacity, including the following:
 - i. Student Loan Repayment: program which repays a portion of a student's loan in exchange for a two year commitment (or equivalent in part-time service) as a (1) primary care provider at a community health center; or (2) behavioral health professional or licensed clinical social worker at a community health center, community mental health center, or an Emergency Service Program (ESP).
 - ii. Primary Care Integration Models and Retention: program that provides support for community health centers to allow primary care providers to engage in one-year projects related to accountable care implementation
 - iii. Investment in Primary Care Residency Training: program to help offset the costs of community health center residency slots for both community health centers and hospitals
 - iv. Workforce Development Grant Program: program to support health care workforce development and training to more effectively operate in a new health care system
 - v. Technical Assistance: program to provide technical assistance to ACOs, CPs, or their contracted social service organizations as they participate in payment and care delivery reform
 - vi. Alternative Payment Methods (APM) Preparation Fund: program to support providers that are not yet ready to participate in an ACO, but want to take steps towards APM adoption
 - vii. Enhanced Diversionary Behavioral Health Activities: program to support investment in

new or enhanced diversionary levels of care that will meet the needs of patients with behavioral health needs at risk for ED boarding within the least restrictive, most clinically appropriate settings

- viii. Improved accessibility for people with disabilities and for whom English is a Second Language: programs to assist providers in delivering necessary equipment and expertise to meet the needs of person with disabilities and those for whom English is not their primary language
 - ix. Information Domains for Each Statewide Investment: The DSRIP Protocol will provide additional information for each statewide investment regarding the following domains (at a minimum):
 - 1. Eligibility for funding
 - 2. Amount of funding available
 - 3. Allowable funding uses
 - 4. Obligations for entities receiving funding support through the statewide investments
- b.) State Operations and Implementation. DSRIP expenditure authority includes necessary state operations and implementation support to help administer and provide robust oversight for the DSRIP program including state employees and vendors to provide the following support:
- i. ACO and CP administration, oversight, and operational support
 - ii. Statewide investments administration, oversight, and operational support
 - iii. DSRIP program support (e.g. project management, communications, evaluation and reporting)

67. State DSRIP Accountability to CMS

- a) At-Risk DSRIP Funding: A portion of the State’s DSRIP expenditure authority will be at-risk. If MassHealth’s DSRIP expenditure authority is reduced based on an Accountability Score that is less than 100%, then MassHealth will reduce future DSRIP payments in proportion to the reduced expenditure authority to ensure sufficient state funding to support the program. This mechanism ensures that all recipients of MassHealth DSRIP funding are accountable to the State achieving its performance commitments.
- b) The portion of the State’s DSRIP expenditure authority that is at-risk will follow the same at-risk Budget Period structure as for the ACOs and CPs. The Budget Period is January 1 through December 31. The 6 month Preparation Budget Period funds will be equal to half of the State’s allocated DSRIP Year 1 funds. Budget Period 1 funds will be equal to the sum of half of the State’s allocated DSRIP Year 1 funds, and half of DSRIP 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 equal to half of the State’s allocated DSRIP Year 5 funds. In the Preparation Budget Period and Budget Period 1, 0% of funds will be at-risk. However, in Budget Periods 2 through 5, the portion of at-risk expenditure authority follows the table below:

DSRIP Budget Period	Prep BP and BP 1 July 1, 2017 – December 31, 2018	BP 2 January 1, 2019- December 31, 2019	BP 3 January 1, 2020- December 2020	BP 4 January 1, 2021- December 31, 2021	BP 5 January 1, 2022- December 31, 2022
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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

- c) State DSRIP Accountability Score: The State will calculate the State’s DSRIP Accountability Score. See DSRIP Protocol 10.1.1. The State DSRIP Accountability will be based on performance in the following domains:
- i. MassHealth ACO/APM Adoption Rate
 - ii. Reduction in State Spending Growth
 - iii. ACO Quality and Utilization Performance

Each domain will be assigned a domain weight for each performance year, such that the sum of the domain weights is 100% each year. State performance in each domain will be multiplied by the associated weight, and then summed together to create an aggregate score, namely the State’s DSRIP Accountability Score. The State will report its Accountability Score to CMS once it is available, and the score will then be used by the State and CMS to determine whether the State’s DSRIP expenditure authority might be reduced.

- d) Corrective Action Plan. In the event that the State does not achieve a 100% DSRIP Accountability Score, the State will provide CMS with a Corrective Action Plan including steps the State will take to regain any reduction to its DSRIP expenditure authority; and potential modification of accountability targets. The State’s Corrective Action Plan will be subject to CMS approval.
- e) MassHealth ACO/APM Adoption Rate. The State will have target percentages for the number of MassHealth ACO-eligible lives served by ACOs or who receive services from providers paid under APMs. The State will calculate the percentage of ACO-eligible lives served by ACOs or who receive services from providers paid under APMs. The State must meet or surpass its targets in order to earn a 100% score on this domain. If the State does not meet the target, then it will earn a 0% score for that Budget Period.
- f) Reduction in State Spending Growth. The State and CMS will work together to agree to a detailed methodology for calculating the State’s reduction in spending growth. In general, the State will, by CY2022, be accountable to a 2.5% reduction in PMPMs for the ACO-enrolled population, off of “trended PMPMs” (described below). The State’s trend line over the course of the DSRIP program will be 5.3% annually, which is the “without waiver” trend rate calculated by CMS based on the National Health Expenditures per capita data, this trend rate will be applied to the base PMPM rate in CY2017 (i.e. pre-ACO). The trend will be compounded over the five Budget Periods, and the

percent reduction will be determined according to the following calculation: percent reduction = (trended PMPM minus actual PMPM) / (trended PMPM). Prior to CY2022, the State will have target reductions smaller than 2.5% off of the trended PMPM.

Prior to CY2019, spending reduction targets will be adjusted to reflect CY2017 baseline performance. In the detailed methodology that CMS and the State will agree to, these measurements of PMPM spend will:

- i. Be for the ACO-enrolled population
- ii. For the population enrolled in MCO-Administered ACOs, be based on actual MCO expenditures for services to the population attributed to the ACO (categories to be agreed upon by CMS and the State), and not on the State's capitated payments to the MCO
- iii. Include reductions in DSTI supplemental payments to safety net hospitals
- iv. Exclude Hepatitis C drugs, other high-cost emerging drug therapies (such as cystic fibrosis drugs and biologics), long-term services and supports (LTSS) costs, and other potential categories agreed upon by CMS and the State
- v. Allow for adjustments based on changes in population or acuity mix
- vi. Allow for adjustments based on higher than anticipated growth in MassHealth spending due to economic conditions in the state or nationally, or other reasons as agreed upon by CMS and the State.

g) Gap to Goal Methodology. CMS and the State will agree on the detailed methodology two quarters before CY2018. The State will calculate its performance compared to the trended PMPM, and the domain score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed below:

- i. If Actual Reduction < (50% * Reduction Target), then Measure Score = 0%
- ii. If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
- iii. If Actual Reduction ≥ (50% * Reduction Target) AND < (Reduction Target), then Measure Score is equal to: (Actual Reduction - (50% * Reduction Target)) / (Reduction Target - (50% * Reduction Target))

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

h) Overall Statewide Quality and Utilization Performance. MassHealth will annually calculate the State performance score for each quality and utilization domain by aggregating the performance scores of all ACOs on a weighted basis. That is, ACOs with more members will have their domain performance scores weighted more heavily than ACOs with fewer members. See DSRIP Protocols Section 10.1.2.3 for weighted domains. Domains include:

- i. Prevention & Wellness
- ii. Chronic Disease Management
- iii. Behavioral Health/Substance Use
- iv. Long Term Services and Supports
- v. Avoidable Hospital Utilization
- vi. Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-

- Related Social Services
- vii. Member Care Experience

i) Scoring for All Domains Except Avoidable Hospital Utilization. For all domains except the Avoidable Hospital Utilization domain, the State will calculate two scores:

- i. **Aggregate domain score** – the domain score calculated by aggregating scores from all ACOs
- ii. **DSRIP domain score** – the domain score used in the calculation of the State DSRIP Accountability Score; dependent on how aggregate domain scores compare to pooled scores in all previous DSRIP Budget Periods

Using the Prevention & Wellness (P&W) domain in the second performance year (PY2) as an example:

- iii. If the P&W aggregate domain score in PY2 **is not** statistically worse (i.e. comparable or statistically better) than the P&W aggregate domain score in PY1, then the PY2 P&W DSRIP domain score is 100%
- iv. If the P&W aggregate domain score in PY2 **is** statistically worse than the P&W aggregate domain score in PY1, then the PY2 P&W DSRIP domain score is 0%

Using the Prevention & Wellness (P&W) domain in PY4 as an example:

- v. If the P&W aggregate domain score in PY4 **is not** statistically worse (i.e. comparable or statistically better) than the pooled P&W aggregate domain scores in PY1 through PY3, then the PY4 P&W DSRIP domain score is 100%
- vi. If the P&W aggregate domain score in PY4 **is** statistically worse than the pooled P&W aggregate domain scores in PY1 through PY3, then the PY4 P&W DSRIP domain score is 0%

j) Domain Scoring for Avoidable Hospital Utilization. Given the importance of reducing avoidable hospital utilization, the State will commit to specific reduction targets for ACO-enrolled members. As such, a separate domain scoring mechanism is required for this measure.

- i. Performance will be evaluated on two measures:
 - 1. Potentially preventable admissions (3M's PPA measure)
 - 2. Hospital all-cause readmissions (NQF #1789)
- ii. The reduction targets for the two measures:
 - 1. Apply to the ACO-enrolled population
 - 2. Will be with respect to baseline performance in CY2017
 - 3. Will be based not on raw admissions or readmissions events, but instead on risk-adjusted actual-to-expected event ratios
 - 4. Were determined based on state baseline performance compared to other states, and statewide reduction targets established in other states
 - 5. Will each contribute 50% to the State's performance in this domain

Prior to CY2019, these avoidable utilization reduction targets will be adjusted to reflect

CY2017 baseline performance. The State will calculate the percent reduction for each measure, and compare actual performance to the reduction targets. Each measure's score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed below:

- iii. If Actual Reduction $< (50\% * \text{Reduction Target})$, then Measure Score = 0%
- iv. If Actual Reduction $\geq (\text{Reduction Target})$, then Measure Score = 100%
- v. If Actual Reduction $\geq (50\% * \text{Reduction Target})$ AND $< (\text{Reduction Target})$, then Measure Score is equal to: $(\text{Actual Reduction} - (50\% * \text{Reduction Target})) / ((\text{Reduction Target} - (50\% * \text{Reduction Target}))$ For example, if the State achieves less than 50% of the Reduction Target, then the measure score will be equal to 0%. If the State achieves 75% of the Reduction Target, then the measure score will be equal to $(75\% - 50\%) / (100\% - 50\%) = 50\%$

k) Overall Quality and Utilization Domain Score. The overall DSRIP quality and utilization domain score will be determined by calculating a weighted sum of the domain scores.

68. **State Public Outreach for ACO Expansion.** To provide and demonstrate seamless transitions for MCO and ACO enrollees, the state must (where applicable):

- a) Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.
- b) Provide continued comprehensive outreach, including educational tours for enrollees and providers. Education for enrollees and providers should include plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g. state's website). The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.
- c) Operate a call center independent of the PCC, ACO, and MCO plans. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 days, if all entities are consistently meeting contractual requirements the state can decrease the frequency of the review of call center statistics, but no more than 120 days should elapse between reviews.
- d) The state will provide language assistance, including in written materials, in accordance with Section 1557 of the Affordable Care Act.
- e) Member materials sent to beneficiaries will be culturally competent, and the state will provide culturally competent and available translation and navigation services. The state will make available navigation resources upon beneficiary request.

69. **CMS Evaluation of State.**

- a) Assessment of Performance, and Interim Evaluation. A mid-point assessment of the DSRIP program will be completed by an independent evaluator that will be procured by MassHealth using DSRIP expenditure authority. The midpoint assessment will provide an independent analysis of the DSRIP program through December 2020, using both quantitative and qualitative methodologies, to evaluate whether the investments made through the DSRIP program have contributed to achieving the demonstration goals as described in STC 57. The results from the midpoint assessment will be used to develop an interim evaluation of the DSRIP program, which will be submitted to CMS by the end of June 2021.
- b) Final Evaluation. A final evaluation of the DSRIP program will be conducted by an independent evaluator. 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 made contributed to achieving the demonstration goals as described in STC 57. The final evaluation will be submitted to CMS by the end of June 2024.

70. **Independent Assessor.** The state will identify independent entities with expertise in delivery system improvement to assist with DSRIP administration, oversight and monitoring, including an independent assessor and/or evaluator. An independent assessor will review ACO and CP proposals, progress reports and other related documents, to ensure compliance with approved STCs and Protocols, provided that initial ACO and CP proposals are not subject to review from the independent assessor. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to plans to make them approvable. This entity (or another entity identified by the state) will also assist with the progress reports and mid-point assessment and any other ongoing reviews of DSRIP project plan; and assist with continuous quality improvement activities. Expenditures for the independent assessor are administrative costs the state incurs associated with the management of DSRIP reports and other data.

The state must describe the functions of each independent entity and their relationship with the state as part of its Quarterly report requirements.

Spending on the independent entities and other administrative cost associated within the DSRIP fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the DSRIP Fund.

71. **DSRIP Advisory Committee.** The state will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement, and clinical data used in performance improvement initiatives, quality, and best practices.

Final decision-making authority will be retained by the state and CMS, although all recommendations of the committee will be considered by the State and CMS.

Specifically, the Committee will provide feedback to the state regarding:

- i. Selection of additional metrics for providers that have reached baseline performance thresholds or exceeded performance targets
- ii. Assessing the effectiveness of cross-cutting measures, to understand how aspects of one system are effecting the other. For example, are BH/SUD/LTSS performance focus areas effecting physical health outcomes?
- iii. Alignment of measures between systems with purpose, to enable the state to assess the effectiveness in their outcomes across systems
Identify actionable new areas of priority,
- iv. Make systems-based recommendations for initiatives to improve cross-cutting performance.

a.) Composition of the Committee

The membership of the committee must consist of between nine to fifteen members with no more than three members employed by Massachusetts hospitals, ACOs or Community Partners. All members will be appointed by MassHealth based on the following composition criteria:

- i. Representation from community health centers serving the Medicaid population.
- ii. Clinical experts in each of the following specialty care areas: Behavioral Health, Substance Use Disorder, and Long Term Services & Supports. Clinical experts are physicians, physician assistants, nurse practitioners, licensed clinical social workers, licensed mental health counselors, psychologists, and registered nurses.
- iii. At least 30% of the members must have significant expertise in clinical quality measurement of hospitals, primary care providers, community health centers, clinics and managed care plans. Significant expertise is defined as not less than five years of recent full time employment in quality measurement in government service or from companies providing quality measurement services to above listed provider types and managed care plans.
- iv. Advocacy Members: Consumers or consumer representatives, including at least one representative for people with disabilities and, separately, at least one representative for people with complex medical conditions,
- v. Members must agree to recuse themselves from review of specific DSRIP matters when they have a conflict of interest. MassHealth shall develop conflict of interest guidelines.

72. **SNCP Additional Reporting Requirements.** All SNCP expenditures must be reported as specified in section XII, STC 89. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

- a) Charts A – B of Attachment E. The Commonwealth must submit to CMS for approval, updates to Charts A – B of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Years (SFYs) 2017-2022, and identify the non-federal share for each line item, no later than 45 business days after enactment of the State budget for each SFY. CMS shall approve the Commonwealth’s projected SNCP payments and expenditures within 30 business days of the Commonwealth’s submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 52.

Before it can claim FFP, the Commonwealth must notify CMS and receive CMS approval, for any SNCP payments and expenditures outlined in Charts A-B of Attachment E that are in excess of the approved projected SNCP payments and expenditures by a variance greater than 10 percent. Any variance in SNCP payments and expenditures must adhere to the SNCP expenditure limits pursuant to STC 52. The Commonwealth must submit to CMS for approval updates to Charts A – B that include these variations in projected SNCP payments and expenditures. CMS shall approve the Commonwealth’s revised projected SNCP payments and expenditures within 30 business days of the Commonwealth’s submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 52.

The Commonwealth must submit to CMS for approval updates to Charts A – B of Attachment E that reflect actual payments and expenditures for each SFY, within 180 calendar days after the close of the SFY. CMS shall approve the Commonwealth’s actual SNCP expenditures within 45 business days of the Commonwealth’s submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in STC 52.

The Commonwealth must submit to CMS for approval further updates to any or all of these charts as part of the quarterly operational report and at such other times as may be required to reflect projected or actual changes in SNCP payments and expenditures. CMS must approve the Commonwealth’s updated charts within 45 business days of the Commonwealth’s submission of the update, provided that all SNCP payments and expenditures are within the applicable limits specified in STC 51.

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

- b) DSHP Reporting for Connector Care. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 79. This data must, at a minimum, include:
 - 1) The number of individuals served by the program;
 - 2) The size of the subsidies; and
 - 3) A comparison of projected costs with actual costs.
- c) DSRIP Reporting: DSRIP reporting is required as specified in Section X and the approved DSRIP Protocol.

IX. GENERAL REPORTING REQUIREMENTS

- 73. **Submission of Post-approval Deliverables**. The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs (“deliverables”). The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

74. **Deferral for Failure to Provide Deliverables on Time.** The state agrees that CMS may require the state to cease drawing down federal funds until such deliverables are submitted in a satisfactory form, until the amount of federal funds not drawn down would exceed \$5,000,000. Specifically:
- a. Thirty (30) calendar days after the deliverable was due, CMS is required to issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
 - b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps that the state has taken to address such issue, the estimated time for submission of the deliverable, and whether additional measures could be taken to expedite the schedule for such submission. CMS will only grant such a request if CMS finds that the state faced unforeseen circumstances, and has taken reasonable measures to submit the deliverable as soon as practicable. CMS could grant the requested extension in whole or in part. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
 - c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
 - d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
 - e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
 - f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.
75. **Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.
76. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully and timely with CMS and its contractors' evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required of the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral

being issued as outlined in STC 74.

77. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

X. MONITORING

78. **Quarterly and Annual Report Timelines.** The state must submit three Quarterly Reports and one compiled Annual Report each DY. The Quarterly Reports are due no later than 60 days following the end of each demonstration quarter. The compiled Annual Report is due no later than 90 days following the end of the DY.
79. **Quarterly and Annual Report Scope.** The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report. (Additional links not referenced in the document may be listed in a Reference/Bibliography section).
- a. **Quarterly and Annual Report Outline.** The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.
- i. **Operational Updates** – The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
 - ii. **Performance Metrics** – Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.
 - iii. **Budget Neutrality and Financial Reporting Requirements** – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

- iv. Evaluation Activities and Interim Findings – The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

80. **Additional Demonstration Annual Operational Report Requirements.** The Annual Report must include all items outlined in STC 79. In addition, the Annual Report must, at a minimum, include the requirements outlined below:

- i. All items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;
- ii. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
- iii. Total contributions, withdrawals, balances, and credits; and
- iv. Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

81. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

- a) The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration.
- b) CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
- c) The state and CMS will jointly develop the agenda for the calls.
- d) Areas to be addressed during the monitoring call include, but are not limited to:
 - i. Transition and implementation activities;
 - ii. Stakeholder concerns;
 - iii. QHP operations and performance;
 - iv. Enrollment;
 - v. Cost sharing;
 - vi. Quality of care;
 - vii. Beneficiary access;
 - viii. Benefit package and wrap around benefits;
 - ix. Audits;
 - x. Lawsuits;
 - xi. Financial reporting and budget neutrality issues;
 - xii. Progress on evaluation activities and contracts;
 - xiii. Related legislative developments in the state; and
 - xiv. Any demonstration changes or amendments the state is considering.

82. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the

planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XI. EVALUATION

83. **Independent Evaluator.** At the beginning of the demonstration period, the state must acquire an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made in advance of running any data or due to mid-course changes in the operation of the demonstration.
84. **Evaluation Design and Implementation.** The State shall submit a draft evaluation design for MassHealth 1115 Demonstration to CMS no later than 120 days after the award of the Demonstration extension. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the insert old demo name, if applicable. The state must submit a final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval. The state must implement the evaluation design and submit their evaluation implementation progress in each of the Quarterly and Annual Reports as outlined in STC 79.
- a) **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
 - b) **Cost-effectiveness.** While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the demonstration when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.
 - i. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

- ii. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the demonstration compared to what would have happened for a comparable population absent the demonstration.
 - iii. The state will compare total costs under the demonstration to costs of what would have happened without the demonstration. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.
 - iv. The State will compare changes in access and quality to associated changes in costs within the demonstration. To the extent possible, component contributions to changes in access and quality and their associated levels of investment will be determined and compared to improvement efforts undertaken in other delivery systems.
- c) **Evaluation Requirements.** The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.
- i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.
 - ii. The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.
- d) **Evaluation Design.** The Evaluation Design shall include the following core components to be approved by CMS:
- i. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

1. The formation of new partnerships and collaborations within the delivery system
2. The increased acceptance of TCOC risk-based payments among MassHealth providers
3. Improvements in the member experience of care, particularly through increased member engagement in the primary care setting or closer coordination among providers
4. Reductions in the growth of avoidable inpatient utilization
5. Reductions in the growth of TCOC for MassHealth’s managed care-eligible population

6. More robust EHR and other infrastructure capabilities and interconnectivity among providers
7. Increased coordination across silos of care (e.g., physical health, behavioral health, LTSS, social supports)
8. Maintenance or improvement of clinical quality
9. The enhancement of safety net providers' capacity to serve Medicaid and uninsured patients in the Commonwealth
10. The strength of aggregate provider networks in the ACO and MCO programs (excluding Primary Care ACOs) relative to the PCC Plan, in first three years of demonstration, including:
 - a) Types of providers
 - b) Breadth of providers
 - c) Quality of services
 - d) Outcomes of services

These hypotheses should be addressed in the demonstration reporting described in STC 84 with regard to progress towards the expected outcomes.

ii. Data: This discussion shall include:

1. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;
2. Method of data collection
3. Frequency and timing of data collection.

The following shall be considered and included as appropriate:

1. Medicaid encounters and claims data,
2. Enrollment data, and
3. Consumer and provider surveys

iii. Study Design: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

iv. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include

the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.

- v. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the State may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.
 - vi. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.
 - vii. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.
 - viii. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, and the deliverables outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.
 - ix. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.
 - x. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.
- e) **Interim Evaluation Report.** The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending June 30, 2022. The Interim Evaluation Report shall include the same core components as identified in STC 84 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 business days after receipt of CMS' comments.
- f) **Summative Evaluation Reports.**

- i. The state shall provide the summative evaluation reports described below to capture the demonstration period covered by this renewal.
 1. The state shall provide a Summative Evaluation Report (SER) for the demonstration period starting July 1, 2017 through June 30, 2022.
 - a) A preliminary draft of the SER is due within 180 calendar days of the end of this demonstration period. This report shall include documentation of outstanding assessments due to data lags to complete the interim evaluation.
 - b) The second of these is due within 500 calendar days of the end of this demonstration period. The state should respond to comments and submit the final SER within 30 calendar days after receipt of CMS' comments.

- ii. The Summative Evaluation Report shall include the following core components:
 1. **Executive Summary.** This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
 2. **Demonstration Description.** This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
 3. **Study Design.** This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.
 4. **Discussion of Findings and Conclusions.** This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
 5. **Policy Implications.** This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.
 6. **Interactions with Other State Initiatives.** This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

- g) **State Presentations for CMS.** The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 84. The State will present on its interim evaluation in conjunction with STC 84. The State will present on its summative evaluation in conjunction with STC

- h) **Public Access.** The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

XI. CLOSE OUT REPORTING

- 85. **Close out Reports.** Within 120 days prior to the end of the demonstration, the state must submit a Draft Final Operational Report and a Draft Final Evaluation to CMS for comments.
 - a) The draft final reports must comply with the most current Guidance from CMS, and include all components required in the approved Evaluation Design.
 - b) The state will present to and participate in a discussion with CMS on the Close-Out reports.
 - c) The state must take into consideration CMS' comments for incorporation into the final Close-Out Reports.
 - d) The Final Close-Out Reports are due to CMS no later than 30 days after receipt of CMS' comments.
 - e) A delay in submitting the draft or final versions of the Close-Out Reports could subject the state to penalties described above.

- 86. **Public Access.** The state shall post the final approved Annual Reports, Final Operational Report, Evaluation Design, Interim Evaluation Report(s), Summative Evaluation Report(s), and Final Evaluation Report on the state's Medicaid website within 30 days of approval by CMS.

- 87. **Presentations and Publications.** During the demonstration period, and for 24 months following the expiration of the demonstration, CMS will be provided with notification regarding the public release, presentation or publication of Interim, Summative, and/or Final Evaluations and Operational Reports.
 - 1. The state will make every effort to inform the CMS Project Officer, as far in advance as possible, of pending news articles or reports about the demonstration that are of a significant nature. A bibliographic reference of news articles and reports about the demonstration will be included in the next Quarterly Report.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

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

- 89. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
 - a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must

report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00030/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

- b) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- c) Pharmacy Rebates. When claiming these expenditures the Commonwealth may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf>). The Commonwealth must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

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

- d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the Commonwealth under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narr by demonstration year.
- e) Demonstration year reporting. Notwithstanding the two-year filing rule, the Commonwealth may report expenditures and adjustments to particular demonstration years as described below:
 - i. Beginning July 1, 2014 (SFY 2015/DY 18), all expenditures and adjustments for demonstration years 1-14 previously reported in sections i.-viii. will be reported as demonstration year 14, all expenditures and adjustments for demonstration years 15-17

will be reported as demonstration 17, and separate schedules will be completed for demonstration years 18, 19 and 20.

- ii. Beginning July 1, 2017 (SFY 2018/DY 21), all expenditures and adjustments for demonstration years 1-17 previously reported in sections i.-ix. will be reported as demonstration year 17, all expenditures and adjustments for demonstration years 18-20 will be reported as demonstration 20, and separate schedules will be completed for demonstration years 21, 22, 23, 24, and 25.

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

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

- 9) **1902 (r)(2) XXI RO:** Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted
- 10) **CommonHealth XXI:** Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted
- 11) **Fam Assist XXI:** Title XXI-eligible children through 200 percent of the FPL eligible for Family Assistance under the demonstration after the allotment is exhausted
- 12) **e-HIV/FA:** Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance
- 13) **SBE:** Subsidies or reimbursement for ESI made to eligible individuals
- 14) **SNCP-DSRIP:** Expenditures for Delivery System Reform Payments (DSRIP) for the period July 1, 2017 through June 30, 2022
- 15) **SNCP-PHTII:** Expenditures authorized under the Public Hospital Transformation and Incentives Initiative
- 16) **SNCP-DSH:** Expenditures authorized under the Disproportionate Share Hospital Pool
- 17) **SNCP-UCC:** Expenditures authorized under the Uncompensated Care Pool
- 18) **SNCP-OTHER:** All other expenditures authorized under the SNCP
- 19) **Asthma:** All expenditures authorized through the pediatric asthma bundled pilot program
- 20) **New Adult Group :** Report for all expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119
- 21) **Health Connector Subsidy:** Expenditures for subsidy wrap under the demonstration.
- 22) **Provisional Eligibility:** Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority
- 23) **TANF/EAEDC:** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children.

- 24) **End of Month Coverage:** Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.
- 25) **Continuous Eligibility:** Expenditures for continuous eligibility period up to 12 months for those enrolled in a student health insurance program.

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

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

- a) **Exhaustion of Title XXI Funds.** If the Commonwealth has exhausted title XXI funds, expenditures for these optional targeted low-income children may be claimed as title XIX expenditures as approved in the Medicaid state plan. The Commonwealth shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 89 (Reporting Expenditures Under the Demonstration).
- b) **Exhaustion of Title XXI Funds Notification.** The Commonwealth must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures.
- c) If the Commonwealth chooses to claim expenditures for **Base Families XXI RO, 1902(r)(2) RO, and CommonHealth XXI** groups under title XIX, the expenditures and caseload attributable to these EGs will:
 - i. Count toward the budget neutrality expenditure limit calculated under section XI, STC 107 (Budget Neutrality Annual Expenditure Limit); and
 - ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 107, so that the Commonwealth is not at risk for caseload while claiming title XIX federal matching funds when title XXI funds are exhausted.
- d) If the Commonwealth chooses to claim expenditures for **Fam Assist XXI** under title XIX, the

expenditures and caseload attributable to this EG will be considered expenditures subject to the budget neutrality agreement as defined in STC 107. The Commonwealth is at risk for both caseload and expenditures while claiming Title XIX federal matching funds for this population when title XXI funds are exhausted.

91. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term “expenditures subject to the budget neutrality agreement” means expenditures for the EGs outlined in section IV of the STCs, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.
92. **Premium Collection Adjustment.** The Commonwealth must include demonstration premium collections as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis on the CMS-64 Summary Sheet and on the budget neutrality monitoring workbook submitted on a quarterly basis.
93. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the Commonwealth must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
94. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the Commonwealth made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.
95. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:
 - a) For the purpose of calculating the budget neutrality agreement and for other purposes, the Commonwealth must provide to CMS, as part of the quarterly report required under STC 79, the actual number of eligible member months for the EGs 1-12 and EGs 20 - 22 and 25 defined in STC 89. The Commonwealth must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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

contribute two eligible member month to the total, for a total of four eligible member months.

96. Cost Settlement.

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

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

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

- a) Administrative costs, including those associated with the administration of the demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c) Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period, including expenditures under the Safety Net Care Pool.

99. **Sources of Non-Federal Share.** The Commonwealth provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The Commonwealth further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
- a) CMS may review at any time the sources of the non-federal share of funding for the demonstration. The Commonwealth agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
 - b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
 - c) The Commonwealth assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.
100. **State Certification of Funding Conditions.** The Commonwealth must certify that the following conditions for non-federal share of Demonstration expenditures are met:
- a) Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
 - b) To the extent, the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
 - c) To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies as allowable under 42 C.F.R. § 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;
 - d) The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from state or local monies and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
 - e) Under all circumstances, health care providers must retain 100 percent of the claimed

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

101. **Monitoring the Demonstration.** The Commonwealth will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.
102. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

103. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning July 1, 2017.
104. **Limit on Title XIX Funding.** Massachusetts will be subject to a limit on the amount of federal title XIX funding that the Commonwealth may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual DSH allotment that would have applied to the Commonwealth absent the demonstration (DSH allotment). Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the Commonwealth using the procedures described in section XII, STC 89. The data supplied by the Commonwealth to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Commonwealth's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.
105. **Risk.** Massachusetts shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Massachusetts will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Massachusetts at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.
106. **Expenditures Excluded From Budget Neutrality Test.** Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on

behalf of enrollees under age 65 who are institutionalized in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded, or a state psychiatric hospital for other than a short-term rehabilitative stay;

- b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient, and home and community-based waiver services, except pursuant to STC 105; For demonstration years 1 and 2, LTSS costs will be excluded from budget neutrality. Over the course of the demonstration, LTSS will be included no later than DY 24 into budget neutrality if MassHealth incorporates LTSS into managed care delivery models and TCOC for ACOs.
 - i. *Exception.* Hospice services provided to individuals in the MassHealth Basic and Essential programs are subject to the budget neutrality test.
- c) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement; and
- d) Allowable administrative expenditures.

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

- a) Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the Commonwealth under section XII, STC 89 for each EG, including the hypothetical populations, times the appropriate estimated per member/per month (PMPM) costs from the table in subparagraph (v) below;
 - ii. Starting in SFY 2006, actual expenditures for the CommonHealth EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline CommonHealth costs, or actual CommonHealth per member per most cost experience for SFYs2018-2022;
 - iii. The amount of actual expenditures included will be the lower of the trended baseline costs, or actual per member per most cost experience for each eligibility group in SFYs2018-2022;
 - iv. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior demonstration periods are provided in Attachment D; and
 - v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Group (EG)	Trend Rate	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
Mandatory and Optional State Plan Groups						
Base Families	3.8%	\$753.10	\$781.72	\$811.42	\$842.25	\$874.26
Base Disabled/MCB	4.0%	\$1,647.49	\$1,713.39	\$1,781.93	\$1,853.21	\$1,927.34
1902 (r) 2 Children	3.6%	\$597.02	\$618.51	\$640.78	\$663.85	\$687.75
1902 (r) 2 Disabled	3.6%	\$1,284.97	\$1,331.23	\$1,379.15	\$1,428.80	\$1,480.24
1902 (r) 2 BCCDP	3.6%	\$4,928.56	\$5,105.99	\$5,289.81	\$5,480.24	\$5,677.53
Hypothetical Populations*						
CommonHealth	4.4%	\$776.08	\$813.33	\$852.37	\$893.28	\$936.16

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

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

Eligibility Group (EG)	Trend Rate	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
<u>New Adult Group</u>	4.3 percent	\$561.68	\$585.83	\$611.02	\$637.29	\$664.70

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

c) The Supplemental Budget Neutrality Test is calculated by taking the PMPM cost

projection for the New Adult Group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap is obtained by multiplying total computable Supplemental Cap by the Composite Federal Share described in STC 109.

- d) The Supplemental Budget Neutrality Test is a comparison between the federal share of the Supplemental Cap and total FFP reported by the State for the New Adult Group.
- e) If total FFP for the New Adult Group should exceed the federal share of the Supplemental Budget Neutrality Test after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in STC 106.
- f) The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure limits. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the Commonwealth may receive for expenditures on behalf of demonstration populations as well as demonstration services described in Table B in STC 38 during the demonstration period.
- g) Limit B. The Commonwealth's annual DSH allotment.
- h) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) adjustment:

The Commonwealth must present to CMS for approval a draft evaluation plan outlining the methodology to track the following:

- 1) Baseline measurement of EPSDT service utilization prior to the EPSDT court-ordered remedial plan in *Rosie D. v Romney* (the Order) final judgment and final remedial plan established on July 16, 2007;
- 2) Increase, following entry of the Order, in utilization of :
 - a) EPSDT screenings;
 - b) Standardized behavioral health assessments utilizing the Child and Adolescent Needs and Strengths (CANS), or other standardized assessment tool in accordance with the Order; and
 - c) State plan services available prior to the entry of the Court Order.
- 3) Cost and utilization of services contained in State Plan amendments submitted by the Commonwealth in accordance with the Order and approved by CMS;

and

- 4) Methodology for tracking and identifying new EPSDT services for purposes of budget monitoring.

The draft evaluation plan with an appropriate methodology to track new EPSDT expenditures must be approved by CMS through the amendment process described in STC 7. Once an appropriate methodology to track new EPSDT expenditures is approved by CMS, these projected expenditures will be included in the expenditure limit for the Commonwealth, with an effective date beginning with the start of the new EPSDT expenditures, and reconciled to actual expenditure experience.

109. **1115A Duals Demonstration Savings.** When Massachusetts' section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the Duals demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the Duals Demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal. This evaluation of estimated and certified amounts of actual title XIX savings will reflect addendums and amendments to the 1115A Duals Demonstration contract and adjustment to the MassHealth Component of the capitation rate, including interim and final risk corridor settlements.

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

DY 1						
CCY 2015/ DY2 – Fallon Total Care (FTC)	\$1,000 PMPM	1.5%	\$15 PMPM	1,000	\$0	\$15 PMPM * 1,000 = \$15,000
CCY 2015/ DY 2 – One Care Plans other than FTC	\$1,000 PMPM	0%	\$15 PMPM	1,000	\$10,000	\$15 PMPM * 1,000 == 5,000
CCY 2016/ DY 3	\$1,000 PMPM	>40% (Per	\$40 PMPM	1,000		[\$40 PMPM 1,000 = = \$0

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

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

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

In each quarterly report, the Commonwealth must provide the information in the above- named

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

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

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

The Commonwealth must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A Duals demonstration. The Commonwealth may add columns to identify risk corridor payments and other adjustments in subsequent quarterly reporting. Note, the savings percentages may be updated in the Duals Demonstration contract, and the amount considered in the budget neutrality worksheets must reflect any adjustments, addendums, or amendments made in the Duals Demonstration contract.

110. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the Commonwealth on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C. with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

111. **Recognized Budget Neutrality Savings.**

- a) Beginning July 1, 2017 (SFY 2018/DY21), recognized budget neutrality savings is limited to savings realized beginning in July 1, 2011 (SFY 2012/DY 15). No deficit or savings is carried over from years prior to SFY 2012. Accordingly, the budget neutrality demonstration includes "with waiver" expenditures and "without waiver" expenditure limit calculations beginning in SFY 2012.
- b. Savings Phase-out: Beginning July 1, 2017 (SFY 2018/DY21), the net variance between the without-waiver cost and actual with-waiver cost will be reduced for selected Medicaid population based EGs. The reduced variance, to be calculated as a percentage of the total

variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) For the first five years that an eligibility group is enrolled in managed care savings are carried forward in full. For the first five years that a set of services (e.g. LTSS) is subject to managed care, savings are also carried forward in full. The formula for calculating the reduced variance is: reduced variance equals total variance times applicable percentage. The applicable percentages for each EG and DY are determined based how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer established managed care populations. The EGs affected by this provision and the applicable percentages are shown in the table below, except that if the total variance for an EG in a DY is negative, the applicable percentage is 100 percent.

EG	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
Base Families	25%	25%	25%	25%	25%
Base Disabled/MCB	25%	25%	25%	25%	25%
1902 (r) 2 Children	25%	25%	25%	25%	25%
1902 (r) 2 Disabled	25%	25%	25%	25%	25%
1902 (r) 2 BCCDP	25%	25%	25%	25%	25%

112. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the demonstration as adjusted July 1, 2008, rather than on an annual basis. However, if the Commonwealth exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the Commonwealth must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
DY 21	Cumulative budget neutrality limit plus:	2.0percent
DY 21 through DY 22	Cumulative budget neutrality limit plus:	1.5 percent
DY 21 through DY 23	Cumulative budget neutrality limit plus:	1.0 percent
DY 21 through 24	Cumulative budget neutrality limit plus:	.5 percent
DY 21 through 25	Cumulative budget neutrality limit plus:	0 percent

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

113. **Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end

of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 110, composite federal share ratio. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

114. **Budget Neutrality Monitoring Tool.** The state and CMS will jointly develop a budget neutrality monitoring tool (using a mutually agreeable spreadsheet program) for the state to use for quarterly budget neutrality status updates and other in situations when an analysis of budget neutrality is required. The tool will incorporate the Schedule C Report for monitoring actual expenditures subject to budget neutrality. A working version of the monitoring tool will be available for the state’s first Quarterly Progress Report in 2018.

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

116. **Treatment of DSH Allotment.** The amount of any DSH-like payments must be prorated if necessary so that DSH-like payments will not exceed the percentage of the DSH allotment corresponding to the percentage of the federal fiscal year for which payment of DSH-like payments is required).

XIV. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

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

Date – Specific	Deliverable	Section Reference
Within 120 days from the award of the demonstration	Draft Evaluation Design	Section X
Within 60 days of receipt of CMS comments	Final Evaluation Design and Implementation	Section X
Within 180 days after the expiration of the demonstration	Final Report	
Annually		

October 1 st	Draft Annual Report,	Section X
30 days of the receipt of CMS comments	Final Annual Report, including DSRIP, ACO, flexible services and expenditures.	Section X
No later than 45 days after enactment of the state budget for each SFY	Updates to Charts A-B of Attachment E that reflect projected annual SNCP expenditures and identify the non-Federal share for each line item	Section XIV, XV
No later than 45 days after enactment of the state budget for each SFY	Projected annual DSHP expenditures	Section XIV
180 days after the close of the SFY (December 31)	Updates to Charts A-B of Attachment E that reflect actual SNCP payments and expenditures	Section XIV, XV
Quarterly		
60 days following the end of the quarter	Quarterly Operational Reports, including DSRIP, ACO, Flexible Services and payments reporting and eligible member months	Section X
60 days following the end of the quarter	Quarterly Expenditure Reports	Section X

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

	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Unborn Targeted Low Income Child	0 through 200%	Uninsured	No (through December 31, 2013) Yes (effective January 1, 2014)	Separate XXI		Healthy Start (through December 31, 2013) Standard (effective January 1, 2014)	

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

Newborn Children Under age 1	AFDC-Poverty Level Infants 0 through 185%	Any	Yes	XIX via Medicaid state plan	<u>Base Families</u> <i>Without Waiver</i>	Standard	
	185.1 through 200%	Insured	Yes	XIX via Medicaid state plan	<u>1902(r)(2) Children</u> <i>Without Waiver</i>	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI Medicaid Expansion (via Medicaid state plan and XXI state plan) Funded through title XIX if XXI is exhausted	<u>1902(r)(2) XXI RO</u> <i>Without Waiver</i> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

This chart is provided for informational purposes only.

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

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Newborn Children Under Age 1 and Disabled	200.1-300%	Insured	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance with wraparound to direct coverage CommonHealth	
		Uninsured at the time of application	Yes (if XXI is exhausted)	Separate XXI Funded through XIX if XXI is exhausted via demonstration authority	<u>CommonHealth XXI</u> <i>Hypothetical</i> (member months and expenditures for these children are only reported if XXI)	CommonHealth	The CommonHealth program was in existence prior to the separate XXI Children’s Health Insurance Program and was not affected by the maintenance of effort date. The

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

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

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

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

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

	Age 6 through 17: 0 through 114% Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets						
	AFDC-Poverty Level Children Age 6 through 17: 114.1% through 133% Age 18: 0 through 133%	Insured	Yes	XIX	<u>Base Families</u> <i>Without waiver</i>	Standard	
		Uninsured	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	<u>Base Fam XXI</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

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

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

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

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

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

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

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

Children Aged 1 through 18 and Disabled	150.1 through 300%	Insured	Yes	XIX via demonstration authority only	<p style="text-align: center;"><u>CommonHealth</u></p> <p style="text-align: center;"><i>Hypothetical</i></p>	CommonHealth/ Premium Assistance With wrap to direct	
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**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

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

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

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

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

**ATTACHMENT B
COST SHARING**

Cost-sharing 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.

**ATTACHMENT B
COST SHARING**

MassHealth Family Assistance: HIV/AIDS	\$15-\$35 depending on income	MassHealth Standard co-payments apply.
MassHealth Family Assistance: Premium Assistance	\$12 per child, \$36 max per family group	Member is responsible for all co-payments required under private insurance with a cost sharing limit of 5 percent of family income

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

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

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

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

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

Above 400% to 600%	70% per above
Above 600% to 800%	75% per above
Above 800% to 1000%	80% 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 D
 MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS**

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.

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

BCCTP	
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<u>Eligibility Group</u>	<u>Current Enrollees (to date)</u>
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 XIV.

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				
<u>Small Business Employee Premium Assistance</u>				
<u>DSHP- Health Connector Subsidies</u>				
Base Fam XXI RO				
1902(r)(2) RO				
CommonHealth XXI				
Fam Assist XXI				

Consumer Issues

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

Quality Assurance/Monitoring Activity

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

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS

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

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

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

1. MCB EG was subsumed into the Disabled EG;
2. A new EG, 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) Disabled		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
6	SFY 2003	\$288.58	7.71%	\$677.56	10.0%	\$236.9	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 Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
12	SFY 2009	\$466.84	6.95%	\$1,011.95	6.86%	\$382.45	6.95%	\$791.4	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%	\$1,155.55	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 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

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

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

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

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

ATTACHMENT P
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- 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 with incomes 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 to coverage;
- 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, successful care 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 Commonwealth 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.

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 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (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		
<i>System Transformation Incentive Based Pools</i>											
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC57, STC 60	\$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	
<i>System Transformation Incentive Based Pools Subtotal</i>					<i>\$734.0</i>	<i>\$668.0</i>	<i>\$500.0</i>	<i>\$425.0</i>	<i>\$325.0</i>	<i>\$2,652.0</i>	
<i>Disproportionate Share Hospital (DSH) Pool</i>											
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)
		DSH									
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	(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 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart A: Approved SNCP Payments for the period from 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 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

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

9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals	\$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 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart A: Approved SNCP Payments for the period from 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)
	<i>DSHP – Health Connector Subtotal</i>			\$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 and STC 60 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.
- (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 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC53(a).

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

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

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

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (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		
<i>System Transformation Incentive Based Pools</i>											
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC 57 and STC 60.	\$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
<i>System Transformation Incentive Based Pools Subtotal</i>					\$734.0	\$668.0	\$500.0	\$425.0	\$325.0	\$2,652.0	
<i>Disproportionate Share Hospital (DSH) Pool</i>											

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

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

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (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
		DSH									
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
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 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (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 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (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
	<i>Disproportionate Share Hospital (DSH) Pool Subtotal:</i>				\$675.0	\$675.0	\$675.0	\$675.0	\$675.0	\$3,375.0	
	<i>Uncompensated Care (UCC) Pool</i>										
9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals	\$0.0	\$10.0	\$10.0	\$10.0	\$10.0	\$40.0	General Fund, including provider assessment funding transferred to the HSN Trust
10	Special Population State-Owned Non-Acute Hospitals Operated by the Department	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 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

	Department 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 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

	<i>Uncompensated Care (UCC) Pool Subtotal:</i>			<i>\$212.0</i>	<i>\$100.0</i>	<i>\$100.0</i>	<i>\$100.0</i>	<i>\$100.0</i>	<i>\$612.0</i>		
	<i>ConnectorCare Subsidies</i>										
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
	<i>DSHP – Health Connector Subtotal</i>			<i>\$250.0</i>	<i>\$250.0</i>	<i>\$250.0</i>	<i>\$250.0</i>	<i>\$250.0</i>	<i>\$1250.0</i>		
	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 53(b).

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

**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 51 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 51.

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 51. 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.

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

6. 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.

7. 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.

8. 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.