

Attachment M

Massachusetts Delivery System Reform Incentive Payment (DSRIP) Protocol

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Section 1. DSRIP Overview and Goals

1.1 MassHealth Medicaid Section 1115 Demonstration

The DSRIP Protocol provides additional detail to the State's DSRIP proposal, beyond those set forth in the Section 1115 Demonstration and Special Terms and Conditions (STCs). The DSRIP Protocol applies during the demonstration Approval Period (July 1, 2017 - June 30, 2022).

1.2 Overview - Delivery System Reform Incentive Payment Program (DSRIP)

In accordance with STC 57(e) and as set forth in this document, the State may allocate DSRIP funds to four purposes: (1) Accountable Care Organization (ACO) funding, which supports the implementation of three ACO models, including transitional funding for certain safety net hospitals; (2) Community Partners (CP) funding, which supports the formation and payment of Behavioral Health (BH) and Long Term Services and Supports (LTSS) CPs and funding for Community Service Agencies (CSAs); (3) Statewide Investments, which are initiatives related to statewide infrastructure and workforce capacity to support successful reform implementation; and (4) State Operations and Implementation, which includes the State's oversight of the DSRIP program.

1.3 Goals of DSRIP Program

Massachusetts' DSRIP program provides an opportunity for the State to emphasize value in care delivery, better meet members' needs through more integrated and coordinated care, and moderate the cost trend while maintaining the clinical quality of care. The State's DSRIP goals are to (1) implement payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improve integration among physical health, behavioral health, long-term services and supports and health-related social services; and (3) sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals.

1.4 DSRIP Funding Streams

To accomplish the goals of the DSRIP program, Massachusetts plans to launch and support with DSRIP funding the following initiatives:

- **Accountable Care Organizations** – Generally provider-led health systems or organizations with an explicit focus on integration of physical health, behavioral health, long term services and supports and health-related social service needs. ACOs will be financially accountable for the cost and quality of their members' care.
- **Community Partners / Community Service Agencies (CSAs)** – Community-based BH and LTSS organizations who support eligible members with BH and LTSS needs.
- **Statewide Investments** – Set of direct state investments in scalable infrastructure and workforce capacity.

Additionally, the State will utilize DSRIP funding to support Statewide Operations and Implementation, including oversight, of the DSRIP program.

Exhibit 1 shows anticipated amounts of funding per DSRIP funding stream by demonstration year as well as the overall anticipated percentage of funding distributed to each stream in total. Please see Section 4.7 for discussion of situations in which funding may be shifted between funding streams or carried forward from one demonstration year to the next.

EXHIBIT 1 – DSRIP Anticipated Funding Streams By Demonstration Year (\$M)

Funding Stream	Demo Y1	DY2	DY3	DY4	DY5	Total	% of Total*
ACOs	\$329.2M	\$289.9M	\$229.4M	\$152.0M	\$65.1M	\$1,065.6M	59%
Community Partners (including CSAs)	\$57.0M	\$95.9M	\$132.2M	\$133.6M	\$128.0M	\$546.6M	30%
Statewide Investments	\$24.2M	\$24.6M	\$23.8M	\$24.8M	\$17.4M	\$114.8M	6%
State Operations and Implementation	\$14.6M	\$14.6M	\$14.6M	\$14.6M	\$14.6M	\$73.0M	4%
Total:	\$425.0M	\$425.0M	\$400.0M	\$325.0M	\$225.0M	\$1,800.0M	

*Percentages do not sum to 100% due to rounding

1.4.1 Accountable Care Organizations

To achieve Massachusetts’ DSRIP goals as described above, the State intends to launch a new Accountable Care Organization program. Massachusetts has designed three ACO payment models that respond to the diversity of the State’s delivery system, and intends to select ACOs across all three models through a competitive procurement. Massachusetts intends to contract with ACOs across all three ACO models starting in 2017.

Massachusetts’ three ACO models are:

- **Accountable Care Partnership Plan (a Partnership Plan):** either a MCO with a separate, designated ACO partner, or a single, integrated entity that meets the requirements of both. Partnership Plans are vertically integrated between the health plan and ACO delivery system, and take accountability for the cost and quality of care under prospective capitation
- **Primary Care Accountable Care Organization:** a provider-led health care system or other provider-based organization, contracting directly with MassHealth, with savings and risk shared retrospectively
- **MCO-Administered ACO:** a provider-led health care system or other provider-based organization that contracts with MCOs and takes financial accountability for shared savings and risk as part of MCO networks

1.4.2 Community Partners and CSAs

Community Partners will provide support to eligible members with complex BH and LTSS needs, including linkages to community resources, allowing providers to deliver comprehensive care for the whole person and improvement in member health outcomes. Community Partners (CPs) will receive DSRIP funds for care coordination activities, as well as to support infrastructure and workforce capacity building. CPs will be required to partner with the ACOs and MCOs. ACOs and MCOs will similarly be required to partner with both BH and LTSS CPs. The goals of Community Partners include:

- Creating explicit opportunities for ACOs and MCOs to leverage existing community-based expertise and capabilities to best support members with LTSS and BH needs
- Breaking down existing silos in the care delivery system across BH, LTSS and physical health
- Ensuring care is person-centered, and avoiding over-medicalization of care for members with LTSS needs

- Preserving conflict-free principles including consideration of care options for members and limitations on self-referrals
- Making investments in community-based infrastructure within an overall framework of performance accountability
- Requiring ACOs, MCOs and Community Partners to formalize how they work together, e.g., for care coordination and performance management

Massachusetts will selectively procure two types of Community Partners:

- **Behavioral Health Community Partners (BH CPs):** BH CPs will support eligible adult members with a diagnosis of Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD) as well as adult members who exhibit SMI and SUD needs, but have not been diagnosed, as defined by the State.
- **LTSS Community Partners (LTSS CPs):** LTSS CPs will support eligible members ages three and older with complex LTSS needs, which may include members with physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD) and others, as defined by the State.

Community Service Agencies (CSAs): Additionally, existing provider entities, known as Community Service Agencies (CSAs) currently provide State Plan intensive care coordination services to eligible MassHealth members under 21 years of age with Serious Emotional Disturbances (SED). These CSAs will be eligible to receive DSRIP funds for infrastructure and workforce capacity building. CSAs will not receive DSRIP funds as payment for the provision of Massachusetts State Plan services.

1.4.3 Statewide Investments

Statewide Investments are part of the State’s strategy to efficiently scale up statewide infrastructure and workforce capacity, and will play a key role in moving Massachusetts towards achievement of its care delivery and payment reform goals. Massachusetts will utilize DSRIP funds to invest in the following eight high priority initiatives:

1. Student loan repayment program
2. Primary care integration models and retention program
3. Expanded support of residency slots at community health centers
4. Workforce professional development grant program
5. Technical assistance to ACOs and CPs (scalable, state-procured approach)
6. Alternative payment methods preparation fund
7. Enhanced diversionary behavioral health services
8. Improved accessibility for people with disabilities or for whom English is not a primary language

These eight initiatives are further detailed in Section 4.6.

1.4.4 State Operations and Implementation

The State will allocate a portion of DSRIP funding to support robust operations, implementation and oversight of the DSRIP program (see Section 6 for detail). An integrated team of state administrative staff will implement and oversee general and day-to-day administration of ACOs, CPs and Statewide

Investments programs to ensure success and movement towards state goals. This team will manage several contracted vendors that support key aspects of program implementation. In addition, several independent entities will support the State’s oversight of the DSRIP program, including the DSRIP Steering Committee, DSRIP Advisory Committee on Quality, Independent Assessor and Independent Evaluator (see Sections 3.4.1.2 and 6.4 for further details on each). The State Operations and Implementation funding stream will support these personnel/fringe and contractual costs.

Section 2. Delivery System Models

Please see Appendix A for discussion of Delivery System Models, including a description of the procurement process for ACOs and CPs, as well as a high-level description of selection criteria for these entities.

Section 3. Participation Plans, Budgets, and Budget Narratives

In order to receive DSRIP funding, each ACO, CP and CSA will be required to submit for the State’s approval: (1) a Participation Plan for the five-year demonstration period; and (2) a Budget and Budget Narrative for each annual budget period. These documents will detail how ACOs, CPs and CSAs will use DSRIP funding. The Participation Plan will cover the five years of the demonstration period. There will be two Participation Plans submitted – (1) “Preliminary Participation Plan” – providing an initial five-year plan and (2) “Full Participation Plan” – submitted to provide a revised five-year plan based on refined estimates of projected funding amounts. The State will use its review and approval processes of these documents to align with ACOs, CPs and CSAs on initiatives, goals and investments and to hold ACOs, CPs and CSAs accountable to the State’s delivery system reform goals. The State will also use these documents to report to CMS, as requested.

Because the DSRIP Participation Plans are based around the ACOs’, CPs’ and CSAs’ budget periods, this section begins by explaining the DSRIP budget periods that will apply to these entities. The section then discusses the details of the Preliminary Participations Plans, Full Participation Plans, Budgets and Budget Narratives that ACOs, CPs and CSAs will submit to the State, including what information will be included in each. The Section then details the State’s review and approval process for each of these documents.

3.1 DSRIP Budget Periods

3.1.1 ACO Budget Periods

The State’s 1115 demonstration aligns with the State’s fiscal year (July 1 to June 30). Performance years (PYs) for the State’s ACO Program (i.e., the time periods which the State will use to calculate cost and quality accountability for ACOs) align with the calendar year (January 1 to December 31), and are thus offset from the State’s demonstration years by 6 months.

The State will disburse DSRIP funding to ACOs using six “Budget Periods” (BPs) that align with ACO performance years. The State anticipates that the first BP, the “Preparation Budget Period,” will begin on July 1, 2017 or when contracts between the State and the ACOs are executed (whichever is later) and end December 31, 2017. ACOs will therefore have completed their contracting with the State prior to the start of the Preparation Budget Period. During this Preparation Budget Period, ACOs will have the opportunity to make investments and arrangements necessary to succeed as an ACO. Moving to a Total Cost of Care (TCOC) model is a significant undertaking that requires preparation and investment such as training staff, purchasing appropriate infrastructure, and setting up electronic, secure communications. The Preparation Budget Period will allow for such actions to occur. Investments may include, but are not

limited to: health information technology, performance management infrastructure, network development/contracting, project management, and care coordination/management investment.

During this Preparation Budget Period, the State will work with ACOs to ensure they are ready for the responsibilities of the full TCOC model (e.g., enrolling members, taking financial risk, receiving data supports) including holding regular meetings with ACOs, performing a structured “readiness review” process similar to the one the State undertakes for its MCOs, and providing preliminary data supports. Additionally, ACOs will be required to submit Budgets and Budget Narratives that lay out their plans and goals for DSRIP funding. The State will review and approve such plans, requesting additional information where necessary.

Budget Periods 1-5 (BP 1-5) will each last for one full calendar year, with Budget Period 1 beginning January 1, 2018 and ending December 31, 2018, etc. Please see Exhibit 2 for the schedule of the DSRIP ACO Budget Periods.

EXHIBIT 2 – Schedule of DSRIP ACO Budget Periods

CY2017		CY2018				CY2019				CY2020				CY2021				CY2022			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
State Demonstration Y1		Demo Y2				Demo Y3				Demo Y4				Demo Y5							
		ACO Performance Y1				ACO PY 2				ACO PY 3				ACO PY 4				ACO PY 5			
Prep Budget Period		Budget Period 1				BP 2				BP 3				BP 4				BP 5			

The budget period approach will not change the amount of funding that an ACO receives for a given demonstration year. Specifically, the Preparation Budget Period funds will be sourced from demonstration year 1 funds. Budget Period 1 funds will be sourced from demonstration year 1 and year 2 funds. Budget Periods 2 through 4 will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds will be sourced only from demonstration year 5 funds.

3.1.2 Community Partner and CSA Budget Periods

The State’s 1115 demonstration years align with the State’s fiscal year (July 1 to June 30). Performance years for the State’s CP program (i.e., the time periods the State will use to calculate accountability for CPs) align with the calendar year (January 1 to December 31), with the exception of Performance Year 1, which is seven months from June 1, 2018 to December 31, 2018. CP performance years are thus generally offset from the State’s demonstration years by six months.

The State will disburse DSRIP funding to CPs and CSAs using six “Budget Periods” (BPs) that align with CP and CSA Performance Years. The first BP, the “Preparation Budget Period” will begin when contracts between the State and the CPs and CSAs are executed (anticipated October/November 2017) and end May 31, 2018. During the Preparation Budget Period, CPs will utilize infrastructure dollars to invest in technology, workforce development, business startup costs and/or operational infrastructure. During the Preparation Budget Period, CSAs will utilize infrastructure dollars to invest in technology, workforce development and/or operational infrastructure.

In order to align CP and CSA Budget Periods with CP and CSA Performance Years, CP and CSA Budget Period 1 will be seven months from June 1, 2018 to December 31, 2018 (aligning with CP and CSA Performance Year 1, which is also seven months). The remaining four budget periods (BP 2-5) will each last for one full calendar year, with Budget Period 2 beginning January 1, 2019 and ending December 31, 2019, etc. If the State changes the schedule for CP and CSA performance years, the State may adjust the

CP and CSA Budget Periods to align with the performance years. Please see Exhibit 3 for the anticipated schedule of the DSRIP CP and CSA Budget Periods.

EXHIBIT 3 – Schedule of DSRIP CP/CSAs Budget Periods

CY2017		CY2018				CY2019				CY2020				CY2021				CY2022			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
State Demonstration Y1		Demo Y2				Demo Y3				Demo Y4				Demo Y5							
		CP Performance Y1		CP PY 2				CP PY 3				CP PY 4				CP PY 5					
Prep Budget Period		Budget Period 1 (7 mo.)		BP 2				BP 3				BP 4				BP 5					

This budget period approach will not change the amount of funding that a CP or CSA receives for a given demonstration year. Specifically, the Preparation Budget Period funds will be sourced from demonstration year 1 funds. Budget Period 1 funds will be sourced from demonstration year 1 and year 2 funds. Budget Periods 2 through 4 will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds will be sourced only from demonstration year 5 funds.

3.1.3 Funding Adjustments for Budget Period 5

The second half of Budget Period 5 (July 1, 2022 to December 31, 2022) falls outside of the approved demonstration period (July 1, 2017 to June 30, 2022). To account for this, the following payments will be attributed to the first half of BP5:

- ACO Startup/Ongoing payments (see Section 4.4.1)
- ACO DSTI Glide Path payments (see Section 4.4.3)
- ACO Flexible Services payments (see Section 4.2.2)
- CP and CSA Infrastructure and Capacity Building payments (see Sections 4.5.2, 4.5.5, and 4.5.7)

The ACO Startup/Ongoing, DSTI Glide Path, and CP/CSA Infrastructure and Capacity Building payments attributed to the first half of BP5 will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had \$100 total of non-at-risk startup/ongoing funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 (\$50 each), as opposed to \$25 attributed across each of the four quarters of BP5 (see Section 4.4.1 for more specific funding details). Similarly, if a CP had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total amount would be attributed to the first half of BP5 (see Section 4.5.2 for more specific funding details).

For ACO flexible services funding, during the first half of BP5, the State will pay out the full BP5 flexible services funding prospectively, based on the ACO’s approved BP5 flexible services budgets. ACOs will still need to submit their flexible services documentation and claims during BP5. If the ACOs do not use all of their flexible services allocation in BP5, or if the ACOs make expenditures that are deemed unacceptable by the State, then the ACOs will have to return the appropriate amount of flexible services funding to the State. See Section 4.2.2 for more specific funding details.

3.2 Participation Plans

3.2.1 Preliminary Participation Plans

Preliminary Participation Plans document ACOs’, CPs’ and CSAs’ plans for DSRIP expenditure. For the Preparation Budget Period and the first quarterly payment of Budget Period 1, the State will not disburse DSRIP funds to an ACO, CP or CSA that does not have a state-approved Preliminary Participation Plan.

The State may withhold DSRIP funds from an ACO, CP or CSA if there are outstanding State requests for amendments to its Preliminary Participation Plan.

3.2.1.1 ACOs

Each ACO will submit for the State's approval a Preliminary Participation Plan with its response to the ACO procurement. Once approved, the State may request amendments to the Preliminary Participation Plan as necessary. At a minimum, this Preliminary Participation Plan will include information such as:

- The ACO's five-year business plan, including the ACO's goals and identified challenges under the ACO contract with MassHealth
- The ACO's planned investments and spending plan, including specific investments or programs the ACO anticipates supporting with DSRIP funds. Such investments and programs may include but are not limited to:
 - Care coordination or care management programs, including any programs to manage high-risk populations or other population health initiatives and including the ACO's transitional care management program
 - Efforts to address members' health-related social needs, including expanding community linkages between the ACO and providers, Community Partners or other social service organizations, and including any spending on allowable flexible services to address health-related social needs
 - Ensuring appropriate workforce capacity and professional development opportunities to meet increased expectations for care coordination, management and integration
 - Investments in the ACO's and providers' data and analytics capabilities
 - Programs to shift service volume or capital away from avoidable inpatient care toward outpatient, community-based primary and preventive care, or from institutional care towards community-based LTSS, including capital investments to downsize or repurpose inpatient or institutional capacity¹, investments in expanding outpatient and community capacity and costs associated with piloting new care delivery models, such as those involving alternate settings of care and the use of telehealth or home-based services
 - Investments in improved linguistic and cultural competency of care, including hiring translators and providers fluent in members' preferred languages
 - Other investments or programs identified and proposed by the ACO that align with other requirements that MassHealth will have of the ACO

3.2.1.2 Community Partners/CSAs

Each CP and CSA will submit for the State's approval a Preliminary Participation Plan with their procurement responses and requests for funding respectively. Once approved, the State may request amendments to Preliminary Participation Plans as necessary. The Preliminary Participation Plan may include:

¹ Payments will be made to support providers' reform efforts that focus on the goals of reducing hospitalization and promotion of preventative care in the community, not directly to offset revenue from reduced hospital utilization.

- Executive Summary: This section will summarize the CP's or CSA's DSRIP Participation Plan and describe the CP's or CSA's five-year business plan, goals and identified challenges.
- Partnerships: This section will list providers with which the CP or CSA will partner and describe these relationships and how they will align with the CP's or CSA's proposed investments and programs, as well as the CP's or CSA's core goals, such as improving the quality of member care.
- Member and Community Population: This section will include a description of the CP's or CSA's member population and surrounding communities, regions and service areas covered and how the CP or CSA will both promote the health and well-being of these individuals, and also actively initiate and maintain engagement with them.
- Narrative: The narrative will describe
 - The CP's Care Model (CPs only):
 - Proposed staffing models
 - Proposed outreach and engagement strategies
 - Proposed process for assessment and person-centered care planning
 - Proposed process for managing transitions of care
 - Proposed methods for how the CP will address members' health and wellness issues
 - Proposed methods for how CP will connect the member to community resources and social services
 - Proposed methods and processes for how the CP will enable continuous quality and member experience improvement
 - The CP's or CSA's investment plan:
 - Identifying specific investments or programs that the CP or CSA will support with DSRIP funds
 - Estimating the amount and structure (e.g., one-time vs. annual) of costs associated with each investment or program
 - Explaining how each investment or program will support the CP's or CSA's core goals, such as improving the quality of member care and ensuring integration of care across different settings of care
 - Specifying goals, internal evaluation, measurement or performance management strategies the CP or CSA will apply to these investments or programs to demonstrate effectiveness and inform subsequent revisions to the Participation Plan
 - Examples of domains for potential CP or CSA investments or programs include but are not limited to:
 - Workforce capacity development
 - Data and analytics
 - HIT
 - Performance management capabilities
 - Contracting/networking development

- Project management capabilities
- Care coordination and community linkages
 - Implementation of care model requirements
- Spending Categories and Amounts: This section will include the CP's or CSA's anticipated spend over the five years in broad based funding categories.
- Timeline: This section will include a five-year timeline for the CP's or CSA's proposed investments and programs.
- Sustainability: This section will describe the CP's or CSA's plan to sustainably fund proposed investments and programs after the five-year period. This section may include information about other funding opportunities available to the CP or CSA, as well as information about any tools, resources or processes that the CP or CSA intends to develop using DSRIP funding and continue using after the end of the DSRIP investment.
- Metrics and Measures: This section will describe the CP's or CSA's plan to report on the various DSRIP accountability metrics set forth in Appendix D.

3.2.2 Full Participation Plans

Full Participation Plans build on the information contained in Preliminary Participation Plans. For all DSRIP payments except the Preparation Budget Period and the first quarter's payments for Budget Period 1, the State will not disburse DSRIP funds to an ACO, CP or CSA that does not have a state-approved Full Participation Plan. The State may withhold DSRIP funds from an ACO, CP or CSA if there are outstanding State requests for amendments to its Full Participation Plans.

3.2.2.1 ACOs

Once each ACO is notified of (1) its anticipated amount of Budget Period 1 funds, and (2) its tentative amount of Budget Period 2 through 5 funds, the ACO will submit a Full Participation Plan (see section 3.4.2 for timeline). The Full Participation Plan will expand on the information submitted with the Preliminary Participation Plan, and will include information such as:

- The ACO's five-year business plan, including the ACO's goals and identified challenges under the ACO contract with MassHealth
- The providers and organizations with which the ACO is partnering or plans to partner, the governance structure and a description of how these partnerships will support the ACO's planned activities and proposed investments
- A population and community needs assessment
- The ACO's planned investments and spending plan, including specific investments or programs the ACO anticipates supporting with DSRIP funds. Such investments and programs may include but are not limited to:
 - Care coordination or care management programs, including any programs to manage high-risk populations or other population health initiatives and including the ACO's transitional care management program
 - Efforts to address members' health-related social needs, including expanding community linkages between the ACO and providers, Community Partners or other social service organizations, and including any spending on allowable flexible services to address health-related social needs

- Ensuring appropriate workforce capacity and professional development opportunities to meet increased expectations for care coordination, management and integration
 - Investments in the ACO's and providers' data and analytics capabilities
 - Programs to shift service volume or capital away from avoidable inpatient care toward outpatient, community-based primary and preventive care or from institutional care towards community-based LTSS, including capital investments to downsize or repurpose inpatient or institutional capacity, investments in expanding outpatient and community capacity and costs associated with piloting new care delivery models, such as those involving alternate settings of care and the use of telehealth or home-based services
 - Investments in improved linguistic and cultural competency of care, including hiring translators and providers fluent in members' preferred languages
 - Other investments or programs identified and proposed by the ACO that align with other requirements that MassHealth will have of the ACO
- Estimates of the amount and structure (e.g., one-time vs. annual) of costs associated with each investment or program identified in the ACO's Participation Plan
 - Descriptions of how each investment or program will support the ACO's performance
 - Specific goals, evaluation plans, measurable outcomes and performance management strategies the ACO will apply to each investment or program
 - A five-year timeline of the ACO's proposed investments and programs
 - A description of the ACO's plan to sustainably fund proposed investments and programs over the five-year period as DSRIP funding levels decrease
 - Descriptions of how the ACO will fulfill its contract requirements, including:
 - Investments, value-based payment arrangements and performance management for its primary care providers
 - Care delivery improvement and care management strategies
 - Relationships with other providers, state agencies and other entities involved in the care of its members
 - Relationships with CPs
 - Activities to ensure the ACO's compliance with contract management, reporting and administrative requirements described in the ACO contract
 - A plan to increase the ACO's capabilities to share information among providers involved in care of its members. Such plan will include, at a minimum:
 - The ACO's current event notification capabilities and procedures to ensure that the ACO's primary care providers are aware of members' inpatient admissions and emergency department visits
 - The ACO's self-assessed gaps in such capabilities and procedures, and how the ACO

plans to address such gaps

- A description of the ACO's plans, if any, to increase the use of EHR technologies certified by the Office of the National Coordinator (ONC)
 - A description of how the ACO plans to ensure the ACO's providers consistently use the statewide health information exchange to send or receive legally and clinically appropriate patient clinical information and support transitions of care
- Attestations to ensure non-duplication of funding

3.2.2.2 Community Partners

Once the CP or CSA is notified of (1) the amount of Budget Period 1 funds, and (2) the tentative amount of Budget Period 2 through 5 funds, the CP or CSA will be required to submit a Full Participation Plan. The Full Participation Plan will expand on the information submitted within the Preliminary Participation Plan and will reflect the new information available to CPs or CSAs about their anticipated funding amounts (see section 3.4.3 for timeline). Examples of additional detail that CPs and CSAs will be contractually required to provide include:

- The community-based organizations and providers with which the CP or CSA is partnering or plans to partner, the CSA or CP consortium governance structure and a description of how these partnerships will support the CP's or CSA's planned activities and proposed investments
- Descriptions of specific investments or programs the CP or CSA will support with DSRIP funds, including cost estimates, measures, goals and performance management and sustainability plans in the following areas:
 - Relationships with state agencies, community-based organizations, providers and other entities involved in the care of its members
 - Relationships with ACOs and MCOs
 - Activities to ensure the CP's or CSA's compliance with contract management, reporting and administrative requirements described in the CP's or CSA's contract with MassHealth and agreements with ACOs and MCOs
 - Workforce development and stability
- A plan to increase the CP's or CSA's capabilities to share information with ACOs and MCOs and among providers involved in care of its members. Such plan will include, at a minimum:
 - The CP's or CSA's current communication practices and capabilities
 - The CP's or CSA's self-assessed gaps in such capabilities and procedures, and how the CP or CSA plans to address such gaps
 - A description of the CP's or CSA's plans, if any, to increase the use of Electronic Health Record and Care Management technology
 - A description of how the CP or CSA plans to ensure the CP or CSA and its partners consistently use the statewide health information exchange to send or receive legally and clinically appropriate patient clinical information and support transitions of care
- Details about how the CP or CSA will not duplicate existing infrastructure with their planned

DSRIP investments

3.3 Budgets and Budget Narratives

Each ACO, CP and CSA will submit a Budget and Budget Narrative to MassHealth for approval for each budget period. ACOs will submit a Budget and Budget Narrative to the State prior to each budget period. CPs and CSAs may submit a Budget and Budget Narrative to the State after the start of a budget period. The Budget is an itemized budget for the ACO's, CP's or CSA's proposed DSRIP-funded investments and programs for the Budget Period; the accompanying Budget Narrative explains uses of the funds. The State will provide a budget template for ACOs, CPs and CSAs to utilize. The State will not disburse DSRIP funds for a given budget period to an ACO, CP or CSA that does not have a state-approved Budget and Budget Narrative for that Budget Period. The State may withhold DSRIP funds from an ACO, CP or CSA if there are outstanding State requests for amendments to its Budgets or Budget Narratives.

3.4 Review and Approval Process and Timelines

3.4.1 Roles and Responsibilities

3.4.1.1 State

The State will review, approve and/or request revisions to ACOs', CPs' and CSAs' Preliminary and Full Participation Plans, Budgets and Budget Narratives. If necessary, the State will work collaboratively with ACOs, CPs and CSAs on revisions to Participation Plans, Budgets and Budget Narratives.

3.4.1.2 Independent Assessor

The Independent Assessor will review ACOs', CPs' and CSAs' Full Participation Plans, Budgets (from BP 1 onwards) and Budget Narratives (from BP 1 onwards), as well as any formal requests for modification to these documents submitted by ACOs, CPs and CSAs. The Independent Assessor will make recommendations to the State for each such document or request; these recommendations may be recommendations to approve, deny or propose certain changes to these documents or requests. The State will work closely with the Independent Assessor, and consider its recommendations during the review process. The State retains final decision-making authority regarding approvals, denials or requests for changes to Participation Plans, Budgets and Budget Narratives, as well as to any modification requests. If the Independent Assessor makes a recommendation to the State that differs from the State's final decision, the State will document its decision in the State's quarterly reports to CMS. The Independent Assessor will not determine whether a request to amend a Participation Plan, Budget, Budget Narrative, or Performance Remediation Plan is a material deviation, as this is the responsibility solely of the State.

3.4.1.3 CMS

CMS may request to review Participation Plans (Preliminary and Full), Budgets and Budget Narratives. The State will provide requested documents within 45 calendar days of receiving the request. All final approved Participation Plans, Budgets, and Budget Narratives will be sent to CMS. The State will provide the following information to be posted on Medicaid.gov: (1) an executive summary of each ACO's and CP's participation plan; (2) list of each ACO and CP as well as the populations they serve and their website; (3) an executive summary of each ACO's and CP's progress reports; and (4) each ACO's and CP's DSRIP yearly funding amount.

3.4.2 Process for State Approval of ACO Participation Plans

3.4.2.1 Preliminary Participation Plan Approval for ACOs

The State's process for submission, review and approval of Preliminary Participation Plans for ACOs will be as follows:

- ACOs submit Preliminary Participation Plans with their procurement response

- The State reviews Preliminary Participation Plans with ACOs' procurement submissions
- At the end of this review process, the State will approve or deny the Preliminary Participation Plans or request additional information and resubmissions of the Preliminary Plans before approval.
- The State anticipates completing approval of ACOs' Preliminary Participation Plans in July/August 2017.

3.4.2.2 Full Participation Plans for ACOs

The process for submission, review and approval of Full Participation Plans for ACOs will be as follows:

- The State notifies ACOs of anticipated BP1 funding amounts and tentative BP2 through BP5 funding amounts and requests a Full Participation Plan
- ACOs submit Full Participation Plans to the State (the State will provide ACOs up to 30 calendar days from the date of notification). The State intends to work with ACOs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Full Participation Plans in parallel. The State intends to complete its review of the Full Participation Plans, including evaluating the Independent Assessor's recommendations, within 45 calendar days of ACOs' submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the ACOs' Full Participation Plans.
- **The State therefore anticipates completing approvals of Full Participation Plans within 75 calendar days of requesting them from ACOs as follows:**
 - The State anticipates approving Full Participation Plans in April 2018

3.4.3 Process for State Approval of CPs and CSAs Participation Plans

3.4.3.1 Preliminary Participation Plan approval for CPs and CSAs

The State's process for submission, review and approval of Preliminary Participation Plans for CPs and CSAs will be as follows:

- CPs submit Preliminary Participation Plans with their request for funding
- CSAs submit Preliminary Participation Plans with their request for funding
- The State reviews CP and CSA Preliminary Participation Plans within 75 calendar days of their submission
- At the end of this review process, the State will approve, deny or request additional information regarding the Preliminary Participation Plan. The State intends to work with CPs and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission.
- **The State therefore anticipates completing reviews and approvals of Preliminary Participation Plans within 75 calendar days of submission as follows:**
 - The State anticipates approval of Preliminary Participation Plans in August 2017

3.4.3.2 Full Participation Plans for CPs and CSAs

The process for submission, review and approval of Full Participation Plans will be as follows:

- The State notifies CPs and CSAs of actual BP1 funding and tentative BP2 through BP5 funding amounts and requests a Full Participation Plan
- CPs and CSAs submit Full Participation Plans to the State within 30 calendar days from the date of notification).
 - The State intends to work with CPs and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Full Participation Plans in parallel. The State intends to complete its review of the Full Participation Plans, including evaluating the Independent Assessor's recommendations, within 45 calendar days of CPs' and CSAs' submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the Full Participation Plans.
- **The State therefore anticipates completing approvals of Full Participation Plans within 75 calendar days of requesting them from CPs and CSAs as follows:**
 - For CPs and CSAs, the State anticipates approving Full Participation Plans in May 2018

3.4.4 Process for State approval of Budgets and Budget Narratives

3.4.4.1 Process for State approval of ACO Budgets and Budget Narratives

The process for submission, review and approval of Budgets and Budget Narratives for Budget Period 1-5 for ACOs will be as follows:

- The State notifies ACOs of the upcoming budget period's anticipated funding amounts, and requests each ACO submit a Budget and a Budget Narrative for the upcoming budget period (See Section 4.4).
- ACOs submit to the State their Budgets and Budget Narratives for the upcoming BP within 30 calendar days of receiving the State's request. The State intends to work with ACOs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Budgets and Budget Narratives in parallel. The State intends to complete its review of the Budgets and Budget Narratives, including evaluating the Independent Assessor's recommendations, within 45 calendar days of their submission. Requests for additional information and resubmissions may require additional time.
- At the end of this review process, the State approves, denies or requests additional information regarding the Budgets and Budget Narratives.
 - After approval, the State will disburse the first quarterly DSRIP payment for the new Budget Period.
- If the data required to calculate funding amounts for a given budget period are not available by August of the preceding Budget Period, then the State may provide ACOs with a preliminary funding amount to construct their Budgets and Budget Narratives. The State would disburse the first quarterly payment based on the preliminary funding amount, and then calculate final funding amounts as well as a reconciliation amount to be added to or subtracted from the ACO's subsequent quarterly DSRIP payments in that Budget Period, such that payments for the budget period total the final funding amount for that budget period.
 - If the funding amount for a given ACO changes by more than 20% from the preliminary funding amount on which the ACO based its Budget and Budget Narrative, the State will

ask the ACO to revise and resubmit its Budget and Budget Narrative. The State may also request revisions in its discretion.

- **The State therefore anticipates completing approvals of Budgets and Budget Narratives within 75 calendar days of requesting them from ACOs as follows:**
 - For Preparation Budget
 - The State anticipates notifying ACOs of anticipated Preparation Budget funding amounts in June 2017
 - The State anticipates ACOs submitting Preparation Budgets and Budget Narratives in July 2017
 - The State anticipates approving Budgets and Budget Narratives in August 2017
 - For BP 1-5:
 - The State anticipates providing ACOs with anticipated funding amounts in October of the preceding budget period
 - The State anticipates ACOs will submit to the State their Budgets and Budget Narratives and their updated safety net revenue calculation in November of the preceding budget period
 - The State anticipates approving ACOs' Budgets and Budget Narratives in January of the new budget period
 - If the preliminary member count for BP 1 is estimated prior to the Operational Start Date of the program and therefore prior to actual member enrollments being effective, the State may postpone this timeline by several months for BP 1, and delay the first quarterly payment of BP 1 at its discretion. This process may allow the State to adjust for changes in enrollment levels if, for example, member movement exceeds expectations

3.4.4.2 Process for State Approval of CP and CSA Budget and Budget Narratives

CPs will receive bi-annual infrastructure development funding as well as be reimbursed monthly for care management and care coordination activities based on the number of members assigned and engaged. CSAs will receive DSRIP funding for Infrastructure development only.

The process for submission, review and approval of CP and CSA Budgets and Budget Narratives for Budget Period 1-5 will be as follows:

- The State notifies CPs and CSAs of preliminary upcoming budget period's funding amounts and requests the Budgets and Budget Narratives for the upcoming budget period
 - Infrastructure development payments will be based on a member snapshot
 - For CPs, the BP1 member snapshot will be an estimate of member engagement
 - For CSAs, the member snapshots will be based on actual caseload
- Within 30 calendar days, CPs and CSAs submit to the State their Budgets and Budget Narratives for the upcoming BP
 - The State intends to work with CPS and CSAs who request additional time or fail to respond in a timely fashion to ensure prompt submission
- The State and Independent Assessor review Budgets and Budget Narratives in parallel. The State intends to complete its review of the Budgets and Budget Narratives, including evaluating the Independent Assessor's recommendations, within 45 calendar days of their submission. Requests for additional information and resubmissions may require additional time.

- At the end of this review process, the State approves, denies or requests additional information regarding the Budgets and Budget Narratives.
- After approval, the State will disburse funding bi-annually for infrastructure funding and monthly for care coordination funding.
- **The State therefore anticipates completing approvals of Budgets and Budget Narratives within 75 calendar days of requesting them from CPs and CSAs as follows:**
 - For Preparation Budget
 - The State anticipates notifying CPs and CSAs of Preparation Budget funding in August 2017
 - The State anticipates CPs and CSAs submitting Preparation Budgets and Budget Narratives in September 2017
 - The State anticipates approving Budgets and Budget Narratives in October 2017
 - For BP 1:
 - The State anticipates providing CPs and CSAs with a preliminary version of their anticipated payments in February 2018
 - The State anticipates that CPs and CSAs will submit their BP1 Budgets and Budget Narratives to the State in March 2018
 - The State anticipates approving CP and CSA Budgets and Budget Narratives in May 2018
 - For BP 2-5:
 - The State anticipates providing CPs and CSAs with a preliminary version of their anticipated payments in December of the preceding budget period
 - The State anticipates that CPs and CSAs will submit their current year budget period Budgets and Budget Narratives to the State in January of the budget period
 - The State anticipates approving CP and CSA Budgets and Budget Narratives in March of the budget period
 - The State anticipates making bi-annual infrastructure payments in April and October of the budget period and monthly care coordination payments

3.4.5 Process for State Approval of Modifications to Participation Plans, Budgets and Budget Narratives

ACOs, CPs and CSAs may submit ad hoc requests to amend their Participation Plans, Budgets, and Budget Narratives at any time except within 75 days of the end of the Budget Period. ACOs, CPs or CSAs will not be allowed to materially deviate from their approved spending plans without formally requesting such modification and having the modification approved by the State. The State has sole discretion to determine whether an amendment request is a material deviation, and thus a modification. In addition, the State may require ACOs, CPs or CSAs to modify their Full Participation Plans, Budgets or Budget Narratives in certain circumstances (e.g., if a primary care practice where an ACO had previously proposed making investments goes out of business).

The State's process for submission, review and approval of modification requests will be as follows:

- ACOs, CPs or CSAs submit a modification request
- The State and Independent Assessor review the modification request in parallel. The State intends to complete its review of modification requests, including evaluating the Independent

Assessor’s recommendations, within 45 calendar days of their submission. Further requests for additional information and resubmissions may require additional time.

- At the end of this review process, the State approves, denies or requests additional information
- The State therefore anticipates completing approvals of modification requests within 45 calendar days of requesting them from ACOs, CPs and CSAs

If the State denies the modification request, the State and Independent Assessor will provide feedback about why the request was denied, and the State may allow the entity to resubmit their modification request after revisions, as appropriate. The timeline for review would restart upon resubmission, and the same processes would be followed as for an initial submission.

Section 4. DSRIP Payments (ACOs, CPs, CSAs and Statewide Investments)

DSRIP funding will support four streams, as described in Section 1. This Section (Section 4) outlines parameters for DSRIP payments to ACOs, CPs, CSAs and Statewide Investments including sub-streams. A portion of payments from the State to ACOs, CPs and CSAs are at risk based on the ACO, CP and CSA Accountability Framework described in Section 5. Section 5 also describes the linkage between ACO, CP and CSA accountability to the State. Section 4 explores DSRIP payments to ACOs, CPs or CSAs and the sub-streams within them.

Each of ACO and CP payment streams has several “sub-streams,” which differ from each other with respect to three characteristics: (1) purpose/allowable uses; (2) calculation methodology; (3) and accountability. These three characteristics are detailed for each sub-stream in the following three subsections 4.1-4.3, respectively. Section 4.5 provides additional detail on how Accountability Scores are calculated using the accountability framework laid out in Section 4.4.

- Section 4.1: provides an overview of the sub-streams of DSRIP funding for ACOs, CPs and CSAs, as well as their amounts and the process for the State to vary those amounts
- Section 4.2: provides detail on purpose and allowable uses for ACO sub-streams
- Section 4.3: provides detail on purpose and allowable uses for CP and CSA sub-streams
- Section 4.4: provides detail on payment calculation and timing for ACO sub-streams
- Section 4.5: provides detail on payment calculation and timing for CP and CSA sub-streams
- Section 4.6: provides funding information on Statewide Investments
- Section 4.7: provides detail on DSRIP carry forward capacity

4.1 Overview and Outline

The State has divided the ACO, CPs and CSA DSRIP funding streams into eleven sub-streams: four for ACOs, three each for BH CPs and LTSS CPs and one for CSAs.

EXHIBIT 4 – ACO, CP and CSA Sub-Streams

ACo Funding Stream 4 sub-streams	CP and CSA Funding Stream 7 sub-streams		
	BH CPs: <i>3 sub-streams</i>	LTSS CPs: <i>3 sub-streams</i>	CSAs: <i>1 sub-stream</i>

<ul style="list-style-type: none"> ● Startup/Ongoing: primary care investment ● Startup/Ongoing: discretionary ● Flexible services ● DSTI Glide Path 	<ul style="list-style-type: none"> ● Care coordination ● Infrastructure and Capacity Building ● Outcomes-based 	<ul style="list-style-type: none"> ● Infrastructure and Capacity Building
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Per STC 57(e), the State may reallocate funding amounts between the “ACO Funding Stream” and the “CP and CSA Funding Stream” at its discretion. If the actual funding amounts for the ACO Funding Stream or the CP and CSA Funding stream differ from the amounts set forth in Table F of STC 57(e) by more than 15%, the State must notify CMS 60 calendar days prior to the effective reallocation of funds. CMS reserves the right to disapprove any such reallocations prior to the effective date of the reallocation.

Within the “ACO Funding Stream” or “CP Funding Stream”, the State may distribute payments for a given demonstration year among the sub-streams to best meet the State’s programmatic needs, in its discretion without notifying CMS, subject to the parameters described in STC 57(e). Because the mechanisms for holding ACOs and CPs financially accountable differ among these sub-streams, changes in the distribution of funding among the sub-streams may change the amount of funding for an individual ACO or CP that is at risk. For example, if funding is shifted from the “Startup/Ongoing: Discretionary” ACO sub-stream to the “Startup/Ongoing: Primary Care Investment” ACO sub-stream, this would lead to less at-risk funding because funds have shifted from a sub-stream with an at-risk component to a sub-stream without an at-risk component (see Exhibit 19). Exhibit 5 below shows the State’s distribution of DSRIP payments to ACOs, CPs and CSAs by funding stream for each budget period, as well as the State’s anticipated sample distribution of DSRIP payments within the ACO and CP funding streams by sub-stream. The table also shows the percent and total funding for each stream and sub-stream that is at-risk based on the ACOs’, CPs’ and CSAs’ accountability to the State (see Section 5 for more information on accountability). This Exhibit is provided for illustrative purposes only and is an estimate of anticipated funding among funding streams and sub-streams at this point in time.

EXHIBIT 5 – Provider Accountability to State

Provider Accountability to State		Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5	Total	
ACOs	Total Funds	\$118.1M	\$318.0M	\$251.4M	\$197.9M	\$120.9M	\$59.2M	\$1,065.5M	
	At-Risk %	0%	4%	10%	17%	24%	11%	10%	
	At-Risk Funds	\$0.0M	\$12.0M	\$23.9M	\$34.3M	\$28.4M	\$6.3M	\$104.9M	
<i>Startup/Ongoing: Primary Care Investment (Not At-Risk)</i>		Total Funds	\$23.4M	\$47.5M	\$36.7M	\$37.8M	\$13.0M	\$13.4M	\$171.8M
<i>Startup/Ongoing: Discretionary</i>		Total Funds	\$73.1M	\$204.9M	\$152.0M	\$108.6M	\$66.5M	\$10.5M	\$615.7M
		At-Risk %	0%	5%	15%	30%	40%	50%	16%
		At-Risk Funds	\$0.0M	\$10.2M	\$22.8M	\$32.6M	\$26.6M	\$5.3M	\$97.5M
<i>Flexible Services (Not At-Risk)</i>		Total Funds	\$0.0M	\$31.0M	\$39.8M	\$34.7M	\$29.2M	\$30.1M	\$164.7M
<i>DSTI Glide Path Funding</i>		Total Funds	\$21.5M	\$34.6M	\$23.0M	\$16.8M	\$12.2M	\$5.2M	\$113.4M
		At-Risk %	0%	5%	5%	10%	15%	20%	7%
		At-Risk Funds	\$0.0M	\$1.7M	\$1.1M	\$1.7M	\$1.8M	\$1.0M	\$7.4M
Community Partners		Total Funds	\$20.0M	\$62.9M	\$105.8M	\$120.8M	\$118.4M	\$118.8M	\$546.7M
Behavioral Health CPs		At-Risk %	0%	0%	5%	10%	15%	20%	11%
		At-Risk Funds	\$0.0M	\$0.0M	\$5.3M	\$11.9M	\$17.5M	\$23.5M	\$58.2M
		Total Funds	\$9.3M	\$42.7M	\$74.6M	\$90.3M	\$88.3M	\$88.3M	\$393.4M
<i>Care Coordination Supports</i>		At-Risk %	0%	0%	5%	10%	15%	20%	12%
		At-Risk Funds	\$0.0M	\$0.0M	\$3.2M	\$8.3M	\$12.3M	\$16.4M	\$40.2M
		Total Funds	\$0.0M	\$32.4M	\$64.7M	\$82.9M	\$81.8M	\$82.2M	\$344.0M
<i>Infrastructure and Capacity Building</i>		At-Risk %	0%	0%	5%	10%	15%	20%	6%
		At-Risk Funds	\$0.0M	\$0.0M	\$0.5M	\$0.6M	\$0.8M	\$1.0M	\$3.0M
		Total Funds	\$9.3M	\$10.3M	\$9.8M	\$6.4M	\$5.5M	\$5.1M	\$46.4M
<i>Outcomes-Based Stream (Incentive Pool, Not At-Risk)</i>		Total Funds	\$0.0M	\$0.0M	\$0.0M	\$1.0M	\$1.0M	\$1.0M	\$3.0M
CSAs (Infrastructure and Capacity Building only)		At-Risk %	0%	0%	5%	10%	15%	20%	4%
		At-Risk Funds	\$0.0M	\$0.0M	\$0.1M	\$0.1M	\$0.1M	\$0.1M	\$0.3M
		Total Funds	\$3.2M	\$1.8M	\$1.1M	\$0.6M	\$0.5M	\$0.5M	\$7.8M
LTSS CPs		At-Risk %	0%	0%	5%	10%	15%	20%	10%
		At-Risk Funds	\$0.0M	\$0.0M	\$1.5M	\$2.9M	\$4.4M	\$5.9M	\$14.7M
		Total Funds	\$7.5M	\$18.5M	\$30.1M	\$29.9M	\$29.6M	\$30.0M	\$145.5M
<i>Care Coordination Supports</i>		At-Risk %	0%	0%	5%	10%	15%	20%	11%
		At-Risk Funds	\$0.0M	\$0.0M	\$1.2M	\$2.6M	\$4.0M	\$5.4M	\$13.3M
		Total Funds	\$0.0M	\$11.4M	\$24.8M	\$26.2M	\$26.7M	\$27.1M	\$116.2M
<i>Infrastructure and Capacity Building</i>		At-Risk %	0%	0%	5%	10%	15%	20%	5%
		At-Risk Funds	\$0.0M	\$0.0M	\$0.3M	\$0.3M	\$0.4M	\$0.5M	\$1.4M
		Total Funds	\$7.5M	\$7.1M	\$5.3M	\$3.1M	\$2.4M	\$2.3M	\$27.8M
<i>Outcomes-Based Stream (Incentive Pool, Not At-Risk)</i>		Total Funds	\$0.0M	\$0.0M	\$0.0M	\$0.5M	\$0.5M	\$0.5M	\$1.5M

4.2 Purpose and Allowable Uses for ACO Funding Sub-Streams

4.2.1 ACO Sub-Streams 1 & 2: Startup/Ongoing Funding (Primary Care & Discretionary)

ACO sub-streams 1 and 2 are for Startup/Ongoing funds. Startup/Ongoing funds are split into two sub-streams. Sub-stream 1 is explicitly dedicated for primary care investment. ACOs will be required to spend these funds on state-approved investments that support the ACO’s primary care providers such as capital investments in primary care practices (e.g., inter-operable EHR systems), trainings for primary care providers and support staff in population health management protocols, administrative staff to support

front-line providers with clinical quality initiatives, etc. Having a dedicated funding stream for primary care investment is an important mechanism for the State to ensure that ACOs and their PCPs are mutually committed to each other, having mutual discussions about business decisions and working together to meet the State's delivery system reform goals. In order to ensure that primary care investments supported by DSRIP do not duplicate other federal or state investments, ACOs will be required to disclose in their Full Participation Plans what state and federal investments the ACO is using to support primary care investments, and how the ACO is ensuring non-duplication with proposed DSRIP funding uses.

Sub-stream 2 is for discretionary Startup/Ongoing funding and may be used by the ACO for other state-approved investments. Some examples of investment opportunities for ACOs include, but are not limited to: health information technology, contracting/network development, project management, and care coordination/management investment, assessments for members with identified LTSS needs, workforce capacity development and new or expanded telemedicine capability.

The funding amounts for these two sub-streams decrease over the five demonstration years and are intended to support ACO investments as they start their ACO models and provide operating funds to support (during initial years) the ongoing costs of these models. As ACOs progress through the five demonstration years, the State expects ACOs to increasingly self-fund these investments and expenses out of their TCOC-based revenue (e.g., medical gains under capitation rates, or shared savings payments).

4.2.2 ACO Sub-Stream 3: Flexible Services Funding

A portion of ACO DSRIP funds will be dedicated to spending on flexible services. Flexible services funding will be used to address health-related social needs by providing supports that are not currently reimbursed by MassHealth or other publicly-funded programs. These flexible services must satisfy the criteria described in STC 60(b)(iii), 60(c), and 60(d). Flexible services will be retrospectively reimbursed by the State up to a cap set by the State, except for BP5. During the first half of BP5, the State will pay out the full BP5 flexible services funding amount prospectively, based on the ACO's approved BP5 flexible services budgets. ACOs will still need to submit their flex services documentation and claims during BP5. If the ACOs do not use all of their flexible services allocation in BP5, or if the ACOs make expenditures that are deemed unacceptable by the State, then the ACOs will have to return the appropriate amount of flexible services funding to the State. Additional details about flexible services will be delineated in the Flexible Services Protocol (Attachment R), which is to be reviewed and approved by CMS by July 2017.

If CMS does not approve the Flexible Services Protocol by August 2017, then the State may reallocate the Budget Period 1 flexible services funding allocation detailed in Exhibit 5 to other Budget Period 1 DSRIP funding streams so that the State's expenditure authority is not reduced due to non-approval of the Flexible Services Protocol, or it may carry forward the expenditure authority into subsequent Budget Periods without counting against the 15% benchmark described in STC 57(d)(iii). Similarly, the State may continue to reallocate the flexible services funding allocation for each Budget Period to other DSRIP funding streams for that Budget Period if CMS does not approve the Flexible Services Protocol by the July of the preceding Budget Period. Any such reallocation will be included in an updated funding allocation table in the next quarterly progress report to CMS. CMS will have 90 calendar days to request modifications to the reallocation proposal.

4.2.3 ACO Sub-Stream 4: DSTI Glide Path Funding

During the five-year demonstration, the State will restructure demonstration funding for safety net hospital systems to be more sustainable and aligned with value-based care delivery and payment incentives. The seven safety net hospitals currently receiving funding through the Delivery System Transformation Initiatives (DSTI) program will instead receive a reduced amount of ongoing operational support through Safety Net Provider payments authorized under the State's restructured Safety Net Care

Pool. To create a sustainable transition from current funding levels to these new, reduced levels, the State will provide transitional DSRIP funding to these DSTI safety net hospitals.

Payment of the DSTI Glide Path funding is contingent on a safety net hospital's approved participation with a MassHealth ACO (and therefore on their financial accountability for cost and quality). To receive this funding, a safety net hospital must have a provider arrangement or contract with an ACO that demonstrates its participation in that ACO's efforts, including at a minimum documented participation in the ACO's transitional care management and other contractual responsibilities (e.g., data integration), and financial accountability including the potential for the safety net hospital to share gains from savings and share responsibility for losses.

This DSTI Glide Path funding will be paid directly to any ACO that has a provider arrangement or contract with one of these seven DSTI safety net hospitals. The ACO will be required to give the full amount of this funding to the participating safety net hospitals. The amount of DSTI Glide Path funding will decrease each year, sustainably transitioning safety net hospitals to lower levels of supplemental support.

4.3 Purpose and Allowable Uses for CP and CSA Funding Sub-Streams

MCOs and ACOs will delegate comprehensive care management responsibility to the BH CP for members diagnosed with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD), as well as adult members who exhibit SMI and SUD, but have not been diagnosed, and who are assigned to the BH CPs. BH CPs are required to coordinate care for members enrolled with the BH CP across the full healthcare continuum, including physical and behavioral health, LTSS and social service needs. This section describes the purpose and allowable uses for the three funding sub-streams for each CP (care coordination, infrastructure and capacity building and outcome-based payments) and one sub-stream for CSAs (infrastructure and capacity building):

4.3.1 BH CP Sub-Stream 1: Care Coordination Supports Funding

BH CPs will receive funds under BH CP sub-stream 1 to perform the following functions for assigned members:

1. Outreaching to and actively engaging members
2. Identifying and facilitating a care team for every engaged member
3. Person-centered treatment planning for every engaged member
4. Coordinating services across the care continuum to ensure that the member is in the right place for the right services at the right time
5. Supporting transitions between care settings
6. Providing health and wellness coaching
7. Facilitating access and referrals to social services and other community services

4.3.2 BH CP Sub-Stream 2: Infrastructure and Capacity Building Funding

BH CPs will receive funds under BH CP sub-stream 2 to make infrastructure investments to advance their capabilities to support their member populations and to form partnerships with MCOs and ACOs. Infrastructure funding for BH CPs will be disbursed across four categories:

1. Technology – e.g., HIT and care management software, IT project management resources, data analytics capabilities, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring or electronic medication dispensers, and reporting software
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications
3. Business Startup Costs – e.g., staffing and startup costs to develop full caseloads.

4. Operational Infrastructure – e.g., project management, system change resources and performance management capabilities, additional operational support.

4.3.3 BH CP Sub-Stream 3: Outcomes-Based Payments

BH CPs will have the opportunity to earn additional payments under BH CP sub-stream 3 in Budget Periods 3 through 5 by reaching high levels of achievement on avoidable utilization metrics. The State anticipates setting preliminary performance targets by August 2019 (i.e. BP2) following analysis of claims data for BP1. The State will then finalize the performance targets for BP3 by August 2020 (i.e. BP3) once the BP2 claims data is available (see Section 5.4.6 for more details). The State will set the performance standards subject to CMS approval.

4.3.4 LTSS CP Sub-Stream 1: Care Coordination Supports Funding

MCOs and ACOs will have responsibility for conducting the comprehensive assessment for enrollees assigned to LTSS CPs and other enrollees identified by EOHHS as having LTSS needs, as specified in their contracts with the State. The LTSS CP will review the results of the comprehensive assessment with a LTSS assigned member as part of the person-centered LTSS care planning process and will inform the member about his or her options for specific LTSS services, programs and providers that may meet the member's identified LTSS needs. LTSS CPs will receive funds under LTSS CP sub-stream 1 to perform the following functions for assigned members:

1. Providing disability expertise consultation as requested by MassHealth, the member's MassHealth managed care entity, or the member on the comprehensive assessment
2. Providing LTSS care planning using a person-centered approach and choice counseling
3. Participating on the member's care team to support LTSS care needs decisions and LTSS integration, as directed by the member
4. Providing LTSS care coordination and support during transitions of care
5. Providing health and wellness coaching
6. Connecting the member to social services and community resources.

The State also intends to allow LTSS CPs to provide optional enhanced functions for members with complex LTSS needs who would benefit from comprehensive care management provided by a LTSS CP. The enhanced supports care model will be similar to that of the BH CP, including the performance of a comprehensive assessment, although adapted to the specific LTSS population to be served, and will include a PMPM rate reflective of the BH CP model. The State will select LTSS CPs to perform enhanced supports via a competitive procurement.

4.3.5 LTSS CP Sub-Stream 2: Infrastructure and Capacity Building Funding

LTSS CPs will receive funds under LTSS CP sub-stream 2 to make investments to advance the organization's overall capabilities to support its member population and form partnerships with MCOs and ACOs. Infrastructure funding for LTSS CPs will be disbursed across four categories:

1. Technology – e.g., HIT and care management software, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring, electronic medication dispensers and reporting software;
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications;
3. Business Startup Costs – e.g., staffing and startup costs to develop full caseload capacities
4. Operational Infrastructure – e.g., IT project management, system change resources, data analytics capabilities performance management capabilities and additional operational support

4.3.6 LTSS CP Sub-Stream 3: Outcomes-Based Payments

LTSS CPs will have the opportunity to earn additional payments under LTSS CP sub-stream 3 in Budget Periods 3 through 5 by reaching high levels of achievement on avoidable utilization metrics. The State anticipates setting preliminary performance targets by August 2019 (i.e. BP2) following analysis of claims data for BP1. The State will then finalize the performance targets for BP3 by August 2020 (i.e. BP3) once the BP2 claims data is available (see Section 5.4.6 for more details). The State will set the performance standards subject to CMS approval.

4.3.7 CSA Sub-Stream 1: Infrastructure and Capacity Building Funding

CSAs will receive funds under CSA sub-stream 1 to make investments to advance their overall capabilities to support their member populations and to form partnerships with MCOs and ACOs. Infrastructure funding for CSAs will be disbursed across three categories:

1. Technology – e.g., HIT and care management software, mobile technology including tablets, laptops and smartphones for CP staff, service delivery technology such as remote monitoring, electronic medication dispensers reporting software
2. Workforce Development - e.g., recruitment support, training and coaching programs and certifications;
3. Operational Infrastructure – e.g., IT project management, system change resources, data analytics capabilities performance management capabilities and additional operational support

4.4 Payment Calculation and Timing for ACO Sub-Streams

4.4.1 ACO Sub-Streams 1 & 2: Startup/Ongoing Funding (Primary Care & Discretionary)

Each ACO will receive an amount of Startup/Ongoing funds (combined across sub-streams 1 and 2) for each Budget Period that is determined by multiplying the number of members enrolled in or attributed to the ACO by a per member per month (PMPM) amount. The State will determine the number of members.

The State will determine each ACO's PMPM amount during the Preparation Budget Period and BP 1 – 5 as follows:

- Step 1: The State will set a base rate
- Step 2: The State will increase this rate for each ACO based on the ACO's safety net category
 - The State will calculate each ACO's payer revenue mix based on the percentage of its gross patient service revenue that comes from care for MassHealth members or uninsured individuals
 - The State will categorize ACOs into five categories based on their payer revenue mix (each category has a percentage increase associated with it)
 - During the DSRIP program, the State may adjust the safety net PMPM adjustment methodology as described later in this section
- Step 3: The State will further increase this rate for each ACO based on the ACO's choice of model and risk track (each model/risk track combination has a percentage increase associated with it – (as detailed in Exhibit 8))

Exhibit 6 shows the State's anticipated average adjusted PMPMs for the ACO Startup/Ongoing sub-streams, after following the steps described above.

EXHIBIT 6 – Average Adjusted PMPMs for ACO Startup/Ongoing Support

Average Adjusted PMPMs for ACO Startup/Ongoing Support					
Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5
\$21.43	\$19.16	\$18.14	\$14.24	\$9.17	\$3.12

Given the potential for variation in anticipated ACO and member participation, these average adjusted PMPMs represent an estimate, and the State may disburse, on average, PMPMs that differ from the PMPMs displayed in Exhibit 6 by up to +/- \$6. Individual ACO PMPMs may vary by greater amounts due to the adjustments described in this section. If a new ACO joins after BP1, e.g. in BP3, it will have the same BP3 base PMPMs as the existing ACOs and will not be assigned PMPMs differently.

ACOs with a higher percentage of revenue generated from Medicaid and uninsured patient services revenue will be placed into a higher safety net category, corresponding to a larger percentage PMPM increase. To determine each ACO’s safety net category, ACOs must submit a payer revenue mix attestation form. The form contains detailed instructions on how to calculate revenue as well as the types of revenue that ACOs must provide. For example, the State requires ACOs to include patient health care service revenue from various categories, which include but are not limited to: (1) MassHealth, inclusive of Medicaid and the Children’s Health Insurance Plan, (2) Health Safety Net, (3) Medicare, (4) Commercial Health Plans, (5) Other Government Sources, such as Veterans Affairs and Tricare and (6) Other Revenue Sources, such as Self-pay and Workers’ Compensation). Using this information, the State will determine the Gross Patient Service Revenue (GPSR) from MassHealth and uninsured patients and place each ACO in the appropriate safety net category. See Exhibit 7 for the PMPM adjustment schedule based on safety net category.

EXHIBIT 7 – Safety Net PMPM Adjustment

Safety Net PMPM Adjustment					
Safety Net Category	5	4	3	2	1
% PMPM Increase	40%	30%	20%	10%	0%

As mentioned earlier, the State may also adjust the safety net PMPM adjustment methodology during the DSRIP program, as follows:

- Startup/ongoing PMPMs for members attributed to community health centers may receive a higher safety net PMPM adjustment (e.g., the maximum safety net adjustment of +40%), as described in Exhibit 7, regardless of the ACO’s safety net category, reflecting the unique safety net status of these providers
- Under this revised methodology, startup/ongoing PMPMs for members attributed to other PCPs would receive a PMPM adjustment based on the ACO’s overall safety net category (i.e., unchanged from current methodology)

The State will also apply a PMPM adjustment each year depending on the ACO’s chosen model and risk track. This adjustment will be additive with the safety net PMPM adjustment. If an ACO switches models or risk tracks during the DSRIP period, then its PMPM adjustment will be updated to align with the new ACO model type. See Exhibit 8 for the PMPM adjustment schedule based on ACO Model and Risk Track.

EXHIBIT 8 – ACO Model and Risk Track PMPM Adjustment

ACO Model PMPM Adjustment						
ACO Model	Accountable Care Partnership Plan (Model A)	Primary Care ACO (Model B)		MCO-Contracted ACO (Model C)		
		Risk Track 2 (more risk)	Risk Track 1 (less risk)	Risk Track 3 (more risk)	Risk Track 2 (medium risk)	Risk Track 1 (less risk)
% PMPM Increase	40%	40%	30%	30%	10%	0%

For example, using the standard safety net PMPM adjustment methodology, if the base PMPM rate is \$10, and the ACO is a Primary Care ACO (Risk Track 2) and a safety net category 3 provider, then the adjusted startup/ongoing PMPM would be $\$10 * (100\% + 40\% + 20\%) = \16 . If the State modifies its safety net PMPM adjustment methodology, as described above, and this ACO has 60% of members attributed to community health centers, then the ACO would have two different PMPMs for the members attributed to CHCs vs. other PCPs:

- PMPM for members attributed to CHC: $\$10 * (100\% + 40\% + 40\%) = \18
- PMPM for other members: $\$10 * (100\% + 40\% + 20\%) = \16

The PMPMs would be multiplied by their associated member counts, and the sum of these products would be the ACO’s startup/ongoing funding amount.

The amount of funding that ACOs will need to allocate for primary care investment will be based on the following PMPM schedule:

PMPM Schedule for Startup/Ongoing Funds (Primary Care Investment)

	Prep Budget Period	BP1	BP2	BP3	BP4	BP5
Startup/Ongoing Funds Designated for Primary Care Investment (\$PMPM)	\$4	\$4	\$3	\$3	\$1	\$1

All remaining startup/ongoing support (i.e. “discretionary” startup/ongoing funds) can be distributed amongst the ACO’s participating providers, as decided by the ACO. This funding could be used to support additional primary care investment or assessments for members with identified LTSS needs, among other things.

Generally speaking, ACO funding sub-streams 1 and 2 will be paid in four quarterly installments for each Budget Period. The State anticipates these installments will be roughly equal; however, the State may alter the payment amounts, frequency, and timing in its discretion. For example, the State may pay a reduced amount for the first quarterly payment, which may be based on preliminary funding amount calculations, to minimize ACO disruption when funding amounts are finalized and the remaining three payments are adjusted accordingly. During BP5, payments will be attributed to the first half of the year; as such, these attributed amounts will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had \$100 total of non-at-risk startup/ongoing funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 (\$50 each), as opposed to \$25 attributed across each of the four quarters of BP5.

4.4.2 ACO Sub-Stream 3: Flexible Services Funding

Each ACO will receive an allotment of flexible services funding for each Budget Period, except for the Preparation Budget Period during which there are no flexible services funds (because ACOs do not yet have enrolled/attributed members). ACOs will submit requests for reimbursement for approved flexible services expenses quarterly, except during Budget Period 5 (see Section 4.2.2). The State will review reimbursement requests and, if approved, will pay retroactive reimbursements to the ACO up to the allotment determined by the PMPMs detailed in Exhibit 9. The allotment will be determined on a PMPM basis, as set forth in Exhibit 9. Any undisbursed funds up to the allotment are forfeited by the ACO. The State may redistribute any undisbursed flexible services funding among the other DSRIP funding streams at the State’s discretion, following the same parameters as described in Section 5.1.3 for redistribution of funding not distributed to ACOs, CPs, and CSAs. Any such redistributions would be reported to CMS in the State's quarterly progress reports.

The PMPMs for flexible services allotments will decrease over the DSRIP period as set forth in Exhibit 9. The State may vary these PMPMs in its discretion without obtaining CMS approval.

EXHIBIT 9 – PMPMs for Flexible Services

PMPMs for Flexible Services					
Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5
\$0.00	\$3.75	\$3.25	\$2.75	\$2.25	\$2.25

4.4.3 ACO Sub-Stream 4: DSTI Glide Path Funding

The amount of DSTI glide path funding the State will pay to each safety net hospital is detailed in Exhibit 10 below.

EXHIBIT 10 – DSTI Glide Path Funding by State Fiscal Year (\$ Millions)

DSTI Glide Path Funding (\$M) by State Fiscal Year						
Hospital Provider	SFY 18	SFY 19	SFY 20	SFY 21	SFY 22	Total
Boston Medical Center	\$23.74M	\$13.53M	\$10.10M	\$7.82M	\$6.30M	\$61.49M
Cambridge Health Alliance	\$12.07M	\$8.45M	\$6.36M	\$4.09M	\$3.00M	\$33.99M
Holyoke Medical Center	\$2.67M	\$1.58M	\$1.22M	\$0.99M	\$0.63M	\$7.09M
Lawrence General Hospital	\$0.58M	\$0.34M	\$0.26M	\$0.20M	\$0.43M	\$1.81M
Mercy Medical Center	\$1.18M	\$0.69M	\$0.53M	\$0.13M	\$0.00M	\$2.54M
Signature Healthcare Brockton Hospital	\$1.04M	\$0.61M	\$0.47M	\$0.37M	\$0.08M	\$2.56M
Steward Carney Hospital	\$1.80M	\$1.00M	\$0.81M	\$0.30M	\$0.05M	\$3.96M

These hospitals will only receive DSTI glide path funding through DSRIP if they participate in a MassHealth ACO, where participation means that the DSTI hospital has a provider arrangement or contract with the ACO that involves financial accountability, including the potential for the safety net hospital to share gains from savings and share responsibility for losses. For the purposes of this glide path funding, a DSTI hospital can only have a provider arrangement or contract with one ACO. This funding is not PMPM-based, but was developed to establish a glide path from current safety net care pool (SNCP) supplemental payments to reduced SNCP payments

This glide path funding needs to be converted from the state fiscal year framework to the Budget Period framework in order to align with the at-risk schedule described in Exhibit 20. Funds for the 6 month

Preparation Budget Period for each DSTI hospital will be equal to half of the hospital’s glide path payments in SFY18. Budget Period 1 funds for each DSTI hospital will be equal to the sum of half of the hospital’s glide path payments in SFY18 and SFY19. Budget Periods 2 through 4 for each DSTI hospital will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds for each DSTI hospital will be equal to half of the hospital’s glide path payments in SFY22. See Exhibit 11 for a table displaying the DSTI glide path funding by Budget Period.

EXHIBIT 11 – DSTI Glide Path Funding by Budget Period (\$ Millions)

DSTI Glide Path Funding (\$M) by Budget Period							
Hospital Provider	Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5	Total
Boston Medical Center	\$11.87M	\$18.64M	\$11.81M	\$8.96M	\$7.06M	\$3.15M	\$61.49M
Cambridge Health Alliance	\$6.04M	\$10.27M	\$7.41M	\$5.23M	\$3.55M	\$1.50M	\$33.99M
Holyoke Medical Center	\$1.33M	\$2.12M	\$1.40M	\$1.11M	\$0.81M	\$0.32M	\$7.09M
Lawrence General Hospital	\$0.29M	\$0.46M	\$0.30M	\$0.23M	\$0.32M	\$0.21M	\$1.81M
Mercy Medical Center	\$0.59M	\$0.93M	\$0.61M	\$0.33M	\$0.07M	\$0.00M	\$2.54M
Signature Healthcare Brockton Hospital	\$0.52M	\$0.82M	\$0.54M	\$0.42M	\$0.22M	\$0.04M	\$2.56M
Steward Carney Hospital	\$0.90M	\$1.40M	\$0.91M	\$0.56M	\$0.18M	\$0.03M	\$3.96M

Generally speaking, DSTI glide path funding will be paid in four quarterly installments for each Budget Period. The State anticipates these installments will be roughly equal; however, the State may alter the payment amounts, frequency, and timing in its discretion. During BP5, payments will be attributed to the first half of the year; as such, these attributed amounts will be twice the amount as what they would have been if payments had been attributed throughout the whole BP. For example, if an ACO had \$100 total of non-at-risk DSTI glide path funds for BP5, payments attributed to BP5 would be split between the first two quarters of BP5 (\$50 each), as opposed to \$25 attributed across each of the four quarters of BP5.

4.4.4 Detail on calculating member-months

Each ACO will be accountable for a defined population of members. Because ACOs’ responsibilities scale with their populations, the State will use the size of this population to determine the amount of Startup/Ongoing funding and the Flexible Services allotment for each ACO. For Partnership Plans and Primary Care ACOs, the number of members is simply the number of members enrolled in each ACO. Eligible MassHealth members will either choose to enroll or be assigned to these ACOs. MassHealth records members’ enrollments in the agency’s MMIS system and Data Warehouse. The State will tally a count of members enrolled in each ACO based on this record; this count will be multiplied by the DSRIP PMPM values to calculate the payment amounts per ACO.

For MCO-Administered ACOs, the State will use the number of members attributed to each ACO for the purposes of cost and quality accountability. These attributed members are the subset of MassHealth MCO enrollees who have primary care assignments in their MCOs to PCPs who participate in MCO-Administered ACOs. Massachusetts will know who these Participating PCPs are for each MCO-Administered ACO, and will record this information in its Data Warehouse. Each MCO will report to the State on a regular basis the primary care assignments for the MCO’s enrollees. The State will use this information to determine the number of MCO enrollees who have primary care assignments to each MCO-Administered ACO; this number will be multiplied by the DSRIP PMPM values to calculate the payment amounts per MCO-Administered ACO.

The State may use a point-in-time (“snapshot”) count of members for each ACO, or may calculate the average members each ACO has over a particular period (e.g., the most recent quarter) in order to ensure DSRIP payment calculations are robust to temporary fluctuations in member enrollments. Once

Massachusetts has selected ACOs and is able to perform more analytics on historical ACO-level member enrollment movement, Massachusetts intends to finalize such operational details of this calculation.

4.5 Payment Calculation and Timing for CP and CSA Sub-Streams

4.5.1 BH CP Sub-Stream 1: Care Coordination Supports Funding

The State will pay each BH CP a PMPM rate for care coordination supports for each member assigned to and engaged with the BH CP during the month. The PMPM rate has been developed to account, in part, based on the staff required to support the BH CP model, including the need for Registered Nurses, licensed clinicians, and access to a medical director for the performance of supports such as comprehensive assessments and medication reconciliation, as well as community health workers, health outreach workers, peer specialists and recovery coaches for the SMI and/or SUD population. Caseloads for each BH CP are expected to be between 35-50 engaged enrollees per FTE. The rate is anticipated to be \$180 PMPM. The State anticipates that the rate will remain constant for the first two years of the program, at which time the State plans to evaluate the program and revisit the PMPM rate. The State may vary the amount of the PMPM in its discretion at any time during the demonstration.

The State will begin to pay the PMPM rate to the BH CP when the member is assigned to the BH CP. Payment for outreach will only be made to a BH CP if outreach is attempted and documented during each month. A member is considered engaged with the BH CP when a comprehensive assessment is completed and care plan is developed. Payments will be made on a monthly basis. Payments for outreach will discontinue if a member is not engaged within 3 months of assignment to the BH CP.

Example payment calculation with PMPM of \$160:

Example payment amount for one month = (Total number of members assigned but not engaged + total number of members engaged)*\$160

4.5.2 BH CP Sub-Stream 2: Infrastructure and Capacity Building Funding

Each BH CP will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period. BH CPs will propose allocation of funds across the four categories listed in section 4.3.2 in their Preparation Budget Period Budgets and Budget Narratives. The State anticipates disbursing up to \$500,000 to each BH CP for initial infrastructure funding. The State may adjust the amount of the Preparation Budget Period funds disbursed to BH CPs in its discretion.

For Budget Periods 1 through 5, BH CPs will receive infrastructure funds based on the number of members engaged with the CP. For Budget Period 1, this will be the anticipated number of engaged members, as determined by the State. Exhibit 12 sets forth the anticipated PMPM schedule for BH CP infrastructure and capacity building funding. The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to BH CPs and CSAs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CP had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5. .

EXHIBIT 12 – Anticipated Schedule for BH CP for Infrastructure and Capacity Building (PMPM)

BH CP Infrastructure and Capacity Building PMPMs				
BP 1	BP 2	BP 3	BP 4	BP 5
\$35.00 - \$45.00	\$25.00 - \$35.00	\$15.00 - \$25.00	\$10.00 - \$20.00	\$5.00 - \$15.00

The State may vary the amount of the infrastructure PMPMs in its discretion.

As part of the Budget and Budget Narratives, BH CPs will indicate how they intend to use the infrastructure funding for amounts up to a maximum amount of possible funding (i.e., the CP's PMPM multiplied by the number of members engaged). The State may approve a lower amount based on its review of the Budgets and Budget Narratives.

For example, for a BH CP with 1,000 engaged members with a PMPM of \$40.00:

Maximum amount of Budget Period 1 Infrastructure Funds = $\$40.00 * 12 * 1000 = \$480,000$

4.5.3 BH CP Sub-Stream 3: Outcomes-Based Payments

Starting in Budget Period 3, the State will designate an annual pool of funding to award to high performing BH CPs based on metrics related to avoidable utilization (see section 5.4.4). The State anticipates this pool be approximately \$1M annually, but may vary this amount in its discretion. The State will set the achievement standards following analysis of baseline data from Performance Year 1 and Performance Year 2, subject to CMS approval. The total bonus the State allots yearly will be divided amongst the CPs that meet or exceed the achievement standards based on the number of members engaged with each CP relative to the number of total member engaged with all CPs that achieved the standard.

For example: five BH CPs, who collectively engaged with 7000 members, meet or exceed the achievement standard. With an annual outcomes based payment pool of \$1M, a CP who engaged with 1,200 of the 7,000 members would be eligible for 17.14% of the pool or \$171,400.

4.5.4 LTSS CP Sub-Stream 1: Care Coordination Supports Funding

The State will pay each LTSS CP a PMPM rate for care coordination supports for each member assigned to and engaged with the LTSS CP during the month. The PMPM rate has been developed, in part, based on the staff required to support the LTSS CP model, including the need for care coordinators with appropriate supervision at sufficient staffing levels to perform LTSS CP supports. Caseloads for LTSS CPs are expected to be between 70-100 engaged enrollees per FTE. The rate is anticipated to be \$80 PMPM for each member assigned and engaged with the LTSS CPs during the month. The State will set an additional PMPM for enhanced LTSS CP functions and anticipates caseload for enhanced LTSS CP supports to be 35-50 engaged enrollees. The State may vary the amount of the PMPMs in its discretion at any time during the demonstration.

The State anticipates beginning to pay the PMPM rate to the LTSS CP when the member is assigned to the LTSS CP, provided that outreach is attempted and documented during each month. A member is considered engaged in the LTSS CP when the person-centered care plan is completed. Payments will be made on a monthly basis.

Example payment calculation with PMPM of \$80:

Example payment amount for one month = (Total number of members assigned but not engaged + total number of members engaged)*\$80

4.5.5 LTSS CP Sub-Stream 2: Infrastructure and Capacity Building Funding

Each LTSS CP will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period. LTSS CPs will propose allocation of funds across the four categories listed in section 4.3.2 in their Preparation Budget Period Budgets and Budget Narratives. The State anticipates disbursing up to \$500,000 to each LTSS CP for initial infrastructure funding. The State has the discretion to adjust the amount of the Preparation Budget Period funds disbursed to LTSS CPs without obtaining CMS approval.

For Budget Period 1 through 5, LTSS CPs will receive infrastructure funds based on the number of members engaged with the CP. For Year 1 this will be the anticipated number of members engaged as determined by the State. The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to LTSS CPs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CP had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5.

EXHIBIT 13 – Anticipated Schedule for LTSS CP for Infrastructure and Capacity Building (PMPM)

LTSS CP Infrastructure and Capacity Building PMPMs				
BP 1	BP 2	BP 3	BP 4	BP 5
\$30.00 - \$40.00	\$20.00 - \$30.00	\$10.00 - \$20.00	\$8.00 - \$18.00	\$5.00 - \$15.00

The final PMPM will vary based on actual overall enrollment in CPs. The State may vary the amount for the PMPM without CMS approval.

CPs will submit Budgets and Budget Narratives for approval for amounts up to a maximum amount of PMPM * number of members engaged. The State will review and revise budgets as appropriate.

For example, for a LTSS CP with 1,000 engaged members with a PMPM of \$35.00:

$$\text{The maximum amount of Budget Period 1 Infrastructure Funds} = \$35.00 * 12 * 1000 = \$420,000$$

The State may approve a lower amount based on its review of the Budget and Budget Narrative, without CMS approval.

4.5.6 LTSS CP Sub-Stream 3: Outcomes-Based Payments

Starting in Budget Period 3, the State will designate an annual pool of funding (anticipated to be approximately \$500,000 annually) to award to high performing LTSS CPs based on metrics related to avoidable utilization (see section 5.4.4). The State will set the achievement standards following analysis of baseline data from Performance Year 1 and Performance Year 2, subject to CMS approval. Total bonus allotted yearly will be divided amongst the CPs that meet or exceed the achievement standards based on the number of members engaged with each CP relative to the number of total member engaged with all CPs that achieved the standard.

For example: four LTSS CPs, collectively engaged with 5,000 members, meet or exceed achieved the achievement standard. With an annual outcomes based payment pool of \$500,000, a CP who engaged with 800 of the 5,000 members would be eligible for 16% of the pool or \$80,000.

4.5.7 CSA Sub-Stream 1: Infrastructure and Capacity Building Funding

CSAs will receive an initial amount of infrastructure and capacity building funds during the Preparation Budget Period of between \$75,000 and \$350,000. The State will categorize CSAs based on the number of members they serve and the number of CSA contracts held and will advise CSA of their budget for the Preparation Budget Period. CSAs will propose allocation of funds across the three infrastructure categories listed in section 4.3.7 in their Preparation Budgets and Budget Narratives. The State will then disburse initial infrastructure funding to CSAs based on the approved budget. The State may adjust the amount of the Preparation Budget Period funds disbursed to CSAs in its discretion.

Exhibit 14 sets forth the anticipated PMPM schedule for CSA infrastructure and capacity building funding. The State may vary the infrastructure PMPM amount in its discretion.

EXHIBIT 14 – Anticipated Schedule for CSAs for Infrastructure and Capacity Building (PMPM)

CSA Infrastructure and Capacity Building PMPMs				
BP 1	BP 2	BP 3	BP 4	BP 5
\$35.00 - \$45.00	\$25.00 - \$35.00	\$15.00 - \$25.00	\$10.00 - \$20.00	\$5.00 - \$15.00

The State anticipates making infrastructure payments on a bi-annual basis, except during BP1 and BP5. During BP1, the State anticipates making only one payment to CSAs. During BP5, payments will be attributed to the first half; as such, the attributed amount will be twice the amount as what each bi-annual payment would have been if payments had been attributed throughout the whole BP. For example, if a CSA had \$100 total of non-at-risk infrastructure and capacity building funding for BP5, the total payment would be attributed to the first half of BP5.

4.6 Statewide Investments Funding Determination Methodology

The DSRIP Statewide Investment funding stream may be utilized by the State to fund the following initiatives: (1) Student Loan Repayment Program, (2) Primary Care Integration Models and Retention, (3) Investments in Primary Care Residency Training, (4) Workforce Development Grant Program, (5) Technical Assistance, (6) Alternative Payment Methods Preparation Fund, (7) Enhanced Diversionary Behavioral Health Activities and (8) Improved Accessibility for People with Disabilities or for Whom English Is Not a Primary Language. Exhibit 15 shows the anticipated funding breakdown for each initiative by demonstration year.

EXHIBIT 15 – Statewide Investments Funding Breakdown

Statewide Investments	Y1	Y2	Y3	Y4	Y5	Total
Student Loan Repayment Program	\$2.3M	\$3.9M	\$3.8M	\$3.5M	\$2.3M	\$15.8M
Primary Care Integration Models and Retention	\$1.8M	\$2.2M	\$1.7M	\$1.2M	\$1.0M	\$7.9M
Investment in Primary Care Residency Training	\$0.3M	\$1.1M	\$1.8M	\$2.1M	\$2.4M	\$7.6M
Workforce Development Grant Program	\$3.2M	\$2.7M	\$2.5M	\$2.4M	\$2.4M	\$13.2M
Technical Assistance for ACOs and CPs	\$12.3M	\$8.6M	\$8.6M	\$8.3M	\$6.2M	\$44.0M
Alternative Payment Methodology Preparation Funds	\$2.4M	\$2.4M	\$1.9M	\$4.7M	\$1.2M	\$12.6M
Enhanced Diversionary Behavioral Health Activities	\$1.3M	\$1.0M	\$1.0M	\$0.0M	\$0.0M	\$3.3M
Improved Accessibility for Members with Disabilities or for Whom English Is Not a Primary Language	\$0.6M	\$2.6M	\$2.6M	\$2.6M	\$2.0M	\$10.4M
Total	\$24.2M	\$24.6M	\$23.8M	\$24.8M	\$17.4M	\$114.8M

The State may shift funding among and within the eight Statewide Investment initiatives at its discretion, such that the funding totals for each initiative identified in Exhibit 15 and in initiative descriptions in Appendix B may change. The State must obtain CMS approval for any funding shifts within a demonstration year from one investment to another if the shifted amount is (1) greater than 15% of the original funding amount for the investment contributing the shifted amount or (2) if the shifted amount is greater than \$1M, whichever is greater. Otherwise, the State will notify CMS of any funding shifts in its quarterly reports.

Sections 4.6.1 – 4.6.8 discuss the general nature and funding methodology of each Statewide Investment initiative, including which entities or providers will be eligible to apply for DSRIP funds. Appendix B provides additional details on each initiative.

4.6.1 Student Loan Repayment Program

The student loan repayment program will repay a portion of awardees' student loans in exchange for a minimum of a two-year commitment to work in a community setting. Applicants may either be individual providers working at community mental health centers, or the centers themselves. The program will offer a specified amount of funding in each recipient category per year. Provider applicants may be eligible for different amounts of loan repayment based on their discipline and credentialing level. For providers selected to receive awards, the State will pay their student loan servicer directly. The anticipated provider categories and maximum award amounts are as follows:

- Primary Care Physician – Each awardee is eligible for up to \$50K in total student loan repayments
- Psychiatrists and psychologists – Each awardee is eligible for up to \$50K in total student loan repayments
- Advance Practice Registered Nurses, Physician Assistants and Nurse Practitioners – Each awardee is eligible for up to \$30K in total student loan repayments
- Licensed Social Workers and Licensed Behavioral Health Professionals – Each awardee is eligible for up to \$30K in total student loan repayments
- Behavioral Health Professionals (community health workers, peer specialists, recovery support specialists and non-licensed social workers) – Each awardee is eligible for up to \$20K in total student loan repayments

The State may vary the provider categories and award amounts in its discretion. The State may also develop enhancements to the student loan repayment program, such as learning collaboratives that engage distinct cohorts of student loan repayment recipients, which provide additional training and mentorship for providers and deepen their commitment to careers in community settings. The State will define application criteria and eligibility, and then select awardees through a competitive process that will allow the State to evaluate the applicants relative to the criteria established.

4.6.2 Primary Care Integration Models and Retention

The investment in primary care integration models and retention will support a grant program to community health centers (CHCs), community mental health centers, and entities participating in CPs and CSAs that allows primary care and behavioral health providers to design and carry out one-year projects related to accountable care. The State will define application criteria and eligibility, and will select awardees through a competitive process that will allow the State to evaluate the proposed projects for scope, impact, feasibility, cost and need, among other factors. The State anticipates that awardees will receive up to \$40K per project but the amount of funding may vary by project, as determined by the State. The CHC, CMHC, or entity participating in a CP or CSA will be the primary applicant with a primary care or behavioral health provider as a partner. The State will disburse funds directly to the CHC, CMHC, or entity participating in a CP or CSA.

4.6.3 Investment in Primary Care Residency Training

The investment in primary care residency training will help offset hospital and community health center costs of filling community health center (CHCs) and community mental health center (CMHC) residency slots. The State will fund hospitals, community health centers, and community mental health centers that are selected for awards. Hospitals and CHCs/CHMCs will apply jointly for the award in the case of PCPs. The State anticipates that funding will vary based on the resident's discipline as follows:

- Primary Care Provider (PCP) – For each PCP residency slot filled, the State will pay the community health center or community mental health center up to \$150K and the hospital up to \$20K for a total of up to \$170K for each year of residency.
- Nurse Practitioner (NP) – For each NP residency slot filled, the State will pay the community health center or community mental health center up to \$85K for each year of residency.

The State will define application criteria and eligibility, and then select awardees through a competitive process that allows the State to evaluate the applications relative to the criteria established.

4.6.4 Workforce Development Grant Program

The workforce development grant program will support a range of activities to increase and enhance the State’s healthcare workforce capacity (e.g., creation or support for workforce training programs, help providers to attend educational events, help ACOs/CPs/CSAs develop programs (one-on-one and group), outreach to potential workforce). The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

4.6.5 Technical Assistance for ACOs, CPs and CSAs

The technical assistance (TA) program aims to provide ACOs, CPs and CSAs with the training and expertise necessary to implement evidence-based interventions that meet the needs of the new healthcare landscape. For entities that apply and are awarded funding, the State will pay their TA vendor(s) directly. The State will also use this TA funding to invest in resources to ensure the long-term sustainability of the TA provided to eligible recipients.

Recipients may be required to contribute a certain percentage (e.g., up to 30 percent) of the overall TA costs, which will create an incentive for the recipient to work diligently with the TA vendors and the State to effect change.

TA funding will be allocated to ACOs, CPs and CSAs on a PMPM basis. The State will set the PMPM amount and may vary the amount in its discretion, for example, based on enrollment or TA applicant volume. The PMPM funding amount will represent a funding cap; i.e., the State will not award more than this amount to a recipient, but may ultimately pay less than the full PMPM allocation if the recipient’s TA costs are lower than anticipated. The State may redistribute or reallocate unused TA funding in its discretion. If the overall cost of TA exceeds the PMPM allocation and recipient contribution combined, the recipient will be responsible for covering the excess cost. For example, if an ACO is required to pay 30% of the overall TA cost and is allocated \$700,000 in PMPM funding:

- ACO could propose TA plan costing \$1,000,000
 - ACO pays \$300,000 and the State pays \$700,000
- ACO could propose TA plan costing \$1,100,000
 - ACO pays \$400,000 and the State pays \$700,000
- ACO could propose TA plan costing \$900,000
 - ACO pays \$270,000 and the State pays \$630,000
 - State may redistribute or reallocate remaining \$70,000 funding at its discretion

In order to receive TA funds, applicants must submit on a detailed TA plan that explains how funding will be used and demonstrates that funding is not duplicative of TA efforts supported by other funding sources (e.g., federal, state, private). The State will evaluate the proposed plans for scope, impact, feasibility, cost and need, among other factors prior to approval.

4.6.6 Alternative Payment Methods (APM) Preparation Fund

The APM preparation fund will support providers who are not yet ready to participate in an APM but demonstrate interest in and intent to participate in the near future. The State will define application criteria and eligibility, and will select awardees through a competitive process that will allow the State to evaluate the proposed projects for scope, impact, feasibility, cost and need, among other factors. The State will determine the funding amounts based on its evaluation of successful applications. The APM preparation fund may also be used to raise awareness about APM among providers not yet engaged in a MassHealth ACO, CP, or CSA.

4.6.7 Enhanced Diversionary Behavioral Health Activities

The investment in enhanced diversionary behavioral health activities will support the implementation of strategies to ensure members with behavioral health needs receive care in the most appropriate, least restrictive settings. The State will consider a broad spectrum of strategies for investment (e.g., technological solutions to facilitate providers' access to patients' medical histories upon arrival to the ED, data collection and analysis platforms, etc.).

The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

4.6.8 Improved Accessibility for People with Disabilities or for whom English is not a Primary Language

This investment will fund programs to support providers in the acquisition of equipment, resources and expertise that meet the needs of people with disabilities or for whom English is not a primary language. The State will consider a broad spectrum of strategies for investments (e.g., funding for purchasing items necessary to increase accessibility for members, accessible communication assistance and development of educational materials for providers and members).

The State will administer the funded activities with internal staffing resources, or designees determined through competitive procurements, interagency service agreements (ISAs) or other means. The State will determine the funding amounts for various activities within this initiative based on project scope, impact, feasibility, cost and need, among other criteria.

4.7 DSRIP Carry Forward

Given that a significant portion of DSRIP funds will be disbursed on a PMPM basis, lower than anticipated member participation in the ACO or CP programs may lead to lower actual expenditures in a given DSRIP year. Therefore, the State may carry forward prior year DSRIP expenditure authority from one year to the next for reasons related to member participation fluctuations. This carry forward authority will extend to the following funding streams; as these areas are directly related to and impacted by member participation fluctuation.

- All ACO funding streams
- All CP funding streams
- Statewide Investments: technical assistance and workforce development grant programs

- State operations/implementation

The State does not have carry forward authority for other funding streams within statewide investments.

Per STC 57(d)(iii), if the expenditure authority carried forward from one year to another is more than 15% of the prior year's expenditure authority, then the State will submit a request to carry forward the expenditure authority for review and approval by CMS. CMS will respond to the State's request within 60 business days. If approved, the State will provide an updated funding allocation table to CMS in the next quarterly progress report to CMS. If the carryforward amount is less than or equal to 15% of the prior year's expenditure authority, then the State will provide an updated funding allocation table to CMS in the next quarterly progress report to CMS. The State must ensure that carry over does not result in the amount of DSRIP expenditure authority for DSRIP Year 5 being greater than the amount for DSRIP Year 4.

Section 5. DSRIP Accountability Framework (State Accountability to CMS; ACO, CP and CSA Accountability to State)

5.1 Overview

The State has structured an accountability framework for its DSRIP program, under which the State is accountable to CMS for the State's achievement of delivery system reform goals. The State's failure to achieve the standards set for these goals may result in the loss of DSRIP expenditure authority according to the at-risk schedule set forth in STC 67(b). Any lost expenditure authority will result in parallel reduced DSRIP expenditures by the State. If the State experiences reduced expenditure authority from CMS, the State has discretion to determine whether and to what extent to reduce any of the four funding streams to best meet the State's programmatic needs while adhering to the State's DSRIP expenditure authority.

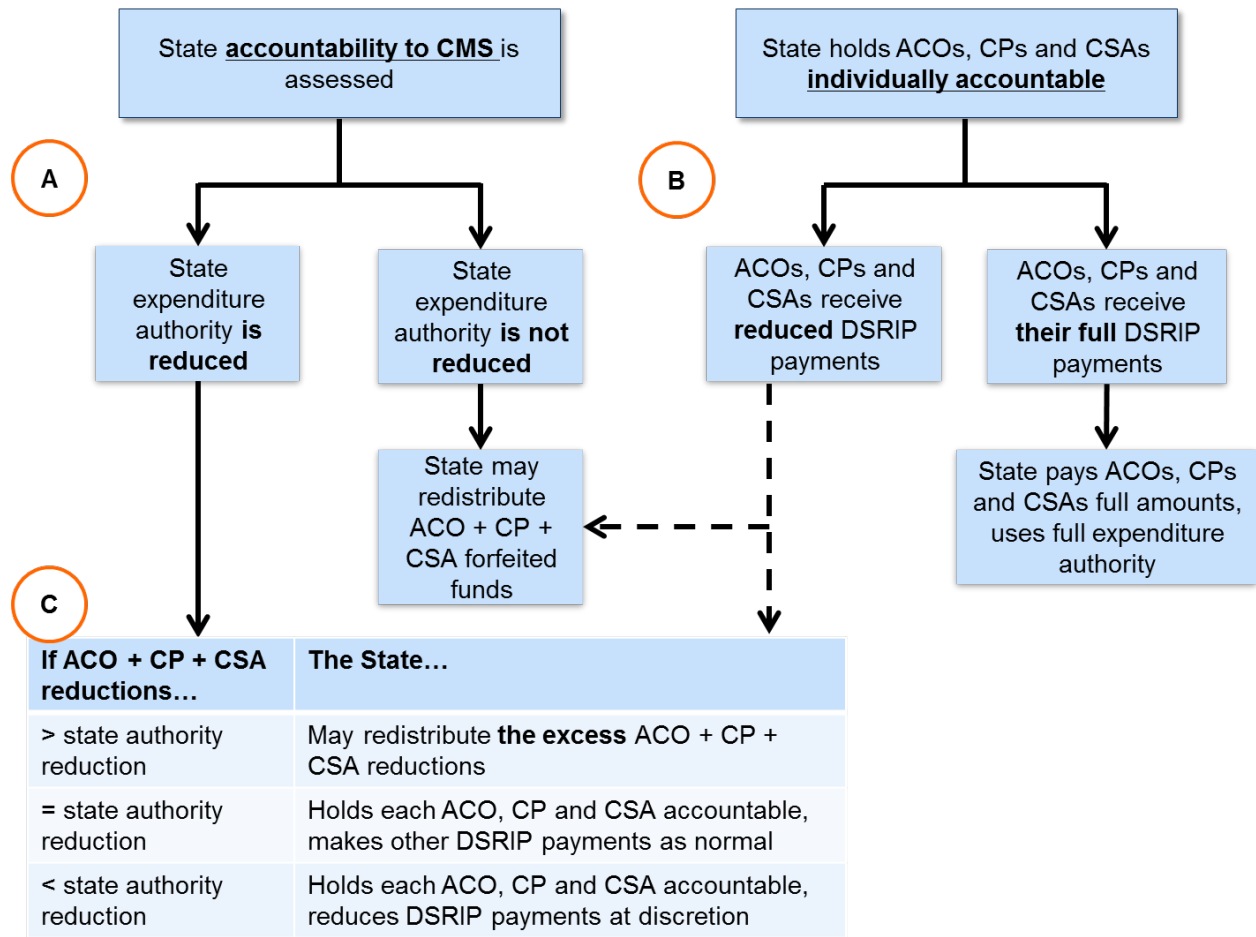
Separately, to maximize incentives for delivery system reform, ACOs, CPs and CSAs that receive DSRIP funds are each accountable to the State for their individual performance. An ACO's, CP's or CSA's failure to achieve the individual accountability standards set by the State may result in the ACO, CP or CSA receiving less DSRIP funding from the state. Any reduction in DSRIP funding experienced by an individual ACO, CP or CSA will not necessarily impact the State's overall DSRIP expenditure authority under the demonstration.

Exhibit 16 below illustrates the State's accountability to CMS, and also illustrates ACOs', CPs' and CSAs' accountability to the State and how these two accountability mechanisms interact.

This section will describe each step of these accountability mechanisms as follows:

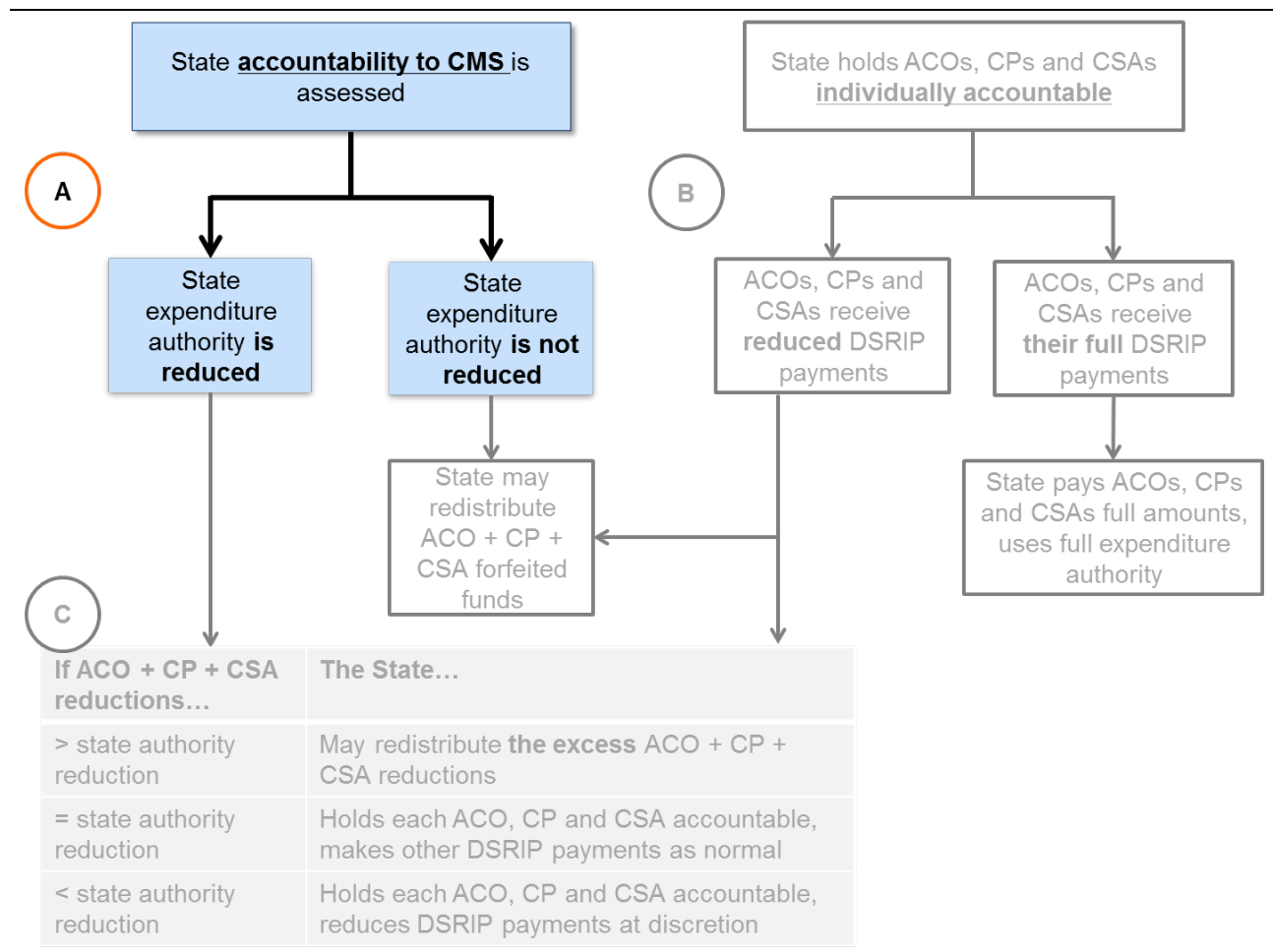
- Section 5.1: provides an overview of DSRIP Accountability Framework for the State to CMS and ACOs, CPs and CSAs to the State
- Section 5.2: provides detail on State Accountability to CMS
- Section 5.3: provides detail on accountability framework and performance based payments for ACOs
- Section 5.4: provides detail on accountability framework and performance based payments for CPs and CSAs
- Section 5.5: outlines reporting requirements for ACOs, CPs and CSAs

EXHIBIT 16 – Process Flow for State Accountability to CMS and Accountability of ACOs, CPs, and CSAs to the State



5.1.1 State Accountability to CMS

EXHIBIT 17 – Process Flow for State Accountability to CMS



A portion of the State’s DSRIP expenditure authority will be at-risk based on the State’s DSRIP Accountability Score according to the schedule set forth in STC 67(b). The portion of the State’s DSRIP expenditure authority that is at-risk will follow the same at-risk Budget Period structure as for the ACOs, CPs and CSAs.

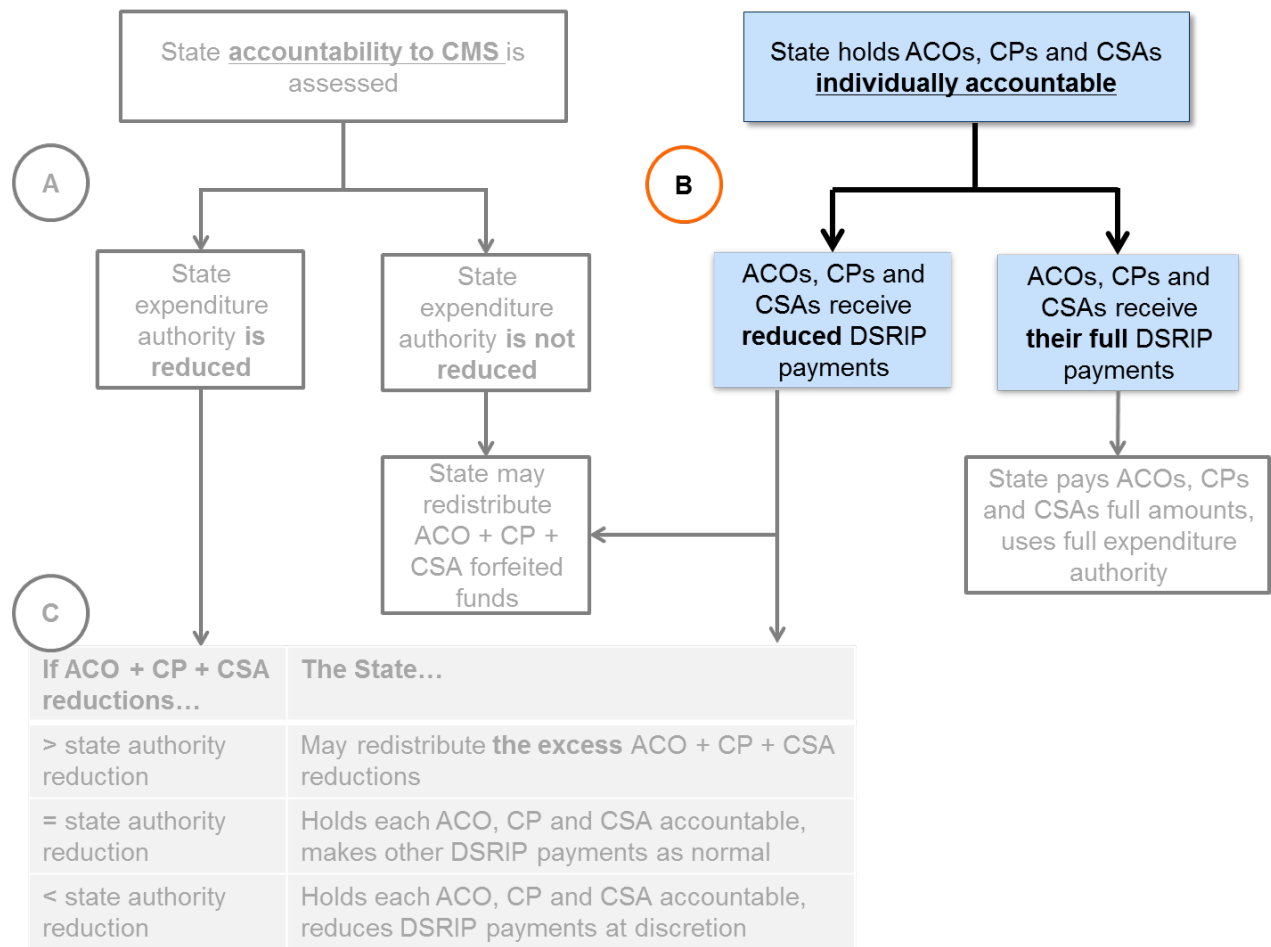
The Preparation Budget Period and BP1 will not have any at-risk expenditure authority. BP 2 has at-risk expenditure authority, and its Accountability Score will not be determined until the fourth quarter of BP3. Thus, the State anticipates that any reduced expenditure authority may be reflected in the State’s reduction of DSRIP payments during BP 4. As an example, if the State’s Accountability Score for BP 2 is 70%, then the State will lose the remaining 30% of its \$20.625M of BP 2 at-risk expenditure authority (i.e., \$6.1875M). The State may reflect this by subtracting up to \$6.1875M from its anticipated \$275M BP 4 DSRIP expenditure authority.

The State may also satisfy any reductions in DSRIP expenditure authority through retroactive recoupments from recipients of DSRIP funds, or through the State paying CMS back for any Federal Financial Participation the State retroactively owes for such reductions. For example, for Budget Periods 4 and 5, the State anticipates that there will be no upcoming Budget Periods for which to reduce DSRIP expenditures by the time the Accountability Scores for these Budget Periods are calculated; the State may therefore satisfy any reductions in DSRIP expenditure authority for these Budget Periods through such recoupments, through paying CMS back, or through identifying other cost savings in the DSRIP program, such as in the statewide investments or implementation/oversight funding streams.

If the State decides to recoup funding from ACOs or CPs, then it will first distribute the recoupment amounts among the ACOs and CPs as a class. One potential approach for this initial distribution is to divide the recoupment amount according to the 5-year DSRIP expenditure authority for the ACO and CP funding streams, as detailed in Table F of the STCs (i.e., ACOs: \$1,065.6M, or 66.1%; CPs: \$546.6M, or 33.9%). To determine how much funding is recouped from individual ACOs, the State may take each ACO's DSRIP Accountability Score and calculate the difference from 100%. The State will then calculate a weight for each ACO that is equal to that ACO's "difference from 100%" divided by the summed total of all the ACOs' "difference from 100%". That weight will then be multiplied by the ACO portion of the recoupment amount to determine the amount of funding that the State will recoup from the ACO. As an example, if the State needs to recoup \$100 for BP4, then it will first divide the recoupment between the ACOs and CPs according to Table F of the STCs (i.e., ACOs and CPs will need to pay back \$66.10 and \$33.90, respectively). If there are two ACOs, and ACO 1 scored a 90%, and ACO 2 scored a 60% (corresponding to "differences from 100%" of 10% and 40%, respectively), then ACO 1 would need to pay back $\$66.10 * (10\% / (10\% + 40\%)) = \13.22 , and ACO 2 would need to pay back $\$66.10 * (40\% / (10\% + 40\%)) = \52.88 . The State may implement a different methodology for recouping funds from CPs and CSAs. The State will make a final determination of its recoupment methodology once it decides that it will recoup funds, and once it understands why the State had to recoup funds. For example, the recoupment methodology described above may be appropriate for poor statewide quality performance, but inappropriate for poor statewide APM adoption.

5.1.2 ACO, CP and CSA Accountability to the State

EXHIBIT 18 – Process Flow for ACO, CP and CSA Accountability to the State



Regardless of the State’s performance with respect to its accountability to CMS, the State will separately hold each ACO, CP and CSA that receives DSRIP funds individually accountable for its performance on a slate of quality and performance measures. This structure maximizes performance incentives for these recipients.

This individual accountability is applied to each ACO’s, CP’s and CSA’s at-risk DSRIP funding for each budget period. The State intends to withhold the at-risk portion of ACO’s, CP’s and CSA’s funding until the respective Accountability Scores are calculated. The ACOs, CPs and CSAs will then receive a percentage of their withheld funds based on their Accountability Score (e.g., if an entity scores 0.6, it will receive 60% of the at risk funds) and will not receive the remainder.

As described above, ACOs receive four sub-streams of DSRIP payment. The mechanism for accountability differs slightly by stream, as explained in the table below.

EXHIBIT 19 – ACO Accountability Mechanism by Funding Sub-Stream

ACO Accountability Mechanism by Funding Sub-Stream		
Provider Type	Funding Sub-Stream	Mechanism for Individual Accountability
ACOs	Startup/Ongoing: <i>Primary Care Investment</i>	Fixed amount, not withheld or at-risk
	Startup/Ongoing: <i>Discretionary</i>	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	DSTI Glide Path	Withheld portion is fully at-risk each BP based on ACO's Accountability Score
	Flexible Services	Not at performance risk, but reimbursed retrospectively based on State approval of ACOs' reimbursement requests for costs incurred. ACOs fully at risk for any expenses not approved by the State.

The portion of Startup/Ongoing funding that is provided for each ACO to support primary care investments are not at performance risk in order to provide some measure of predictability and stability in this funding stream, to encourage innovative investments in primary care infrastructure, and to mitigate the risk of costly delays or changes in funding that might make front-line primary care providers more hesitant to invest in practice-level change.

The at-risk withheld amount differs between the discretionary Startup/Ongoing stream, and the DSTI Glide Path. In general, a smaller percentage of the DSTI Glide Path funding is at risk. This difference reflects the safety net status of these hospitals.

EXHIBIT 20 – Percent of ACO Funding At Risk by Budget Period

Percent of ACO Funding At Risk by Budget Period						
DSRIP Budget Period	Prep BP	BP 1	BP 2	BP 3	BP 4	BP 5
Startup/Ongoing (Discretionary) At-Risk	0%	5%	15%	30%	40%	50%
Glide Path Funding At-Risk	0%	5%	5%	10%	15%	20%

For ACOs that join after BP1, their at-risk schedule will start at the BP1 percent (i.e. 5%), and then follow the schedule above with appropriate lag. For example, if an ACO joins in BP3, their at-risk schedule for the discretionary startup/ongoing funds would be: BP3 – 5%, BP4 – 15%, BP5 – 30%

CPs and CSAs also receive several funding streams, as described below. Funds for Care Coordination Supports and Infrastructure and Capacity Building are at risk for BH and LTSS CPs. Infrastructure and Capacity Building funds are at risk for CSAs. The amount of CP funds that are at-risk increases over the course of the program.

The accountability mechanisms for CPs and CSAs also vary by funding sub-streams, as described below. Funds for Care Coordination Supports and Infrastructure and Capacity Building are at risk for BH and LTSS CPs. Infrastructure and Capacity Building funds are at risk for CSAs.

EXHIBIT 21 – CP and CSA Accountability Mechanism by Funding Sub-Stream

CP and CSA Accountability Mechanism by Funding Sub-Stream		
Provider Type	Funding Sub-Stream	Mechanism for Individual Accountability
BH CPs	Care Coordination Supports	Withheld portion is fully at-risk each BP based on CP's Accountability Score
	Infrastructure & Capacity Building	
	Outcome-Based Payments	Incentive pool based on performance on avoidable utilization measures
CSAs	Infrastructure & Capacity Building	Withheld portion is fully at-risk each BP based on CSA's Accountability Score
LTSS CPs	Care Coordination Supports	Withheld portion is fully at-risk each BP based on CP's Accountability Score
	Infrastructure & Capacity Building	
	Outcome-Based Payments	Incentive pool based on performance on avoidable utilization measures

Exhibit 22 sets forth the amount of CP and CSA funding that is at risk by budget period.

EXHIBIT 22 – Amount of CP and CSA Funding At-Risk by Budget Period

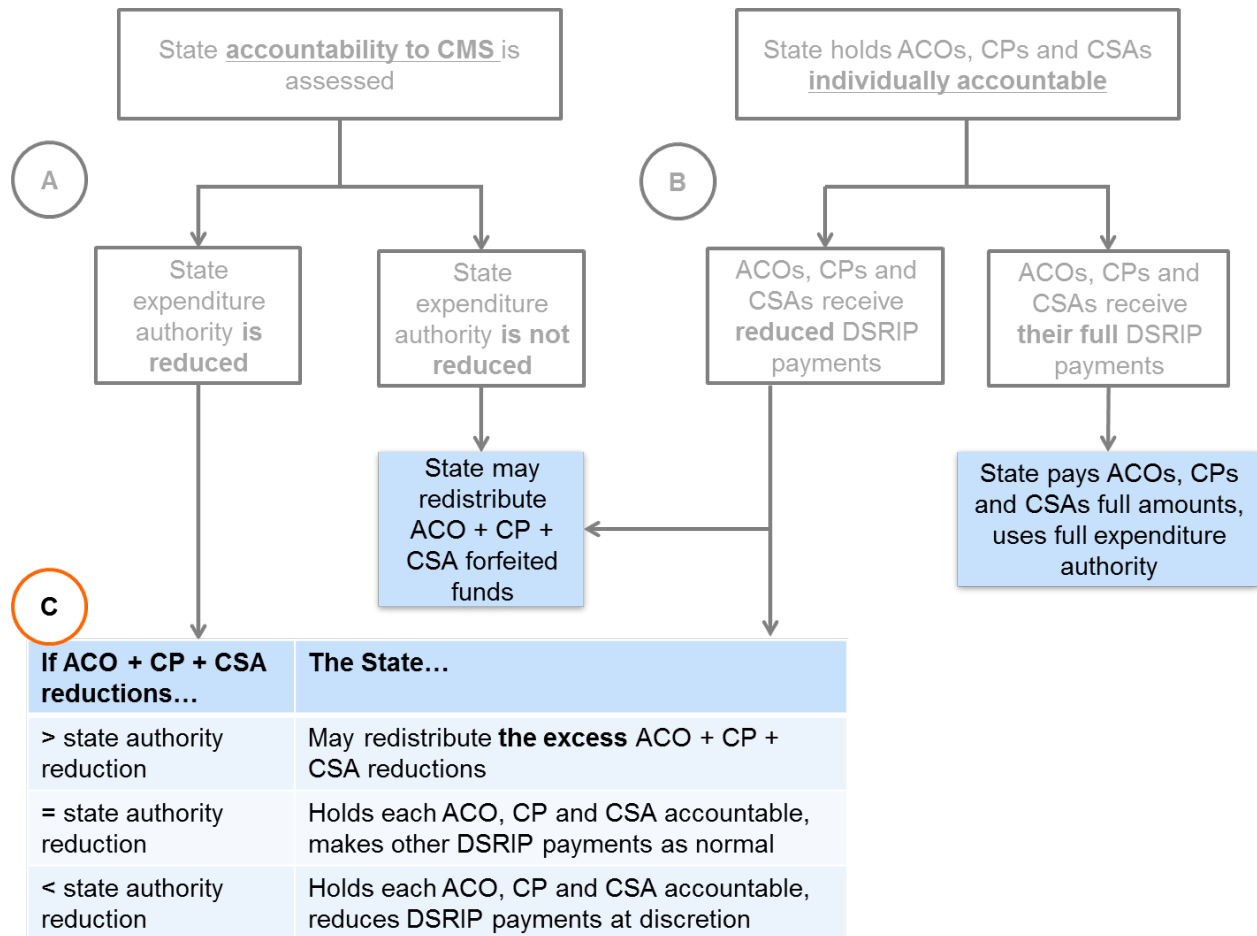
Percent of CP and CSA Funding At-Risk by Budget Period						
DSRIP Budget Period	Prep BP	BP1	BP2	BP3	BP4	BP5
% of CP and CSA Funding At-Risk, excepting Outcome-Based Payments	0%	0%	5%	10%	15%	20%

For CPs or CSAs that join after BP1, their at-risk schedule will start at the BP1 percent (i.e. 0%), and then follow the schedule above with appropriate lag. For example, if a CP joins in BP3, their at-risk schedule for the DSRIP funds would be: BP3 – 0%, BP4 – 5%, BP5 – 10%.

In addition to holding ACOs, CPs, and CSAs accountable by designating a portion of their DSRIP funding as at-risk, the State will manage its contracts with these entities to ensure compliance with and satisfactory performance of contractual requirements related to the DSRIP program. In the event of noncompliance or unsatisfactory performance, the State will determine the appropriate recourse, which may include contract management activities such as, but not limited to: working collaboratively with the ACOs, CPs, or CSAs to identify and implement new strategies to meet their contractual requirements, requiring the ACOs, CPs, or CSAs to implement corrective action plans, or reducing DSRIP payments to the ACOs, CPs, or CSAs. If the State reduces DSRIP payments to ACOs, CPs, or CSAs as part of its contract management efforts, the undisbursed funds may be redistributed among the other DSRIP funding streams at the State's discretion, following the parameters described in Section 5.1.3.

5.1.3 Distribution of Funds Based on Accountability

EXHIBIT 23 – Process Flow for Distribution of Funds Based on Accountability



Based on the State’s assessments of individual accountability for each ACO, CP and CSA, individual ACOs, CPs and CSAs may not receive a certain amount of DSRIP funds each Budget Period, relative to the maximum each could potentially receive.

If the State’s expenditure authority is not reduced based on its accountability to CMS, the State has discretion to redistribute the DSRIP funds not distributed to ACOs, CPs, and CSAs (e.g., to determine how much each of the funding streams and sub-streams is increased) to best meet the State’s programmatic needs, subject to any limits described elsewhere in this Protocol. For example, the State will identify the amount of forfeited DSRIP funds it has available to redistribute, and then determine how it might reallocate the funds to other DSRIP funding streams. Any such redistributions would be reported with CMS in the State’s quarterly progress reports.

For example, in Q4 of BP3, the BP2 Accountability Scores for the State, ACOs, CPs and CSAs will become available. If ACOs lost \$1M of at-risk BP2 funds and the State earned a 100% DSRIP Accountability Score, then the State could reallocate that \$1M to a different funding stream or sub-stream, at the State’s discretion, based on the State’s assessment of program needs, in the remaining time left in BP3 (e.g., increase flexible services allocation for ACOs, increase care coordination funding amounts or the outcomes-based incentive pool for CPs, increase statewide investments funding or

implementation/oversight funding), or may be used for future BP4 or BP5 payments. The allowable categories that the redistributed funds could be reallocated to are:

- ACO funding stream
 - Startup/ongoing
 - Flexible services
- Community Partners funding stream
 - Infrastructure and capacity building
 - Care coordination
 - Outcomes-based payments
- Statewide Investments funding stream
 - All statewide investments

If the State's expenditure authority has been reduced based on its accountability to CMS, the State will base its actions on the relative sizes of these reductions, as follows:

- If the amount of funds not distributed to ACOs, CPs and CSAs pursuant to their accountability scores is equal to the State's expenditure authority reduction based on the State's accountability to CMS, the State will satisfy its obligation to reduce DSRIP spending by reducing payments to these ACOs, CPs and CSAs based on their individual accountability arrangements with the State, and will make other DSRIP payments pursuant to this Protocol
- If the amount of funds not distributed to ACOs, CPs and CSAs pursuant to their accountability scores exceeds the State's expenditure authority reduction based on the State's accountability to CMS, the State will satisfy its obligation to reduce DSRIP spending by reducing payments to these ACOs, CPs and CSAs based on their individual accountability arrangements with the State, but the State may have left over expenditure authority after doing so. The State has discretion to redistribute these excess DSRIP funds not distributed to ACOs, CPs, and CSAs pursuant to their accountability scores (e.g., to determine how much each of the funding streams and sub-streams is increased) to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. Such redistribution of funds would follow the same processes described above for when the State's expenditure authority has not been reduced.
- If the amount of funds not distributed to ACOs, CPs and CSAs is less than the State's expenditure authority reduction based on the State's accountability to CMS (including if ACOs, CPs and CSAs receive all DSRIP funds under their accountability arrangements with the State), the State has discretion to determine whether and to what extent each of the four funding streams and sub-streams is reduced for an upcoming Budget Period to best meet the State's programmatic needs, subject to any limits described elsewhere in this Protocol. The State also has discretion to determine whether and to what extent to satisfy the reduced expenditure authority through retroactive recoupments from recipients of DSRIP payments or through separately paying CMS back for the Federal Financial Participation for any such reduced expenditure authority.
 - State DSRIP expenditures can be categorized as (1) non-at-risk payments and (2) at-risk payments which are dependent on the calculation of Accountability Scores. The at-risk payments cannot be disbursed until CMS approves the Accountability Scores that are used to calculate the at-risk payments, as described in Section 5.2.2. The State will make non-at-risk payments and then retroactively claim FFP for those payments. Given that the FFP claiming for the non-at-risk payments for a particular Budget Period may occur before the State's Accountability Score is calculated for that Budget Period, it is possible for the State to claim more FFP than its reduced expenditure authority would allow. In this scenario, the State would reconcile its claimed FFP amount with CMS. If the State retroactively recoups funds from ACOs, CPs, or CSAs, it will follow the process laid out in Section 5.1.1.

5.2 State Accountability to CMS

As set forth in STC 67, a portion of the State’s DSRIP expenditure authority will be at-risk. In accordance with STC 67, if the State’s DSRIP expenditure authority is reduced based on an Accountability Score that is less than 100%, then the State will reduce future DSRIP payments in proportion to the reduced expenditure authority to ensure sufficient state funding to support the program. The portion of at-risk DSRIP expenditure authority is set forth in Exhibit 24.

EXHIBIT 24 – Percent of DSRIP Expenditure Authority At-Risk

DSRIP Budget Period	Prep BP and BP1	BP 2	BP 3	BP 4	BP 5
DSRIP Expenditure Authority	\$637.5a M	\$412.5M	\$362.5M	\$275M	\$112.5M
% of Expenditure Authority At-Risk	0%	5%	10%	15%	20%
Actual Expenditure Authority At-Risk	\$0M	\$20.625M	\$36.25M	\$41.25M	\$22.5M

The amount of at-risk DSRIP expenditure authority lost will be determined by the State’s DSRIP Accountability Score. The methodology for calculating the State’s DSRIP Accountability Score is discussed in Section 5.2.1.

5.2.1 Calculating the State DSRIP Accountability Score

The State DSRIP Accountability Score will be based on three domains: (1) MassHealth ACO/APM Adoption Rate; (2) Reduction in State Spending Growth; and (3) ACO Quality and Utilization Performance.

Each domain will be assigned a weight that varies by Budget Period. The weights for the State DSRIP Accountability domains are detailed in Exhibit 25:

EXHIBIT 25 – State DSRIP Accountability Domains

State DSRIP Accountability Domain	% Contribution to State DSRIP Accountability Score			
	Prep Budget	BP 1	BP 2	BP 3-5
MassHealth ACO/APM Adoption Rate	NA	NA	30%	20%
Reduction in State Spending Growth	NA	NA	NA	25%
ACO Quality and Utilization Performance	NA	NA	70%	55%

The State will calculate the State DSRIP Accountability Score by multiplying the Score for each State DSRIP Accountability domain by the associated weight and then summing the totals together.

For example, the BP 5 State DSRIP Accountability Score is calculated using the following equation:

$$\text{State DSRIP Accountability Score} = (\text{MassHealth ACO/APM Adoption Rate Score}) * 20\% + (\text{Reduction in State Spending Growth Score}) * 25\% + (\text{ACO Quality and Utilization Performance Score}) * 55\%$$

If the State is able to earn 100% for the MassHealth/APM Adoption Rate Score, 30% for the Reduction in State Spending Growth Score, and 70% for the ACO Quality and Utilization Performance Score, then the State's DSRIP Accountability Score would be:

$$\text{State DSRIP Accountability Score} = (100\%) * 20\% + (30\%) * 25\% + (70\%) * 55\% = 66\%$$

The State estimates that it will take approximately nine months after the close of a Budget Period to calculate the State DSRIP Accountability Score, due to claims rollout and other administrative considerations. Thus, the State anticipates that it will provide its DSRIP Accountability Score and supporting documentation for a given Budget Period during Q4 of the following Budget Period. If the State DSRIP Accountability Score is not 100%, pursuant to STC 67(d), the State will submit to CMS a proposed Corrective Action Plan at the same time as it submits its State DSRIP Accountability Score and supporting documentation.

Corrective Action Plan

The Corrective Action Plan will include steps the State will take to regain any reduction to its DSRIP expenditure authority; and potential modification of accountability targets. The State's Corrective Action Plan will be subject to CMS approval. CMS will render a decision on approval or disapproval of requested Corrective Action Plan within 60 business days of receipt of Plan and prior to determining the amount of reduction to the State's DSRIP expenditure authority. If CMS does not approve the Corrective Action Plan, then the State's DSRIP expenditure authority will be reduced in accordance with the State DSRIP Accountability Score. If CMS approves the Corrective Action Plan, the State's DSRIP expenditure authority for the relevant Budget Period will be held intact and not reduced, contingent on the State successfully implementing the approved Corrective Action Plan. If the State fails to implement the Corrective Action Plan, then CMS will retrospectively reduce the State's DSRIP expenditure authority in accordance with the State's DSRIP Accountability Score. If the State partially implements the Corrective Action Plan, then CMS has the discretion to require a smaller retrospective reduction in the State's DSRIP expenditure authority.

5.2.1.1 State Accountability Domain 1: Calculating the MassHealth ACO/APM Adoption Rate

Under the MassHealth ACO/APM Adoption Rate accountability domain, the State will have target percentages for the number of MassHealth ACO-eligible members who are enrolled in or attributed to ACOs or who receive service from providers paid under APMs. The State will calculate the percentage of ACO-eligible members enrolled in or attributed to ACOs or who receive services from providers paid under APMs, as follows:

- ACO-eligible members shall be all members who are eligible to enroll in or be attributed to MassHealth ACOs
- The State shall count towards the State's achievement of ACO/APM adoption, all members who:
 - Are enrolled in or attributed to an ACO during the Budget Period
 - Are enrolled with a MassHealth MCO and receive primary care from a PCP that is paid by that MCO under a shared savings and/or shared risk arrangement, or is similarly held financially accountable by that MCO for the cost and quality of care under a State-approved APM contract
 - Receive more than 20% of their non-primary care services (either gross patient service revenue or net patient service revenue) from providers who are paid under episode-based payments, shared savings and/or shared risk arrangements, or who are similarly held

financially accountable for the cost and quality of care under a State-approved APM contract

The target adoption percentages will follow the schedule detailed in Exhibit 26.

EXHIBIT 26 – Target ACO/APM Adoption Rates

DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
ACO/APM adoption (as defined above)	NA	25%	30%	35%	40%	45%

If the State meets or surpasses the target for a given Budget Period, the State will earn a 100% score on this domain for that Budget Period. If the State does not meet the target, then it will earn a 0% score for that Budget Period.

5.2.1.2 State Accountability Domain 2: Reduction in State Spending Growth

In accordance with STC 67(g), the State will calculate its performance on reduction in state spending growth compared to the trended PMPM, as detailed in Exhibit 27 and the domain score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed in STC 67(g). The PMPM used will be as follows:

4.4% - 2017 President’s Budget Medicaid Baseline smoothed per capita cost trend, all populations combined, 2017-2022

The State will be accountable to a 2.1% reduction in PMPMs for the ACO-enrolled population, off of “trended PMPMs” (described below) by BP 5. In Budget Periods 3 and 4, the State will have target reductions smaller than 2.1% off of the trended PMPM, as preliminarily detailed in Exhibit 27.

EXHIBIT 27 – Proposed Reduction Targets for ACO-Enrolled PMPMs

DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
% Reduction Target in ACO-enrolled PMPM vs. trended PMPM	NA	NA	NA	0.25% off of trended PMPM	1.1% off of trended PMPM	2.1% off of trended PMPM

Gap to Goal Methodology

In accordance with STC 67(g), the State will calculate its performance on reduction in State spending growth compared to the trended PMPM, and the domain score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed in STC 67(g).

The State will measure spending performance against the PMPM spending reduction target no later than 12 months after the close of each Calendar Year (CY) as follows. Baseline spending trends will be determined no later than January 1st, 2019, according to the following methodology:

- Baseline PMPM spending in CY2017 will be calculated by dividing actual expenditures for dates of service in CY2017 in Included Spending Categories (as defined below), by the number of member months for all MCO and PCC -enrolled members (i.e., ACO-eligible population) for each Rating Category (RC):

- RC 1 – Child: Enrollees who are non-disabled, under the age of 21, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505
- RC 1 – Adult: Enrollees who are non-disabled, age 21 to 64, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505
- RC 2 – Child: Enrollees who are disabled, under the age of 21, and in MassHealth Standard or CommonHealth as described in 130 CMR 505
- RC 2 – Adult: Enrollees who are disabled, age 21 to 64, and in MassHealth Standard or CommonHealth as described in 130 CMR 505
- RC 9: Individuals ages 21 through 64 with incomes up to 133% of the federal poverty level (FPL), who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage
- RC 10: Individuals ages 21 through 64 with incomes up to 133% of the FPL, who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage, who are receiving Emergency Aid to the Elderly, Disabled, and Children (EAEDC) through the Massachusetts Department of Transitional Assistance
- A weighted-average Baseline PMPM will then be calculated by multiplying the PMPM rate for each EG by the proportion of ACO-eligible population member months represented within each RC to derive the Baseline PMPM.

$$Baseline\ PMPM^{CY2017} = \sum_n Actual\ PMPM_{RC\ n}^{CY2017} \times ACOeligiblepopRCproportion_{RC\ n}^{CY2017}$$

- Trended PMPMs for each RC will be calculated by applying a 4.4% annual growth rate to the CY2017 Actual PMPMs for each RC and year from CY2018 through CY2022, summarized as follows:

$$Trended\ PMPM_{RC\ n}^{YEAR\ t} = 1.044^t \times Actual\ PMPM_{RC\ n}$$

- For each measurement period, a weighted average Trended PMPM (the “Avg Trended PMPM”) will then be calculated by multiplying the Trended PMPM for each RC by the proportion of total ACO-enrolled or ACO-attributed (collectively, the “ACO population”) member months represented within each RC, summarized as follows:

$$Avg\ Trended\ PMPM^{YEAR\ t} = \sum_n Trended\ PMPM_{RC\ n}^{YEAR\ t} \times ACOeligiblepopEGproportion_{RC\ n}^{YEAR\ t}$$

- Note that while the Trended PMPM for each RC will remain constant (4.4% annual increase from CY2017), the base PMPM for each calendar year will change based on the actual composition of the ACO population during each measurement period
- If during the measurement period there are changes to Included Spending Categories or other material program changes not captured in the annual growth rate, the CY2017 Baseline and Trended PMPMs may be recalculated to reflect these changes, subject to CMS approval.
 - In particular, if the State identifies a material difference between the CY2017 ACO eligible population and the population of members and provider networks that participate

in the ACO program during the performance years (e.g., if ACOs that have historically high costs for their member populations join the program), the State may request that CMS adjust the CY2017 baseline to account for such difference; the State shall provide supporting analysis in the event of such a request, and CMS will have 90 calendar days to review and approve the request.

For each Calendar Year, performance of the ACO population will be measured as follows:

- The State will divide actual expenditures in Included Spending Categories by eligible member months during the CY to generate raw PMPM spending for the ACO population and also for the ACO-eligible population within each RC. Actual expenditures will be based on date of service, and will be derived from Medicaid claims data, MCO encounter data, and/or accounting reports, summarized as follows:

$$ACO\ Elig\ Pop\ Raw\ PMPM_{RC\ n}^{YEAR\ t} = ACO\ Elig\ Pop\ Actual\ Expenditures_{RC\ n}^{YEAR\ t} \div ACO\ elig\ pop\ MM_{RC\ n}^{YEAR\ t}$$

$$ACO\ Pop\ Raw\ PMPM_{RC\ n}^{YEAR\ t} = ACO\ Pop\ Actual\ Expenditures_{RC\ n}^{YEAR\ t} \div ACO\ pop\ MM_{RC\ n}^{YEAR\ t}$$

- To adjust for differences in acuity, an average risk score based on data from the measurement period will be calculated for each of these two populations in each RC using the DxCG risk model employed for ACO pricing.
- The risk score for the ACO population will be normalized relative to a score of 1.0 for the full ACO-eligible population.
- Raw PMPMs for the ACO population will be divided by normalized risk scores to calculate risk-adjusted PMPMs, summarized as follows:

$$Adj\ PMPM_{RC\ n}^{YEAR\ t} = \frac{Raw\ PMPM_{RC\ n}^{YEAR\ t}}{ACO\ Pop\ Risk\ Score_{RC\ n}^{YEAR\ t} / ACO\ Elig\ Risk\ Score_{RC\ n}^{YEAR\ t}}$$

- A weighted average risk-adjusted PMPM for the ACO population will be calculated by aggregating the products of the risk-adjusted PMPMs for each RC multiplied by the proportion of total ACO population member months represented within each RC, summarized as follows:

$$Avg\ Adj\ PMPM^{Year\ t} = \sum_n Adj\ PMPM_{RC\ n}^{YEAR\ t} \times ACO\ pop\ RC\ proportion_{RC\ n}^{YEAR\ t}$$

- Savings attributed to the “DSTI Glide Path” sub-stream payments will be subtracted from the weighted average risk-adjusted PMPM on an aggregate basis each CY.
 - DSTI Glide Path payments made during the CY will be subtracted from the DSTI payments made during CY2017 and divided by the total member months included in measurement year’s weighted average risk-adjusted PMPM. The resulting savings PMPM will be subtracted from the weighted average risk-adjusted PMPM to derive total PMPM spending for the ACO population (“Actual PMPM”), summarized as follows:

$$\begin{aligned}
 \text{Actual PMPM}^{\text{YEAR } t} &= \frac{\text{Avg Adj PMPM}^{\text{YEAR } t} \times (\text{DSTI payments}^{\text{CY2017}} - \text{DSTI Glide Path payments}^{\text{YEAR } t})}{\text{ACO pop member months}}
 \end{aligned}$$

- The percent reduction in Actual PMPM will be determined according to the following calculation: percent reduction = (Avg Trended PMPM minus Actual PMPM) / (Avg Trended PMPM), summarized as follows:

$$\text{Percent reduction}^{\text{YEAR } t} = \frac{\text{Avg Trended PMPM}^{\text{YEAR } t} - \text{Actual PMPM}^{\text{YEAR } t}}{\text{Avg Trended PMPM}^{\text{YEAR } t}}$$

Included Spending Categories

Determination of spending baseline and actual performance of the ACO population will take into consideration all expenses included in ACOs' capitation rates and TCOC Benchmark calculations for year 1 of the ACO program. For the population of members attributed to MCO-Administered ACOs, the determination of spending will be based on actual MCO expenditures for services to the population attributed to the ACO, and not on the State's capitated payments to the MCO. These costs include costs for covered services such as physical health, behavioral health, and most pharmacy, but do not include costs for Long Term Services and Supports (LTSS) and certain other costs that are similarly excluded from ACO capitation rates and TCOC Benchmarks. In addition, the following expenditure categories shall be excluded from both baseline and actual performance measurement for the purposes of the state's TCOC accountability to CMS, regardless of their inclusion in or exclusion from ACO TCOC:

- Hepatitis C drugs
- Other high-cost emerging drug therapies (e.g., treatment for cystic fibrosis) that result in a significant increase in spending that is not reasonably in the control of an ACO to manage
- Long-term services and supports (LTSS)
- All DSRIP expenditures except those for the DSTI Glide Path sub-stream as described above
- Payments made in accordance with Attachment Q of the 1115 Waiver Demonstration and other quality incentive payments
- All administrative payments made to ACOs, or to MCOs for MCO-Contracted members

The State may submit requests for additional exclusions or Baseline PMPM adjustments for CMS approval by submitting an amendment to the Protocol. CMS will have 60 business days to review and respond to these methodology modification requests.

PMPM Spending Reporting Tool

The State and CMS will jointly develop a reporting tool (using a mutually agreeable spreadsheet program) for the State to use for annual PMPM spending demonstration and in other situations when an analysis of ACO-enrolled population PMPM spending is required. A working version of the reporting tool will be available for the State's report for the first Budget Period.

5.2.1.3 State Accountability Domain 3: Overall Statewide Quality and Utilization Performance

In accordance with STC 67(h), the State will annually calculate the State performance score for each quality and utilization domain by aggregating the performance scores of all ACOs on a member-month

weighted basis. That is, ACOs with more members will have their domain performance scores weighted more heavily than ACOs with fewer members. The anticipated weighting of each domain to the State Overall Statewide Quality and Utilization Performance is detailed in Exhibit 28. The overall DSRIP quality and utilization domain score will be determined by calculating a weighted sum of the DSRIP domain scores, according to the domain weights detailed in Exhibit 28. Please see Appendix D for example calculations.

EXHIBIT 28 – Anticipated Weighting of ACO Quality and Utilization Domains

Domain	Budget Period 1 (reporting only, focused on clinical quality measure)	Budget Periods 2-5
Prevention & Wellness	20%	10%
Chronic Disease Management	20%	15%
Behavioral Health / Substance Use	25%	15%
Long Term Services and Supports	10%	5%
Avoidable Utilization	0%	20%
Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	25%	20%
Member Care Experience	0%	15%

The measures within the domains are the same measures for the State as for the ACOs (i.e., Appendix D). For an ACO, measures within a given domain all contribute to that ACO's domain score equally. For the State Accountability Domain Scores, ACO domain scores are averaged together and weighted by the number of members per ACO, thereby creating a weighted average of domain scores across all ACOs.

Scoring for All Domains Except Avoidable Utilization

In accordance with STC 67(i), for all domains except the Avoidable Utilization domain, the State will calculate two scores:

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

The aggregate domain score is calculated by aggregating scores from all ACOs. For example, if the State has three ACOs (ACO₁, ACO₂, ACO₃) with 10, 20 and 30 members respectively, and they achieve domain scores of 30%, 50% and 70% for the Prevention & Wellness (P&W) domain, respectively, then the aggregate domain score for the P&W domain would be:

$$\text{Aggregate domain score} = (\text{ACO}_1 \text{ contribution}) + (\text{ACO}_2 \text{ contribution}) + (\text{ACO}_3 \text{ contribution}) = (30\% * (10 / (10 + 20 + 30))) + (50\% * (20 / 60)) + (70\% * (30 / 60)) = 5\% + 17\% + 35\% = 57\%.$$

The DSRIP domain score for a particular domain will be equal to 100% if the aggregate domain score in the current Budget Period is not statistically worse (i.e., comparable or statistically better, using a stratified Wilcoxon test; i.e., the van Elteren test) than the pooled aggregate domain score from previous Budget Periods. The DSRIP domain score for a particular domain will be equal to 0% if the aggregate domain score in the current Budget Period is statistically worse than the pooled aggregate domain score

from previous Budget Periods. For the purpose of these statistical tests, an alpha value of ≤ 0.1 will constitute statistically significant improvement or worsening, in alignment with the alpha-value threshold the State will use to evaluate measure improvement for ACOs.

As an example, the pooled aggregate P&W domain score in BP3 for a two-ACO marketplace (ACO₁: 10 members, 40% BP1 score, 60% BP2 score; ACO₂: 20 members, 50% BP1 score, 75% BP2 score) is calculated in the following manner:

Pooled aggregate domain score = ACO₁, BP1 contribution + ACO₂, BP1 contribution + ACO₁, BP2 contribution + ACO₂, BP2 contribution = (ACO₁ BP1 score * (10 / (10 + 10 + 20 + 20))) + (ACO₁ BP2 score * (10 / 60)) + (ACO₂ BP1 score * (20 / 60)) + (ACO₂ BP2 score * (20 / 60)) = (40% / 6) + (60% / 6) + (50% / 3) + (75% / 3) = 58%

Using the Prevention & Wellness (P&W) domain in BP2 as an example:

- If the P&W aggregate domain score in BP 2 is not statistically worse (i.e., comparable or statistically better) than the P&W aggregate domain score in BP 1, then the BP 2 P&W DSRIP domain score is 100%
- If the P&W aggregate domain score in BP 2 is statistically worse than the P&W aggregate domain score in BP 1, then the BP 2 P&W DSRIP domain score is 0%

Using the Prevention & Wellness domain in BP 3 as an example:

- If the P&W aggregate domain score in BP 3 is not statistically worse (i.e., comparable or statistically better) than the pooled P&W aggregate domain scores in BP 1 through BP 2, then the BP 3 P&W DSRIP domain score is 100%
- If the P&W aggregate domain score in BP 3 is statistically worse than the pooled P&W aggregate domain scores in BP 1 through BP 2, then the BP 3 P&W DSRIP domain score is 0%

The State will use a stratified Wilcoxon test (i.e., the van Elteren test) to calculate the statistical difference, given that the aggregate domain score will be a weighted average of the individual ACO domain scores.

Domain Scoring for Avoidable Hospital Utilization

In accordance with STC 67(j), the State's performance on avoidable hospital utilization will be evaluated on two measures:

- Potentially preventable admissions (3M's PPA measure)
- Hospital all-cause readmissions (based off of NQF #1789)

The State will calculate risk-adjusted ratios of observed-to-expected utilization rates for all ACO-attributed members in the State that meet measure eligibility requirements. Calculations will be performed in the following manner:

- Identify all ACO-attributed, measure-eligible members participating in the DSRIP program
- Calculate the observed-to-expected ratio of potentially preventable admission (PPA) weights and observed-to-expected ratio of readmissions for these members. Inherent to these calculations are risk adjustment methodologies for both measures, specifically:

- PPA – Utilize 3M’s proprietary risk adjustment methodology whereby weights are assigned to admissions deemed preventable. Weights are based on member Clinical Risk Groupings (CRGs), Diagnosis Related Groups (DRGs) and Severity of Illness (SOI). This process results in a sum of observed PPA weightings in a measure year, and an expected sum of weightings calculated from a baseline period.
- All Cause Readmissions – Utilize and adapt NQF 1789 risk adjustment whereby the expected number of readmissions is adjusted by the populations’ diagnostic grouping (DxCG), social determinants of health risk scoring, age, and sex. The observed number of readmissions is not risk-adjusted.

The State has preliminarily identified reduction targets for these risk-adjusted ratios of observed-to-expected PPA and readmissions utilization rates (see Exhibit 29); the reduction targets are expressed as percentages, and represent a relative reduction in the rate of PPAs or readmissions (i.e., the absolute change in the rate, divided by the initial rate). The reduction targets for the two measures will account for the factors set forth in STC 67(j). The average of the scores on these two measures will be the State DSRIP domain score for avoidable hospital utilization.

EXHIBIT 29 – Preliminary Avoidable Utilization Reduction Targets

DSRIP Period	Budget	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
PPA Targets	Reduction	Reporting Only	Reporting Only	3%	7%	12%	15%
Readmissions Reduction Targets		Reporting Only	Reporting Only	3%	9%	15%	20%

The reduction targets displayed in Exhibit 29 were developed based on historical pre-CY2017 data. In accordance with STC 67(j), the State will adjust these reduction targets to reflect CY2017 baseline performance. Specifically, by November 2018, the State will compare CY2017 baseline performance with the original pre-CY2017 baseline data. Should it appear that the reduction targets were set too high or too low based on this baseline comparison, the State will develop a proposal to alter the targets based on in-state historical trended data, data from other DSRIP states, and other comparable data sources. Proposals will be presented to the DSRIP Advisory Committee on Quality for review and input. Proposals will then be submitted to CMS, which will have 90 calendar days to respond to the target modification request.

5.2.2 DSRIP Expenditure Authority and Claiming FFP

The State must use a permissible source of non-federal share to support the DSRIP program. The non-federal share of DSRIP payments consists of revenues deposited in the State’s MassHealth Delivery System Reform Trust Fund administered by the Executive Office of Health and Human Services. Sources of funds in the Delivery System Reform Trust Fund are deposited at the direction of the Legislature and include hospital assessments transferred from the Health Safety Net Trust Fund, General Fund dollars, and interest earned. The non-federal share will be used to support claiming of Federal Financial Participation (FFP), up to the State’s DSRIP expenditure authority. The amount of DSRIP expenditure authority is dependent on the State DSRIP Accountability Score, which is described above in Section 5.2.1, which describes:

- How the State DSRIP Accountability Score is calculated

- The review and approval process for the State DSRIP Accountability Score, including how the State may submit a Corrective Action Plan to CMS if the State’s DSRIP Accountability Score is not 100% for a given Budget Period

Federal Financial Participation is only available for DSRIP payments to ACOs and CPs in accordance with the DSRIP Protocol and Participation Plans; or to other entities that receive funding through the DSRIP statewide investments or DSRIP-supported state operations and implementation funding streams. The State may claim FFP for up to two years after the calendar quarter in which the State made DSRIP payments to eligible entities.

The State may claim FFP for up to \$1.8 billion in DSRIP expenditures, subject to all requirements set forth in the demonstration Expenditure Authority, Special Terms and Conditions, and this DSRIP protocol. A portion of DSRIP payments to ACOs, CPs and CSAs are at-risk (Exhibits 15 and 17), and the State will withhold these at-risk payments from the entities until their DSRIP Accountability Scores are calculated by the State and such calculations are approved by CMS. The draw of the FFP match for all at-risk funds, or reporting of payments on the CMS-64 form, will not occur until DSRIP Accountability Scores (see Sections 5.3 and 5.4.1) or DSRIP Performance Remediation Plan Scores (see Sections 5.3.4.2 and 5.4.6.1) have been approved by the State and CMS. As described in Sections 5.3.4.2 and 5.4.6.1, the State will submit the DSRIP Accountability Scores and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the Accountability Scores. Once the at-risk payments are approved, the State will disburse the portion of the withheld at-risk funds that were earned, and the State will report such expenditures on the CMS 64 form and draw down FFP accordingly. The State may not claim FFP for any at-risk expenditures until CMS has issued formal approval.

5.2.3 Modification to State Accountability Targets

The State may modify State Accountability Targets during the demonstration period (e.g., in situations where an expensive, but highly needed prescription drug enters the market). The State will submit modification requests to CMS for review and approval. CMS will review and approve the proposed modifications within 90 calendar days of submission.

5.3 Accountability Framework & Performance Based Payments for ACOs

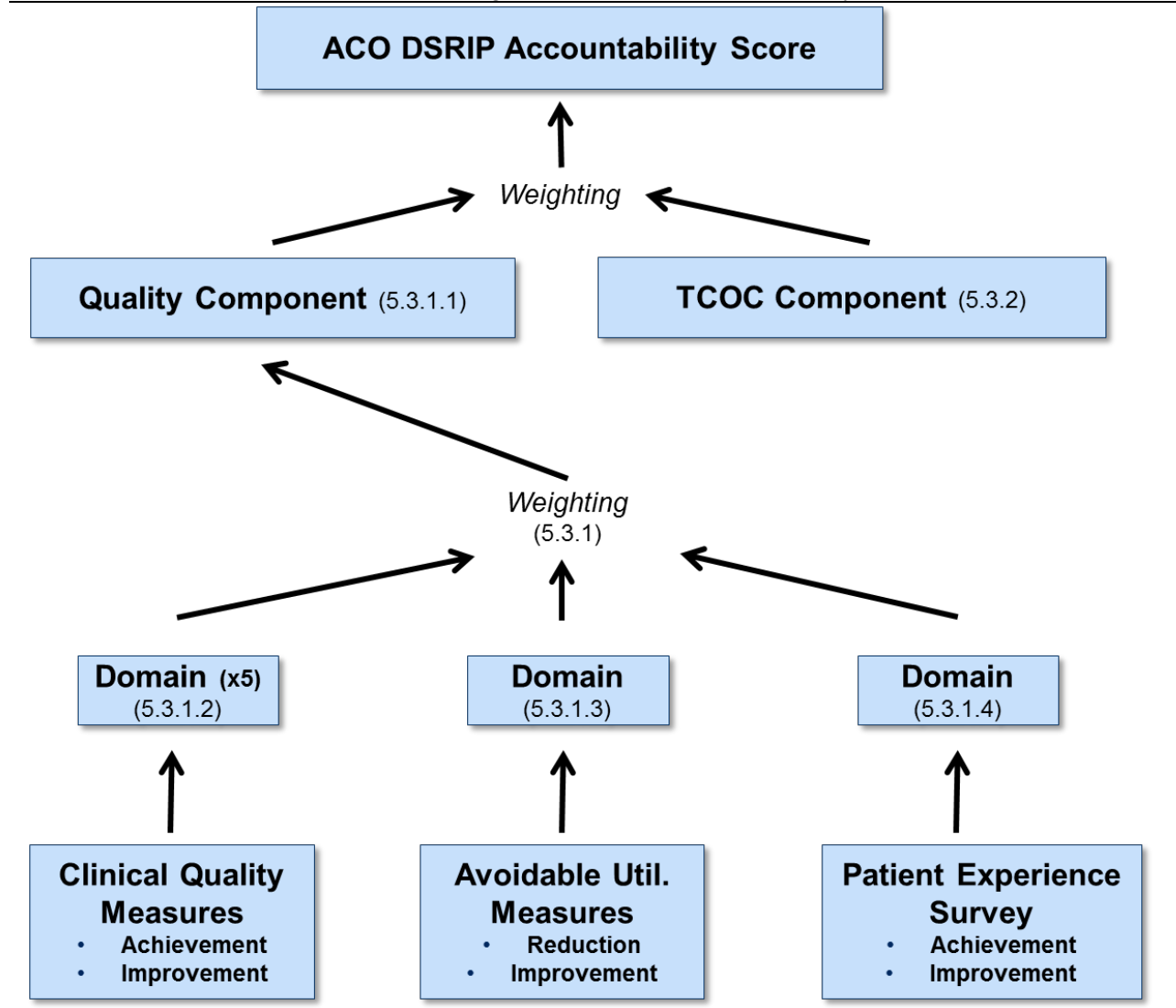
As described in Section 4.4 above, each of the four sub-streams of DSRIP funding that the State will pay to ACOs is subject to an accountability framework that aligns ACO incentives with the State’s delivery system reform goals. For two of these sub-streams (Startup/Ongoing: discretionary; and DSTI Glide Path), the State will hold each ACO accountable for the ACO’s individual performance by withholding a percentage of the funds each Budget Period, and retrospectively paying out a portion of the withheld amounts to the ACO based on the ACO’s performance on clinical quality, avoidable utilization, and member experience measures as well as on Total Cost of Care.

The State will measure ACO performance using a state-calculated score called the “ACO DSRIP Accountability Score.” The ACO DSRIP Accountability Score is a value between zero (0) and one (1), expressed as a percentage (i.e., between 0% and 100%). The State will multiply each ACO’s withheld funds for a given Budget Period by the ACO’s ACO DSRIP Accountability Score for that Budget Period, and will retrospectively pay the ACO the resulting amount. Sections 4.4.1-4.4.3 focus on the technical methodology for calculating these scores. Section 4.4 describes process, timelines, key players and roles and responsibilities for calculating the scores.

- **Section 5.3.1: Quality and TCOC Components of the ACO DSRIP Accountability Score**
- **Section 5.3.2: TCOC Component of the ACO DSRIP Accountability Score**
- **Section 5.3.3: Impact of DSRIP Accountability Scores on Payments to ACOs**

- **Section 5.3.4: Process, Roles, and Responsibilities for calculating the ACO DSRIP Accountability Score**
- **Section 5.3.5: Timeline of ACO DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments**

EXHIBIT 30 – Process Flow for Calculating the ACO DSRIP Accountability Score



5.3.1 Quality and TCOC Components of the ACO DSRIP Accountability Score

Each ACO’s ACO DSRIP Accountability Score is produced by blending two separate measures of the ACO’s performance during the Budget Period: (1) the Quality component of the ACO DSRIP Accountability Score; and (2) TCOC component of the ACO DSRIP Accountability Score. The Quality component of the ACO DSRIP Accountability Score is a score that the State will calculate that represents the ACO’s performance on quality measures during the Budget Period. The TCOC component of the ACO DSRIP Accountability Score is a score that the State will calculate that represents the ACO’s performance on TCOC management during the Budget Period. Each of these two scores is a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%).

For each ACO, the State will blend these two scores each Budget Period using a weighted average (i.e., the Quality component of the ACO DSRIP Accountability Score will be multiplied by a weight; the TCOC component of the ACO DSRIP Accountability Score will be multiplied by a weight; and the two resulting products will be summed to produce the ACO’s ACO DSRIP Accountability Score). Exhibit 31 below shows the anticipated weights for each Budget Period.

EXHIBIT 31 – ACO DSRIP Accountability Domains

ACO DSRIP Accountability Domain Weights			
	Prep BP	BP 1-2	BP 3-5
Quality component of the ACO DSRIP Accountability Score	N/A	100%	75%
TCOC component of the ACO DSRIP Accountability Score	N/A	N/A	25%

ACOs do not have ACO DSRIP Accountability Scores during the Preparation Budget Period because no funds are withheld. ACOs will not have enrolled or attributed members during this period, and the State will therefore not be able to calculate performance on quality measures and TCOC metrics. During Budget Periods 1 and 2, the State will not hold ACOs accountable for TCOC performance in the ACO DSRIP Accountability Score, to allow ACOs time to analyze baseline TCOC performance, which will not be finalized for Budget Period 1 until close to the end of Budget Period 2.

5.3.1.1 Calculating the Quality Component of the ACO DSRIP Accountability Score by Combining Domain Scores

The State will calculate each ACO’s Quality Component of the ACO DSRIP Accountability Score based on the ACO’s performance on a range of State-defined quality measures. The quality measure slate was chosen to support the goals of the DSRIP program including promoting member-driven, integrated, coordinated care and improving integration among physical health, behavioral health, long-term services and supports, and health-related social services. In addition, the ACO measure slate has significant overlap with the CP measure slate, helping to align ACO quality evaluation with CPs and furthering integration.

These measures are organized across seven (7) Quality Domains. The State will calculate a Domain Score for each of these seven Quality Domains; each Domain Score will be a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). The State will combine these seven Domain Scores using a weighted average (i.e., the State will multiply each Domain Score by a weight and will sum the weighted products to produce the ACO’s Quality Score for the Budget Period). The seven Quality Domains and their anticipated weights are listed below in Exhibit 32. If an ACO does not meet eligibility requirements for a specific measure, then the weight assigned to the measure within the measure’s domain will be redistributed equally among all other measures within that domain. Thus, the overall domain weights will not increase or decrease as a result of measure ineligibility. If an ACO is ineligible to provide data on all measures within a given domain, the redistribution of that domain weight to other eligible domains will be reviewed by the DSRIP Quality Committee and the State, and will be submitted to CMS for review and approval within 90 calendar days prior to final DSRIP Accountability scoring.

EXHIBIT 32 – ACO Quality Domains and Domain Weights

ACO Quality Domain Weights			
Quality Domain		Domain Weight: BP 1	Domain Weight: BP 2-5
1	Prevention & Wellness	20%	10%
2	Chronic Disease Management	20%	15%
3	Behavioral Health / Substance Use	25%	15%
4	Long Term Services and Supports	10%	5%
5	Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	25%	20%
6	Avoidable Utilization	0%	20%
7	Member Care Experience	0%	15%

Appendix D displays the 39 proposed measures that comprise these seven domains, including an indication as to whether the measure data will be collected via claims and encounters only or whether clinical chart data will be utilized. Additionally, there is an indication of the expected “reporting” and/or “performance” role in the program by Budget Period. Appendix D includes further details regarding the measures including measure descriptions, measure stewards, benchmark sources and reporting frequency. The State will send the initial measure specifications to CMS for review and approval by July 2017

For Quality Measures that are primarily based on national measure specifications (e.g., NCQA HEDIS), where minimal changes have been made to the specification (e.g., a change from health plan population to ACO population), the State will use nationally available Medicaid benchmarks to establish its Attainment Thresholds and Excellence Benchmarks where feasible (see Section 5.3.1.2). The State will propose these Attainment Thresholds and Excellence Benchmarks to CMS by August 2017.

For Quality Measures for which there are related (i.e., same measure description) national measure specifications (e.g., ADA, AMA, CMS) but where changes may be significant (e.g., a change in risk adjustment methodology or a change from all-payer population to Medicaid-only population), the State will research existing data to determine if the related national and/or state/local data is applicable. If the existing data are relevant, the State will propose Attainment Thresholds and Excellence Benchmarks for these measures to CMS by August 2017. If the existing data are not relevant, the State will propose Attainment Thresholds and Excellence Benchmarks for these measures to CMS by November 2018 using CY2017 data (for claims-based measures) or November 2019 using CY2018 (for measures requiring chart review).

For novel measures, including member experience, the State will attempt to identify similar measures with similar specifications from other data sources (e.g., other DSRIP programs, statewide data, etc.) as a source for Attainment Thresholds and Excellence Benchmarks. Should other sources not be available, the State will use state-specific data reported from its ACOs. In particular, the State anticipates using CY2017 historical MassHealth benchmarks for claims-based measures without appropriate national measure specifications, with the benchmark dataset potentially based on performance of MassHealth ACO-eligible members. For these measures, the State will propose Attainment Thresholds and Excellence Benchmarks to CMS by November 2018.

The State anticipates using CY2018 MassHealth ACO-attributed benchmarks for member experience measures, most measures that require chart review, or for most claims-based measures that were not

previously collected prior to DSRIP (e.g. the integration measures in Domain 5). For these measures, the State will propose Attainment Thresholds and Excellence Benchmarks to CMS by November 2019.

All proposed benchmarks that the State submits to CMS will have been reviewed by the DSRIP Advisory Committee on Quality, and will be accompanied by individual rationales for each benchmark. CMS will provide written feedback on the proposed benchmarks and rationale within 90 calendar days. If CMS has not provided written feedback within 90 calendar days, then the benchmarks will be deemed approved, given the necessity of providing these benchmarks to ACOs prior to the start of their next Budget Period.

5.3.1.2 Calculating the Domain Score for Quality Domains 1-5

The first five Quality Domains comprise measures of clinical quality and the Domain Score for each is calculated using a common methodology, described in this section. For each of these five Quality Domains, each ACO will receive a Domain Score that is a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). This Domain Score will be calculated by assigning the ACO a number of points (detailed below) and dividing the assigned number by the maximum number of points available in the Quality Domain.

Each of the first five Quality Domains is each comprised of several Quality Measures. The State will score each ACO on each Quality Measure unless the ACO does not meet eligibility requirements for a specific measure based on the measure specifications (e.g., a minimum denominator required; see Appendix D for specifications source). ACOs will be assigned points based on their performance on each Quality Measure. ACOs can receive two types of points for each Quality Measure: “achievement points” and “improvement points.”

Achievement Points

Each ACO may receive up to a maximum of two (2) achievement points for each Quality Measure, as follows:

1. The State will establish an “Attainment Threshold” and an “Excellence Benchmark” for each Quality Measure as follows:
 - a. “Attainment Threshold” sets the minimum level of performance at which the ACO can earn achievement points
 - b. “Excellence Benchmark” is a high performance standard above which the ACO earns the maximum number of achievement points (i.e., 2 points)
2. The State will calculate each ACO’s performance score on each Quality Measure based on the measure specifications which will be reviewed and approved by CMS (see Section 5.3.4.2). Each Quality Measure’s specifications will describe the detailed methodology by which this performance score is calculated.
3. The State will award each ACO between zero (0) and two (2) achievement points for each Quality Measure as follows:
 - a. If the ACO’s performance score is less than the Attainment Threshold: 0 achievement points
 - b. If the ACO’s performance score is greater than or equal to the Excellence Benchmark: 2 achievement points
 - c. If the performance score is between the Attainment Threshold and Excellence Benchmark: the ACO receives a portion of the maximum 2 achievement points in

proportion to the ACO’s performance. The State will calculate the number of achievement points using the following formula:

$$i. 2 * ((\text{Performance Score} - \text{Attainment Threshold}) / (\text{Excellence Benchmark} - \text{Attainment Threshold}))$$

4. If the State finds that 75% of ACOs have not met the Attainment Thresholds for a particular measure, then the State may reset this benchmark to a lower standard for future Budget Periods with input from the DSRIP Advisory Committee for Quality, and CMS approval. If the State finds that 75% or more of ACOs have met the Excellence Benchmarks for a particular measure, then the State may reset this benchmark to a higher standard for future Budget Periods with input from the DSRIP Advisory Committee for Quality, and CMS approval. If 75% of ACOs meet the adjusted Excellence Benchmark, then the State may retire the measure and replace it with a new measure from the same domain. The new measure will enter into the slate as reporting only (if claims measure) or pay for reporting (if hybrid measure) for its first reporting year, switching over to pay for performance in the second or third year, depending on benchmark availability. Benchmarking for the new measure will follow the same methodology as outlined in Section 5.3.1.1

Exhibit 33 below shows an example calculation of an ACO’s achievement points for a Quality Measure.

EXHIBIT 33 – Example Calculation of Achievement Points for Measure A

Measure A Attainment Threshold = 45% (e.g., corresponding to 25th percentile of HEDIS benchmarks)

Measure A Excellence Benchmark = 80% (e.g., corresponding to 90th percentile of HEDIS benchmarks)

Example Calculation of Achievement Points for Measure A		
	Measure A Performance Score	Achievement Points Earned
Scenario 1	25%	0
Scenario 2	90%	2
Scenario 3	60%	.86 *

**Achievement points earned = 2*((60% - 45%) / (80% - 45%)) = 0.86 points*

Improvement Points

ACOs may receive up to a maximum of two (2) improvement points for each Quality Measure; however, the total number of improvement points the ACO receives across all the Quality Measures in a given Quality Domain may not exceed 50% of the total number of achievement points available for that Quality Domain. Improvement points will be calculated as follows:

1. The State will calculate each ACO’s performance score on each Quality Measure based on the measure specifications. Each Quality Measure’s specifications will describe the detailed methodology by which this performance score is calculated.

2. The State will compare each ACO’s performance score on each Quality Measure to the ACO’s performance score on that same Quality Measure from the previous Budget Period. The State will award each ACO zero (0) or two (2) improvement points for each Quality Measure as follows:
 - a. If the ACO does not have a performance score for the Quality Measure in the previous Budget Period or if the ACO’s performance score for the Quality Measure does not show statistically significant improvement (e.g., based on a Chi-square test) over the ACO’s performance score during the previous Budget Period with a p-value less than or equal to 0.10: 0 improvement points
 - b. If the ACO’s performance score for the Quality Measure shows statistically significant improvement (e.g., based on a Chi-square test) over the ACO’s performance score during the previous Budget Period with a p-value less than or equal to 0.10: 2 improvement points

Exhibit 34 below shows an example calculation of an ACO’s improvement points for a Quality Measure.

EXHIBIT 34 – Example Calculation of Improvement Points for Measure B

Measure B performance score in Budget period 2 (BP2) = 45%

Measure B performance score in BP3 = 50%

Example Calculation of Improvement Points for Measure B		
	P-value for Comparison of Measure B's Performance Scores in BP2 & BP3	Improvement Points Earned
Scenario 1	0.12	0
Scenario 2	0.04	2

Domain Score

For each ACO, the State will sum the ACO’s achievement and improvement points for all Quality Measures in each Quality Domain, and then divide the resulting sum by the maximum number of achievement points that the ACO is eligible for in the domain (i.e., two points per Quality Measure, multiplied by the number of Quality Measures in the Quality Domain) to produce the ACO’s Domain Score. If an ACO does not meet eligibility requirements for a specific measure, then the measure is not factored into the denominator. Note that improvement points do not count towards the denominator; they are therefore “bonus” points. Domain Scores are each capped at a maximum value of 1.

Exhibit 35 below shows an example calculation of an ACO’s unweighted Domain Score for a Quality Domain

EXHIBIT 35 – Example Calculations of Unweighted Domain Score

Example Calculations of Unweighted Domain Score	
Example 1	Domain only has two Quality Measures (Measure A and Measure B)
	Therefore, maximum number of achievement points is $2 \times 2 = 4$ points
	Measure A:
	Achievement points: 1.5
	Improvement Points: 0
	Measure B:
	Achievement points: 0
	Improvement Points: 2
	Maximum number of improvement points: $4 \times 50\% = 2$
	Total achievement points: $1.5 + 0 = 1.5$
Total improvement points: 2 points	
Sum of achievement and improvement points: $1.5 + 2 = 3.5$ points	
Unweighted domain score = $3.5/4 * 100 = 87.5\%$	
Example 2	Domain only has two Quality Measures (Measure A and Measure B)
	Therefore, maximum number of achievement points is $2 \times 2 = 4$ points
	Measure A:
	Achievement points: 2
	Improvement Points: 2
	Measure B:
	Achievement points: 1.3
	Improvement Points: 2
	Maximum number of improvement points: $4 \times 50\% = 2$
	Total achievement points: $2 + 1.3 = 3.3$
	Total improvement points: 2 points (points restricted by cap)
	Sum of achievement and improvement points: $3.3 + 2 = 5.3$ points
However, total number of points cannot exceed maximum number of achievement points	
Therefore, achievement + improvement = 4	
Unweighted domain score = $4/4 * 100 = 100\%$	

5.3.1.3 Calculating the Domain Score for Quality Domain 6 (Avoidable Utilization)

For the sixth Quality Domain, Avoidable Utilization, the State will use a slightly different methodology to calculate each ACO's Domain Score. This Quality Domain has two measures: (1) potentially preventable admissions (PPAs); and (2) hospital all-cause readmissions.

For each of these two measures, the State will establish a reduction target for each ACO, as follows:

1. The State will rank the baseline performance of all ACOs that are part of the MassHealth ACO Program on each of these two utilization-based Quality Measures. The State anticipates measuring baseline performance using CY2017 data to establish the baseline rankings for Budget Periods 2-5.
2. The State will segment ACOs into quartiles based on the resulting ranking.
3. The State will assign each quartile of ACOs a reduction target for each Budget Period.

Reduction targets are expressed as percentages, and represent a relative reduction in the risk-adjusted actual-to-expected ratios of PPAs or readmissions (i.e., the absolute change in the rate, divided by the initial rate).

Reduction targets will increase each Budget Period, and ACOs in quartiles with worse baseline performance (i.e. higher rates of PPAs or readmissions) will have higher reduction targets.

The State has established preliminary reduction targets, which are listed in Exhibits 36 and 37 below.

EXHIBIT 36 – Preliminary Reduction Targets for 3M’s Potentially Preventable Admissions (PPA) Measure

PPA Quartile	Reduction Targets from Baseline Performance				
	BP 1	BP 2	BP 3	BP 4	BP 5
1 (<i>better</i>)	Reporting only	3%	4.50%	9%	12%
2		4%	7%	12%	15%
3		5%	10%	15%	18%
4 (<i>worse</i>)		6%	13%	18%	21%

EXHIBIT 37 – Preliminary Reduction Targets for NQF #1789 (Hospital All-Cause Readmissions)

NQF #1789 Quartile	Reduction Targets from Baseline Performance				
	BP 1	BP 2	BP 3	BP 4	BP 5
1 (<i>better</i>)	Reporting only	3%	7.5%	12.5%	16%
2		4%	9.5%	15%	20%
3		5%	12.5%	18.5%	24%
4 (<i>worse</i>)		6%	14%	22%	28%

If the ACO meets or surpasses the reduction target for one of these two Quality Measures, then the State will award the ACO the full two (2) achievement points for that Quality Measure. If the ACO does not meet the reduction target for one of these two Quality Measures, then EOHHS will award the ACO zero (0) achievement points for that Quality Measure. All comparisons will be against the baseline CY2017 data. For example, an ACO in Quartile 1 that reduces its hospital all-cause readmissions by 18% in BP4 compared to baseline will earn 2 achievement points. If that same ACO regresses such that its reduction compared to baseline is 17% in BP5, it will still earn 2 achievement points because all comparisons are made against baseline.

Should a new ACO join the program, the new ACO’s CY2017 data will be used to establish baseline data for relevant Quality Measures. Based on these baseline results, the new ACO will be assigned to one of the reduction target quartiles for avoidable utilization-related Quality Measures. An existing ACO’s quartile and reduction targets may change if ACOs join or leave the program, or if the provider organizations that comprise the existing ACOs change in such a way that would lead to ACOs switching quartiles.

The process for adjusting quartiles will include stratifying all ACO performance results based on the most recent historical data available. The results will be used to develop quartiles. ACOs could then be

reassigned to new quartiles based on their performance for future budget periods. The State will review the new quartiles with the DSRIP Advisory Committee on Quality for input.

Budget Period (BP) 1 will be reporting only for avoidable utilization measures. To allow for claims run-out, data warehouse functions, and calculations, the BP1 results will be available approximately in Q4 BP2 or Q1 BP3. These data will be compared to the CY2017 baseline data to assess whether the reduction targets are appropriate. Should it appear in the State’s discretion that the reduction targets were set too high or too low (e.g. all or most ACOs will exceed the targets, or all or most ACOs will not achieve their targets), the State may develop a proposal to alter the targets for BP2 and later Budget Periods. The State will research and review other reduction target performance (e.g., in the published medical literature, from other DSRIP projects) as the State develops new proposed reduction targets. The proposal, along with the State’s research, will be presented to the DSRIP Advisory Committee on Quality for review and input. The proposal, along with the State’s research, will then be submitted to CMS for approval. CMS will have 90 calendar days to respond to the target modification request.

5.3.1.4 Calculating the Domain Score for Quality Domain 7 (Member Experience)

Quality Domain 7, Member Experience, will be calculated based on surveying a representative sample of an ACO’s attributed members to assess their experience of care. The State anticipates assessing member experience for (1) primary care (commencing in CY2018), (2) BH (commencing in CY2019), and (3) LTSS (commencing in CY2020) services.

The State plans to procure a vendor to administer these member experience surveys for ACOs. The State will work in collaboration with its procured vendor to finalize the survey instruments, and identify questions and methodology for calculating survey results. The State is planning to use or adapt (as appropriate) validated instruments wherever possible to capture member experience for each population. For example, the State may use:

- For the population receiving primary care services:
 - CAHPS Clinician and Group Survey + CAHPS PCMH supplemental questions
- For the population receiving behavioral health services:
 - Massachusetts Department of Mental Health, Massachusetts Consumer Surveys (MCS): Based off of the Substance Abuse and Mental Health Services Administrations (SAMHSA’s) Mental Health Statistics Improvement Program (MHSIP) survey
- For the population receiving LTSS Services:
 - HCBS CAHPS Survey: recently released by CMS, is the first cross-disability survey of home and community-based service (HCBS) beneficiary’s experience receiving long-term services and supports

ACOs will be evaluated based on surveys of a representative sample of their attributed members. Scores will be based on performance on a combination of composite and specific questions contained in each survey. Examples of question categories include but are not limited to:

EXHIBIT 38 – Examples of Survey Question Categories

Primary Care	Behavioral Health	LTSS
<ul style="list-style-type: none"> • Access to care • Communications 	<ul style="list-style-type: none"> • Access to services • Quality and appropriateness 	<ul style="list-style-type: none"> • Getting needed services • HCBS staff reliability

<ul style="list-style-type: none"> • Comprehensiveness • Self-management support • Coordination of care • Helpful, Courteous, and Respectful Office Staff • Patient Ratings of the Provider • Self-management support (composite measure) • Comprehensiveness • Integration or coordination of physical health, BH, LTSS, and health-related social services 	<ul style="list-style-type: none"> • Treatment outcomes • Person-centered planning • Social connectedness • Functioning • Self-determination • Integration or coordination of BH services by Community Partners 	<ul style="list-style-type: none"> • Communication with HCBS staff • Getting help from case managers • Choice of services • Personal safety • Adequacy of medical transportation • Community inclusion and empowerment • Employment (supplement) • Integration or coordination of LTSS services by Community Partners
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The scoring approach will be similar to the approach used for clinical quality measures where scoring is based on attainment of benchmarks for excellent performance and/or improved performance off of baseline performance. The State anticipates this methodology will incorporate, for BPs 3-5, benchmarks based on each ACO's performance in BP1 and BP2.

5.3.1.5 Quality Data Collection Approach

Quality measure data will be collected in one of three ways. Claims and encounter data will flow through the normal channels currently used to process and pay claims. Clinical data (i.e., data that will be extracted from EHRs) will initially be submitted to the State by ACOs, using spreadsheets and secure transmission methods (e.g., Secure File Transfer Protocol). The ultimate goal will be to have secure two-way data exchange between the State and ACOs to support continuous sharing of clinical quality data. Member experience will be measured via a patient experience survey performed by a vendor. The State anticipates that the survey will be conducted by typical methodologies such as by mail and/or phone.

5.3.1.6 Pay for Reporting vs. Pay for Performance

As demonstrated in Appendix D, the State anticipates that most Quality Measures will transition from Pay for Reporting (P4R) to Pay for Performance (P4P) over the duration of the program. Budget Period 1 will be P4R only. This will allow time for familiarization with the measures, data collection, reporting, as well as to provide baseline performance. For measures assessed with comparable national benchmarks (e.g. NCQA HEDIS), the State intends to transition the measures to P4P in Budget Period 2. For novel measures and measures without national benchmarks, the State intends to transition measures to P4P in Budget Period 3 of the program to allow for two years of data to confirm, as needed:

- Numerator details
- Denominator details and exclusions
- Sampling methodology
- Data sources
- Measure reliability from year-to-year

5.3.2 TCOC component of the ACO DSRIP Accountability Score

Each ACO's TCOC component of the ACO DSRIP Accountability Score will be a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%) that reflects an ACO's performance at managing

TCOC for its enrolled or attributed members. Each ACO's TCOC component of the ACO DSRIP Accountability Score will be calculated in the following manner:

If the ACO is a Primary Care ACO or MCO-Administered ACO, the State will perform the following comparison:

1. In advance of each Budget Period, the State will establish a Preliminary TCOC Benchmark for each ACO, working with the State's actuaries and following the detailed methodology for setting TCOC Benchmarks outlined in the State's ACO contracts
2. Approximately one year after the Budget Period has ended, the State will retrospectively calculate each ACO's TCOC Performance for the Budget Period
3. The State will retrospectively compare each ACO's TCOC Performance to its Final TCOC Benchmark to determine whether the ACO has achieved savings or losses relative to its Final TCOC Benchmark for the Budget Period. In the process, the State will make several updates to each ACO's Preliminary TCOC Benchmark to produce the ACO's Final TCOC Benchmark, including, for example, actuarial adjustments to account for the ACO's risk profile and population mix during the Budget Period

If the ACO is an Accountable Care Partnership Plan, the State will perform the following comparison:

4. The State will retrospectively compare the Partnership Plan's total medical expense to the Partnership Plan's risk-adjusted medical capitation payments for the Budget Period, following an aligned methodology with how the State applies risk corridors to Partnership Plans. This comparison will determine whether the Plan has achieved medical gains or medical losses. Administrative or underwriting gains or losses will not count towards calculating this TCOC component of the ACO DSRIP Accountability Score

For all ACOs, after performing the above comparisons, the State will calculate the ACO's TCOC component as follows:

5. Based on the comparison, the State will calculate each ACO's TCOC component of the ACO DSRIP Accountability Score as follows:
 - If the ACO has savings or medical gains, then the ACO's TCOC component of the ACO DSRIP Accountability Score equals 100%
 - If the ACO has losses that exceed 5% of the Final TCOC Benchmark or exceed 5% of the ACO's risk adjusted medical capitation payments, then the ACO's TCOC component of the ACO DSRIP Accountability Score equals 0%
 - If the ACO has losses but they do not exceed 5% of the Final TCOC Benchmark or 5% of the ACO's risk adjusted medical capitation payments, then the ACO's TCOC component of the ACO DSRIP Accountability Score is proportionate to the magnitude of the ACO's losses, and is equal to:
 - For Primary Care ACOs and MCO-Administered ACOs: $(105\% * \text{Final TCOC Benchmark} - \text{TCOC Performance}) / (5\% * \text{Final TCOC Benchmark})$
 - For Partnership Plans: $(105\% * \text{risk-adjusted medical capitation payments} - \text{total medical expenditure}) / (5\% * \text{risk adjusted medical capitation payments})$

EXHIBIT 39 – Example Calculations of TCOC component of the ACO DSRIP Accountability Score

Example Calculations of TCOC Component of the ACO DSRIP Accountability Score	
Final TCOC Benchmark = \$500 PMPM	
Scenario 1	ACO's TCOC Performance is \$490 PMPM
	ACO has savings of \$10 PMPM, or 2%
	ACO has achieved savings, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score is 100%
Scenario 2	ACO's TCOC Performance is \$550 PMPM
	ACO has losses of \$50, or 10%
	ACO has losses that exceed 5% of the TCOC Benchmark, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score is 0%
Scenario 3	ACO's TCOC Performance is \$520 PMPM
	ACO has losses of \$20, or 4%
	ACO has losses that are less than 5% of the TCOC Benchmark, therefore the ACO's TCOC component of the ACO DSRIP Accountability Score = ((5% of the TCOC Benchmark - \$20) / 5% of the TCOC Benchmark) = ((\$25 - \$20) / \$25) = (\$5/\$25) = 20%

5.3.3 Impact of DSRIP Accountability Scores on Payments to ACOs

Once the State has determined the ACO's Quality and TCOC components of the ACO's DSRIP Accountability Score, it will calculate the DSRIP Accountability Score using the methodology described in Section 5.3.1. As an example:

Example Calculation of ACO DSRIP Accountability Score in BP4

- Quality Component of DSRIP Accountability Score in BP4: 75% (calculated as described in Section 5.3.1)
- TCOC Component of DSRIP Accountability Score in BP4: 80% (calculated as described in Section 5.3.2)
- Weight for Quality Component of DSRIP Accountability Score in BP4: 75% (as described in Exhibit 31)
- Weight for TCOC Component of DSRIP Accountability Score in BP4: 25% (as described in Exhibit 31)

$$\text{ACO DSRIP Accountability Score} = (\text{Quality Component} * \text{Weight of Quality Component}) + (\text{TCOC Component} * \text{Weight of TCOC Component}) = (75\% * 75\%) + (80\% * 25\%) * 100\% = 76.2\%$$

The DSRIP Accountability Score will then be applied to the ACO funding sub-streams that have a portion of funds at-risk. Specifically:

- ACO Sub-Stream #1 - Startup/Ongoing Funding (Primary Care): No at-risk funds

- ACO Sub-Stream #2 - Startup/Ongoing Funding (Discretionary): Portion of funds are at-risk, according to schedule detailed in Exhibit 20; DSRIP Accountability Score is multiplied by the at-risk funding amount to determine how much is earned
- ACO Sub-Stream #3 - Flexible Services Funding: No at-risk funds
- ACO Sub-Stream #4 - DSTI Glide Path Funding: Portion of funds are at-risk, according to schedule detailed in Exhibit 20; DSRIP Accountability Score is multiplied by the at-risk funding amount to determine how much is earned

5.3.4 Process, Roles, and Responsibilities for calculating the ACO DSRIP Accountability Score

5.3.4.1 Roles and responsibilities

The State will be responsible for establishing the elements that comprise the ACO DSRIP Accountability Score, including its Quality Measures, the specifications for each Quality Measure, the data sources for calculating the Quality Measures, the methodology for setting the Attainment Threshold and Excellence Benchmark for each Quality Measure (where applicable) and the values of the thresholds and benchmarks themselves. This sub-section 5.3.4.1 details the roles and responsibilities of the State, the State's DSRIP Quality Advisory Committee, and CMS with respect to these elements.

5.3.4.2 The State

The State will establish the elements that comprise the ACO DSRIP Accountability Score, based on the advice of the DSRIP Advisory Committee on Quality as described in this Protocol (see Section 6.2.1). By August 2017, the State will submit the Quality Measure slate and specifications, the benchmark sources, and performance thresholds (i.e., Attainment Thresholds and Excellence Benchmarks) to CMS for review and approval.

The State may request modification to any element that comprises the ACO DSRIP Accountability Score, based on its own assessment or on the recommendation of the State's DSRIP Advisory Committee on Quality. In the event that the State wishes to change a previously approved element that is a component of the ACO DSRIP Accountability Score, the State will submit a formal, written modification request to CMS for review and approval. CMS will have 90 calendar days to review and approve.

As part of its program management and contract oversight processes, the State will establish a structured process for ACOs to seek clarification on or request revisions to certain aspects of their ACO DSRIP Accountability Scores (e.g., if an ACO seeks clarification on the inclusion of certain members in the denominator for a Quality Measure's performance score). Each ACO will identify a key contact, responsible for raising such issues to the State and working with the appropriate State personnel to discuss and resolve issues as appropriate. The State will also identify a reciprocal contact to liaise with each ACO and support these types of requests.

If an ACO does not earn 100% DSRIP Accountability Score, then the State may provide an opportunity for ACOs to submit DSRIP Performance Remediation Plans to earn back a portion of the unearned, withheld funds, at the State's discretion. If the State allows this opportunity, then an ACO may choose to provide the State a DSRIP Performance Remediation Plan within 30 calendar days of receipt of the ACO's DSRIP Accountability Score, in which case the ACO may have the opportunity to earn back up to 60% of the unearned, withheld funds, as further described below.

The DSRIP Performance Remediation Plan will include:

- A detailed assessment of the reason(s) why the ACO did not achieve 100% Accountability Score, separately addressing each measure on which the ACO scored less than full points;
- Discrete project(s) the ACO will undertake to address some or all of the reasons for why it did not achieve 100% Accountability Score, along with rationale for why these activities are

appropriate; or other discrete projects that align with the goals of the ACO's DSRIP Participation Plan

- A workplan, which includes a timeline for the implementation of these activities over the first half of the coming Budget Period, as well as identification of the resources that will be responsible for their completion
- An accountability plan for these activities, including any milestones or metrics the ACO anticipates and when the ACO anticipates realizing them, and also including a proposed model for the State to monitor the ACO's implementation of the proposed activities and their success or failure throughout the first half of the coming Budget Period (e.g., a schedule of site visits, staff interviews, desk reviews, etc.)

Within 45 calendar days of receiving the Performance Remediation Plan, the State and the Independent Assessor will review the Plan in parallel, and the State, considering the Independent Assessor's recommendation, will either request additional information regarding the Performance Remediation Plan, or approve it and submit to CMS for review and approval. During the State's review process, it will determine how much of the 60% of unearned, withheld funds the ACO will be able to earn back, based on the Performance Remediation Plan's relevance to the reasons for why the ACO did not achieve 100% Accountability Score, or to the goals of the ACO's DSRIP Participation Plan. CMS will have 90 calendar days to review and approve the Plan. If CMS has not responded to the State's approval request, then the Performance Remediation Plan will be deemed approved, given the need for ACOs to have as much time as possible to implement their projects, which will need to be completed during the first half of the following Budget Period. The State will monitor the Plan during the implementation period on an ongoing basis. Additionally, the State will assign a Performance Remediation Plan Score to the ACO, based on the State's ongoing monitoring of the Plan, and supporting documentation submitted by the ACO in its semiannual progress report for the first half of the Budget Period in question. The Performance Remediation Plan Score will be a single point value between 0 and 10 inclusive, and will determine how much of the ACO's unearned, withheld funds can be earned back.

For example, if (1) an ACO has \$100,000 of unearned, withheld funds; (2) the State determines that an ACO will be able to earn back 50% of the ACO's unearned, withheld funds (out of a 60% maximum percentage); and (3) the ACO achieves a Performance Remediation Plan Score of 7 out of 10, then the ACO's final earned funds will be equal to $\$100,000 * 50\% * (7 / 10) = \$35,000$.

5.3.4.3 The DSRIP Advisory Committee on Quality

See Section 6.2.1 for discussion of the Advisory Committee on Quality's role.

5.3.4.4 CMS

CMS will review and approve State submissions within 90 calendar days. If CMS does not approve the submission within that timeframe, the State and CMS will work collaboratively to align on appropriate modifications and a timeline for prompt approval.

5.3.5 Timeline of ACO DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments

The timeline for ACO DSRIP Accountability Score calculation and disbursement of DSRIP payments to ACOs is anticipated to be as follows:

- ACO Budget Period Closes
- Member experience survey results 270 calendar days of BP closing

- State determines denominators and sample populations (i.e., the specific members whose data each ACO must submit) for the clinical quality measures within 210 calendar days of BP closing
- ACOs submit clinical quality data within 30 calendar days of receiving the denominators and sample populations for the clinical quality measures
- State calculates ACO DSRIP Accountability Score within 90 calendar days of receiving all underlying required data
- Once ACO DSRIP Accountability Scores have been calculated, State submits Scores and supporting documentation to CMS for review and approval
- CMS has 90 calendar days to review and approve the ACO DSRIP Accountability Scores; if CMS has not responded to State's approval request, then the DSRIP Accountability Scores will be deemed approved, given the need to disburse at-risk funding to ACOs in a timely fashion
- State notifies ACOs of ACO DSRIP Accountability Score within 30 calendar days of determining Score
- State disburses DSRIP at-risk payments to ACOs within 30 calendar days after CMS has approved ACO DSRIP Accountability Scores

5.3.6 ACO Exit from the DSRIP Program

Per STC 65(b)(ii), if an ACO decides to exit the DSRIP program prior to the end of the five year 1115 waiver demonstration period, it will be required to return at least 50 percent of DSRIP startup/ongoing and DSTI Glide Path funding received up to that point.

ACO exit from the DSRIP program is defined as termination of the contract between an ACO and MassHealth for reasons other than the following reasons:

- Material financial losses resulting from poor total cost of care performance, as determined by the State
- Reasons outside of the ACO's control, including but not limited to material changes to the Medicaid program, or material changes to the nature of the ACO's participation in MassHealth resulting from legislation or other developments, as determined by the State

5.3.6.1 Other ACO Contract Terminations

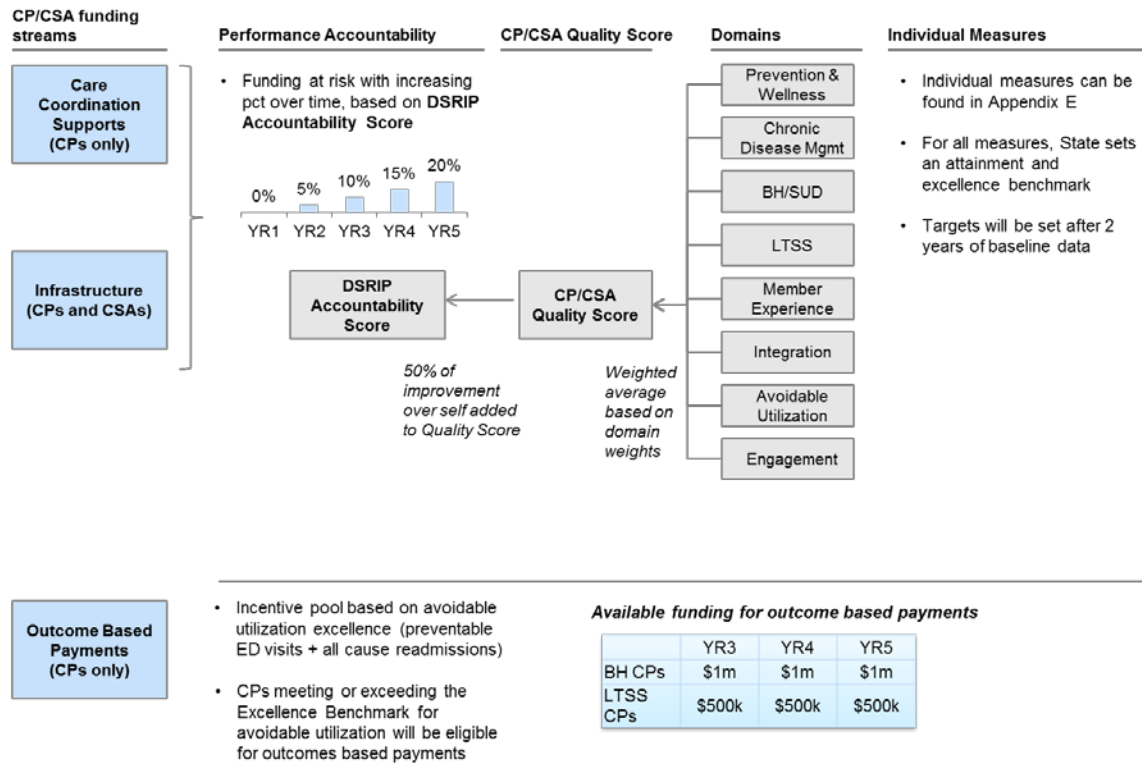
Under its MassHealth contract, an ACO may experience material financial loss, defined as a loss greater than 3% medical losses relative to risk-adjusted medical capitation for Partnership Plans, or relative to the TCOC benchmark for Primary Care ACOs and MCO-Administered ACOs. If an ACO experiences material financial loss in one or more preceding Budget Periods and has a projected material financial loss in the current Budget Period, the contract between the ACO and MassHealth may be terminated and the ACO will be required to return DSRIP startup/ongoing and DSTI Glide Path funding in accordance with percentages established by the State.

5.4 Accountability Framework & Performance Based Payments for CPs and CSAs

5.4.1 Overview

As described in Section 4.5 above, payment streams for CPs and CSAs are subject to an accountability framework that aligns the CPs' and CSAs' incentives with the State's delivery system reform goals. For CPs, a portion of the Care Coordination and Infrastructure funds will be at-risk based on performance. For CSAs, a portion of the Infrastructure funds will be at-risk based on performance.

CP Accountability Framework



5.4.2 Alignment of Quality Measure Slate with Overall Goals of the DSRIP program

The quality measure slate was chosen to support the goals of the DSRIP program including promoting member-driven, integrated, coordinated care and improving integration among physical health, behavioral health, long-term services and supports, and health-related social services. In addition, the CP and CSA measure slate has many cross-cutting measures with the ACO measure slate thus aligning the ACOs with their CPs and with CSAs.

Appendix D contains the measures for the LTSS and BH CPs and CSAs, along with an indication as to whether the measure data will be collected via claims and encounters only or whether chart review will be utilized. Additionally, there is an indication of the expected “reporting” and/or “performance” role in the program by program year. Appendix D includes further details regarding the measures including measure descriptions, measure stewards, benchmark sources and reporting frequency.

5.4.3 Pay for Reporting vs. Pay for Performance

As demonstrated in Appendix D, the State anticipates that most Quality Measures will transition from Pay for Reporting (P4R) to Pay for Performance (P4P) over the duration of the program. All CP measures in the first two performance years are Pay for Reporting (P4R) and transition to Pay for Performance (P4P) starting in Performance Year 3. Given the unique needs and demographics of the member populations supported by the CPs and CSAs, there are challenges to utilizing nationally established benchmarks for performance that reflect the overall population. Therefore, the State will utilize the first two Performance Years of the demonstration to establish an appropriate baseline and achievement targets as described below for the quality measures. This will allow time for familiarization with the measures, data collection, reporting, as well as to provide baseline performance. This will also allow for two years of data to confirm, as needed:

- Numerator details
- Denominator details and exclusions
- Sampling methodology
- Sample size
- Data sources
- Measure reliability from year-to-year

5.4.4 Calculating the CP/CSA DSRIP Accountability Score

The State will measure performance using a state-calculated score called the CP/CSA DSRIP Accountability Score. The CP/CSA DSRIP Accountability Score is a value between zero (0) and one hundred (100), expressed as a percentage (i.e. between 0%-100%). This section details the State's calculation of each CP's and CSA's CP/CSA DSRIP Accountability Score as follows:

- 5.4.4.1 Measure Scoring Methodology for All Measures
- 5.4.4.2 Calculating the Domain Score
- 5.4.4.3 Combining Domain Scores to Produce Quality Score
- 5.4.4.4 Comparing Quality Scores to Calculate the CP/CSA DSRIP Accountability Score

5.4.4.1 Measure Scoring Methodology for All Measures

CPs and CSAs will be accountable for all measures as indicated in Appendix D unless the CP or CSA does not meet eligibility requirements for a specific measure based on the measure's specifications (e.g., a minimum denominator required).

Benchmark Determination

Given that the CP population is defined by utilization criteria and therefore does not have national benchmarks, the State anticipates using the performance of MassHealth CPs in CY2018 to set benchmarks. For example, one of the criteria for inclusion in the BH CP population is anticipated to be a member having a diagnosis of major depression or post-traumatic stress disorder with a behavioral health related inpatient visit or five or more emergency room visits. National benchmarks for a general Medicaid population will be difficult to use for this selected high risk population; accordingly, the State will need to develop state-specific benchmarks. Because CP data will not be available until after the first Budget Period (December 2018) and thus the State will not be able to set benchmarks until that time, the State will submit to CMS for approval measure-by-measure benchmarks in April 2019. All proposed benchmarks that the State submits will have been reviewed by the DSRIP Advisory Committee on Quality, and will be accompanied by individual rationales for each benchmark. CMS will provide written feedback on the proposed benchmarks and rationale within 90 calendar days. If CMS has not provided written feedback within 90 calendar days, then the benchmarks will be deemed approved, given the necessity of providing these benchmarks to CPs so that they have sufficient time to plan accordingly.

Benchmarks will be adjusted based on expert clinical judgment from the DSRIP Advisory Committee on Quality and the State, with approval by CMS. Attainment Thresholds will be reviewed yearly and may be adjusted by the State based on prior CP or CSA performance, in consultation with the DSRIP Advisory Committee for Quality, and CMS approval. If all CPs have high levels of achievement on a particular measure, that measure will be retired and a new one may be added. Excellence Benchmarks will be reviewed yearly and set with respect to the CP performance from the prior year. This will properly reward maintenance of quality, while not overly penalizing CPs.

CPs and CSAs will be assigned achievement points based on their performance on each Quality Measure. The Domain Score will be calculated as the average of the achievement points for all the Quality measures in a given Domain.

Each CP or CSA may receive up to a maximum of one (1) achievement point for each Quality Measure in a given Domain, as follows:

1. The State will establish an “Attainment Threshold” and an “Excellence Benchmark” for each Quality Measure
 - a. “Attainment Threshold” sets the minimum level of performance at which the CP or CSA can earn achievement points
 - b. “Excellence Benchmark” is a high performance standard above which the CP or CSA earns the maximum number of achievement points (i.e., 1 point)
2. The State will calculate each CP’s and CSA’s performance score on each Quality Measure based on the measure specifications which will be reviewed and approved by CMS (see section 5.4.6.1). Each Quality Measure’s specifications will describe the detailed methodology by which this performance score is calculated
3. The State will award each CP or CSA between zero (0) and one (1) achievement point for each Quality Measure as follows:
 - a. If the CP’s or CSA’s performance score is less than the Attainment Threshold: 0 achievement points
 - b. If the CP’s or CSA’s performance score is greater than or equal to the Excellence Benchmark: 1 achievement point
 - c. If the CP’s or CSA’s performance score is between the Attainment Threshold and Excellence Benchmark: the CP or CSA receives a portion of the maximum 1 achievement point; this portion is proportional to the CP’s or CSA’s performance. The State will calculate the achievement point using the following formula:
 - i. $1 * ((\text{Performance Score} - \text{Attainment Threshold}) / (\text{Excellence Benchmark} - \text{Attainment Threshold}))$

Exhibit 41 below shows an example calculation of a CP’s achievement points for a Quality Measure.

EXHIBIT 41 – Example Calculation of Achievement Points for Measure A

Measure A Attainment Threshold = 45%

Measure A Excellence Benchmark = 80%

Example Calculation of Achievement Points for Measure A		
	Measure A Performance Score	Achievement Points Earned
Scenario 1	25%	0
Scenario 2	90%	1
Scenario 3	58%	.37 *

*Achievement points earned = $1 * ((58\% - 45\%) / (80\% - 45\%)) = 0.37$ points

5.4.4.2 Calculating the Domain Score

Each Quality Domain comprises several Quality Measures. For each CP or CSA, the State will calculate the average achievement points for all Quality Measures in each Quality Domain.

Exhibit 42 below shows an example calculation of a CP’s or CSA’s Domain Score for a Quality Domain.

EXHIBIT 42 – Example Calculation of CP or CSA Quality Domain Score

Example Calculation of a CP's or CSA's Domain Score for a Quality Domain				
Measures in Quality Domain	Attainment Threshold	Excellence Benchmark	Performance Score	Achievement Points Earned
Measure A	45%	80%	58%	0.37
Measure B	40%	75%	60%	0.57
Measure C	41%	85%	79%	0.86
Average Achievement Points Earned				0.60

5.4.4.3 Combining Domain Scores to Produce the Quality Score

A CP’s or CSA’s Quality Score will be a weighted average of scores the CP or CSA achieves on the different Domains for which it is accountable. The anticipated Domains and Domain weighting is different across BH CPs, LTSS CPs and CSAs, as set forth in the following Exhibits.

EXHIBIT 43 – Domain Weighting for BH CPs

BH CP Quality Domain Weights		
Quality Domain		Domain Weight
1	Prevention & Wellness	5%
2	Chronic Disease Management	5%
3	Behavioral Health / Substance Use	10%
4	Member Experience	10%
5	Integration	10%
6	Avoidable Utilization	10%
7	Engagement (Care Planning Completed)	50%
TOTAL		100%

See Appendix D for the full list of BH CP Quality Measures

EXHIBIT 44 – Domain Weighting for CSAs

CSA Quality Domain Weights		
Quality Domain		Domain Weight
1	Prevention & Wellness	10%
2	Behavioral Health / Substance Use	20%
3	Member Experience	10%
4	Avoidable Utilization	10%
5	Engagement (Care Planning Completed)	50%
TOTAL		100%

See Appendix D for the full list of CSA Quality Measures.

EXHIBIT 45 – Domain Weighting for LTSS CPs

LTSS CP Quality Domain Weights		
Quality Domain		Domain Weight
1	Prevention & Wellness	5%
2	Member Experience	20%
3	Integration	15%
4	Avoidable Utilization	10%
5	Engagement (Care Planning Completed)	50%
TOTAL		100%

See Appendix D for the full list of LTSS CP Quality Measures

EXHIBIT 46 – Example Calculation of the Quality Score for a BH CP

Example Calculation of Total Quality Score			
Domain	Weighting	Average Attainment Score	Weighted Attainment Score
Prevention & Wellness	5%	0.51	5%*0.51= 2.55%
Chronic Disease Management	5%	0.6	5%*0.60= 3.00%
Behavioral Health / Substance Use	10%	0.73	10%*.73= 7.30%
Member Experience	10%	0.88	10%*0.88= 8.80%
Integration	10%	0.56	10%*0.56= 5.60%
Avoidable Utilization	10%	0.67	10%*0.67= 6.70%
Engagement (Care Planning Completed)	50%	0.93	50%*0.93= 46.50%
Total Quality Score			80.45%

5.4.4.4 Comparing Quality Scores to Calculate the CP/CSA DSRIP Accountability Score

For each Performance Period, CPs and CSAs will be measured on their (1) Total Quality Score and on (2) Improvement Over Self from the previous Performance Period. For each Performance Period, the State will set a Minimum Quality Score Threshold and an Excellence Quality Score Benchmark for LTSS CPs, for BH CPs and for CSAs. Improvement Over Self will be calculated as 50% of the CP’s or CSA’s improvement year over year in percentage points.

The CP/CSA DSRIP Accountability Score, therefore, will be the sum of the (1) Total Quality Score and the (2) Improvement Over Self contribution. CP/CSA DSRIP Accountability Scores will be calculated as follows:

- An entity with a Total Quality Score at or above the Excellence Quality Score Benchmark will receive a DSRIP Accountability Score of 100% and be eligible for 100% of at-risk funds.
- An entity with a Total Quality Score below the Minimum Quality Score Threshold will receive a DSRIP Accountability Score for Total Quality of Zero and will be eligible for only that portion of at-risk funds equal to the Improvement Over Self contribution. The entity would receive a Quality Score equal to 50% of the Improvement Over Self percentage points.
- An entity with a Total Quality Score between the Minimum Quality Score Threshold and the Excellence Quality Score Benchmark will receive a DSRIP Accountability Score = (Total Quality Score) + (50% of the Improvement Over Self percentage points) and will be eligible for that proportion of the at-risk funds.

For example:

In a Performance Period in which, for BH CPs, the Minimum Quality Score Threshold is set at 45% and the Excellence Quality Score Benchmark is set at is 85%

- A BH CP with a Total Quality Score $\geq 85\%$ has a DSRIP Accountability Score of 100% and is eligible for 100% of the at-risk funds

- A BH CP with a Total Quality Score <45% and with no improvement from the previous period has a DSRIP Accountability Score of 0% and is eligible only for improvement points. If a CP's Total Quality Score = 40% and a previous period Total Quality Score of 30%, then they would receive half of their Improvement Over Self percentage points, or $50\% * 10\% = 5\%$ of at-risk DSRIP funds.
- A BH CP with a Quality Score of 75% and a previous period Quality Score of 65% has a DSRIP Accountability Score of 80% ($75\% + 50\%$ of $(75\% - 65\%)$)

Performance Periods 1 and 2 are reporting only. CPs and CSAs will be eligible for funds at risk in Budget Period 2 provided they comply with reporting requirements. For example, if 90% of reporting requirements are met, the entity will be eligible for 90% of the at-risk funds.

Should a new CP or CSA join the program, the new CP's or CSA's first Budget Period will be used to establish baseline data for relevant Quality Measures. Should significant numbers (e.g., 10% increase in members) of new CPs or CSAs join the program, achievement targets may need to be re-calculated. The State will submit any such modification requests as described below in Section 5.4.6.1.

5.4.5 Outcomes Based Payments

Beginning in Performance Year 3, the State will establish an annual outcome-based payment pool for BH and LTSS CPs. Any CP achieving a score of "1" for the Avoidable Utilization domain (i.e., met or exceeded the Excellence Benchmark for each Measure), which includes preventable ED visits and all cause readmissions, will be eligible for Outcomes Based Payments. The CP will receive a portion of funds from the outcome-based payment pool based on their proportion of engaged members relative to all members engaged by all CPs eligible for the pool. For example, if the total number of members engaged with CPs who achieve the Excellence Benchmarks for the Avoidable Utilization domain measures is 5,000 and a CP had 1,000 of those engaged members then that CP would receive 20% of the outcomes-based payment pool.

5.4.6 Process for calculating CP/CSA DSRIP Accountability Scores

5.4.6.1 Roles and responsibilities

The State will be responsible for establishing the elements that comprise the calculating CP/CSA DSRIP Accountability Scores, including its Quality Measures, the specifications for each Quality Measure, the data sources for calculating the Quality Measures, the methodology for setting the Attainment Threshold and Excellence Benchmark for each Quality Measure (where applicable), and the values of the thresholds and benchmarks themselves. The State will also establish the Minimum Quality Score Threshold and the Excellence Quality Score Benchmark used to calculate the CP/CSA DSRIP Accountability Score. This sub-section 5.4.6.1 details the roles and responsibilities of the State, the State's DSRIP Advisory Committee, and CMS with respect to establishing these elements.

The State

The State will establish the elements that comprise the CP and CSA DSRIP Accountability Score, based on the advice of the DSRIP Advisory Committee on Quality (see Section 6.2.1). The State will submit the Quality Measure slate and specifications to CMS for review and approval by November 2017.

Given that the State will be using the first two Budget Periods to gather baseline data to inform performance target setting for BP3 (i.e. CY 2020), it will not have finalized data to calculate the BP3 targets until Q4 of BP3. As such, the State will submit benchmark sources and preliminary performance thresholds (i.e., Attainment Thresholds and Excellence Benchmarks) to CMS for review and approval by August 2019 (i.e. BP2), based on 9 months of BP1 data. CMS will have 90 calendar days to review and approve. Once the State has processed the BP2 data, in August 2020, it will submit finalized performance

targets based on both BP1 and BP2 data to CMS for review and approval. CMS will have 90 calendar days to review and approve.

The State may request modification to any element that comprises the CP/CSA DSRIP Accountability Score, based on its own assessment or on the recommendation of the State's DSRIP Advisory Committee on Quality. In the event that the State wishes to change a previously approved element that is a component of the CP/CSA DSRIP Accountability Score, the State will submit a formal, written modification request to CMS for review and approval. CMS will have 90 calendar days to review and approve.

As part of its program management and contract oversight processes, the State will establish a structured process for CPs and CSAs to seek clarification on or request revisions to certain aspects of their CP/CSA DSRIP Accountability Scores (e.g., if a CP seeks clarification on the inclusion of certain members in the denominator for a Quality Measure's performance score). Each CP and CSA will identify a key contact, responsible for raising such issues to the State and working with the appropriate State personnel to discuss and resolve issues as appropriate. The State will also identify a reciprocal contact to liaise with each CP and CSA and support these types of requests.

If a CP or CSA does not earn 100% DSRIP Accountability Score, then the State may provide an opportunity for CPs or CSAs to submit DSRIP Performance Remediation Plans to earn back a portion of the unearned, withheld funds, at the State's discretion. If the State allows this opportunity, then a CP or CSA may choose to provide the State a DSRIP Performance Remediation Plan within 30 calendar days of receipt of the CP or CSA's DSRIP Accountability Score, in which case the CP or CSA may have the opportunity to earn back up to 60% of the unearned, withheld funds, as further described below.

The DSRIP Performance Remediation Plan will include:

- A detailed assessment of the reason(s) why the CP or CSA did not achieve 100% Accountability Score, separately addressing each measure on which the CP or CSA scored less than full points;
- Discrete project(s) the CP or CSA will undertake to address some or all of the reasons for why it did not achieve 100% Accountability Score, along with rationale for why these activities are appropriate; or other discrete projects that align with the goals of the CP or CSA's DSRIP Participation Plan
- A workplan, which includes a timeline for the implementation of these activities over the first half of the coming Budget Period, as well as identification of the resources that will be responsible for their completion
- An accountability plan for these activities, including any milestones or metrics the CP or CSA anticipates and when the CP or CSA anticipates realizing them, and also including a proposed model for the State to monitor the CP or CSA implementation of the proposed activities and their success or failure throughout the first half of the coming Budget Period (e.g., a schedule of site visits, staff interviews, desk reviews, etc.)

Within 45 calendar days of receiving the Performance Remediation Plan, the State and the Independent Assessor will review the Plan in parallel, and the State, considering the Independent Assessor recommendation, will either request additional information regarding the Performance Remediation Plan, or approve it and submit to CMS for review and approval. During the State's review process, it will determine how much of the 60% of unearned, withheld funds the CP or CSA will be able to earn back, based on the Performance Remediation Plan's relevance to the reasons for why the CP or CSA did not achieve 100% Accountability Score, or to the goals of the CP or CSA's DSRIP Participation Plan. CMS will have 90 calendar days to review and approve the Plan. If CMS has not responded to the State's approval request, then the Performance Remediation Plan will be deemed approved, given the need for

CPs or CSAs to have as much time as possible to implement their projects, which will need to be completed during the first half of the following Budget Period. The State will monitor the Plan during the implementation period on an ongoing basis. Additionally, the State will assign a Performance Remediation Plan Score to the CP or CSA, based on the State's ongoing monitoring of the Plan, and supporting documentation submitted by the CP or CSA in its semiannual progress report for the first half of the Budget Period in question. The Performance Remediation Plan Score will be a single point value between 0 and 10 inclusive, and will determine how much of the CP or CSA's unearned, withheld funds can be earned back.

For example, if (1) a CP or CSA has \$100,000 of unearned, withheld funds; (2) the State determines that a CP or CSA will be able to earn back 50% of the CP or CSA's unearned, withheld funds (out of a 60% maximum percentage); and (3) the CP or CSA achieves a Performance Remediation Plan Score of 7 out of 10, then the CP or CSA's final earned funds will be equal to $\$100,000 * 50% * (7 / 10) = \$35,000$.

The DSRIP Advisory Committee on Quality

See Section 6.2.1 for discussion of the Advisory Committee on Quality's role.

CMS

CMS will review and approve State submissions within 90 calendar days. If CMS does not approve the submission, the State and CMS will work collaboratively together to align on appropriate modifications and a timeline for prompt approval.

5.4.7 Timeline of CP DSRIP Accountability Score data collection, calculation, and disbursement of DSRIP payments

The timeline for CP DSRIP Accountability Score calculation and disbursement of DSRIP payments to CPs is anticipated to be as follows:

- CP and CSA Budget Period Closes
- Member experience survey results within 270 calendar days of BP closing
- State determines denominators and sample populations (i.e., the specific members whose data each CP must submit) for the clinical quality measures within 210 calendar days of BP closing
- CPs and CSAs submit clinical quality data within 30 calendar days of receiving the denominators and sample populations for the clinical quality measures
- State calculates CP and CSA DSRIP Accountability Score within 90 calendar days of receiving all underlying required data
- Once CP and CSA DSRIP Accountability Scores have been calculated, State submits Scores and supporting documentation to CMS for review and approval
- CMS has 90 calendar days to review and approve the CP and CSA DSRIP Accountability Scores; if CMS has not responded to State's approval request, then the DSRIP Accountability Scores will be deemed approved, given the need to disburse at-risk funding to CPs and CSAs in a timely fashion
- State notifies CPs and CSAs of CP and CSA DSRIP Accountability Score within 30 calendar days of determining Score
- State disburses DSRIP at-risk payments to CPs and CSAs within 30 calendar days after CMS has approved CP and CSA DSRIP Accountability Scores

5.5 Reporting Requirements for ACOs, CPs and CSAs

5.5.1 Semiannual Participation Plan Progress Reports

ACOs, CPs, and CSAs participating in the DSRIP program will submit semiannual reports to the State demonstrating progress with their Participation Plans, plans for continued implementation of the approved

Participation Plan, areas for improvement and an account of budget expenditures. The State will provide templates for the semiannual progress report which will specify the data that ACOs, CPs and CSAs will need to submit. ACOs, CPs and CSAs must submit their semiannual progress reports in order to receive further DSRIP funding. For example, if an ACO, CP or CSA submits a semiannual progress report three months after the end of BP2, then it will be able to receive DSRIP payments from three months after the end of BP2 until the next required semiannual progress report submission date (i.e. two months after the midway point of BP3).

ACO semiannual progress reports will be submitted in a form and format prescribed by the State, and may include information such as:

- The ACO's progress toward implementation of the Participation Plan
- The progress and status of specific investments and programs supported by DSRIP funds, including any findings from or modifications to these investments and programs
- Descriptions of recent activities and accomplishments
- Descriptions of upcoming activities and challenges
- Budget expenditures for all DSRIP funding
- If relevant, supporting documentation for a DSRIP Performance Remediation Plan
- Additional information as requested by EOHHS.

As noted above, ACOs will submit progress reports twice annually. The Progress Report 1 will be due two months after the midway point of a given BP and Progress Report 2 will be due three months following the close of the Budget Period. The below provides the timeline for submission of such reports for the Preparation Budget Period as well as Budget Period 1. Budget Periods 2-5 will follow the same pattern as Budget Period 1, adjusted for the respective years.

- **Preparation Budget Period Progress Report:** This report is due no later than **March 31, 2018** and shall include the information detailed above for the **Preparation Budget Period (July 1 – December 31, 2017)**
- **BP1 Progress Report 1:** This report is due no later than **August 31, 2018** and shall include the information detailed above for the period of **January 1 - June 30, 2018**
- **BP1 Progress Report 2:** This report is due no later than **March 31, 2019** and shall include the information detailed above for the period of **January 1 - December 31, 2018**

The content for ACO Progress Reports 1 and 2 for a given Budget Period may differ, as Progress Report 2 provides detailed information about the entire Budget Period, whereas Progress Report 1 only covers the first half of the Budget Period.

For CPs and CSAs, semiannual progress reports will be submitted in a form and format prescribed by the State, and may include:

- Descriptions of successes, barriers, challenges, and lessons learned regarding, at a minimum, outreach, care coordination, and integration of care
- Summary of CP care coordination supports activities

- Budget expenditures for all DSRIP funding
- Supporting documentation for DSRIP Performance Enhancement Plans (if relevant)
- Additional information as requested by EOHHS

The below provides the timelines for submission of such reports for the CPs/CSAs Preparation Budget Period as well as Budget Periods 1 and 2. Budget periods 3-5 will follow the same pattern as Budget Period 2 adjusted for the respective year

- **Preparation Budget Period Progress Report:** This report is due no later than **August 31, 2018** and shall include the information detailed above for the **Preparation Budget Period (October November 2017 – May 31, 2018)**
- **BP1 Progress Report 2:** This report is due no later than **March 31, 2019** and shall include the information detailed above for the period of **June 1, 2018 – December 31, 2018**
- **BP2 Progress Report 1:** This report is due no later than **August 31, 2019** and shall include the information detailed above for the period of **January 1 - June 30, 2019**
- **BP2 Progress Report 2:** This report is due no later than **March 31, 2020** and shall include the information detailed above for the period of **January 1 - December 31, 2019**

The content for CP or CSA Progress Reports 1 and 2 for a given Budget Period may differ, as Progress Report 2 provides detailed information about the entire Budget Period, whereas Progress Report 1 only covers the first half of the Budget Period.

5.5.2 Review and Approval of Semiannual Progress Reports

The State and the Independent Assessor will review the semiannual progress reports (see Section 6.2.2 for details). The State and the Independent Assessor will have a total of 45 calendar days to review and approve the report, or request additional information regarding the information reported. All approved semiannual progress reports will be sent to CMS.

5.5.3 Additional Reporting Requirements

ACOs, CPs, and CSAs must annually submit clinical quality data to the State for quality evaluation purposes. For example, as noted in Appendix D, the State has proposed three types of quality measures. The first type is solely based on claims or administrative data and will be calculated by the State with no further input (other than claims previously submitted) from the ACO/CP/CSA. The second type of quality measure is based on patient experience survey data, and will be collected by a state-procured survey vendor. The third type of quality measure will require both claims information and clinical (e.g. blood pressure) or administrative (e.g. completion of an assessment) information not available through claims. The State will produce the denominators for quality measures based on claims or other information and then submit the denominator to the ACO, CP, or CSA for completion of the numerator information. The State will then receive the numerator information from the ACOs, CPs, or CSAs and calculate performance. The State will conduct audits of the clinical quality data submitted by ACOs, CPs, and CSAs to ensure that the data are accurate.

Additionally, ACOs will need to submit their ACO revenue payer mix for safety net categorization purposes. CPs will need to submit to the State their roster of engaged members. All entities will also be responsible for ad hoc reporting as requested by the State.

Section 6. State Operations, Implementation, Governance, Oversight and Reporting

The State will utilize the small portion of DSRIP funding allocated to the State Operations and Implementation to support robust operations, implementation, governance and oversight of the DSRIP program. These state expenditures associated with implementation of the DSRIP program will be claimed as administrative costs on the CMS 64. Appendix C provides additional detail on anticipated personnel, fringe and contractual costs.

6.1 Internal Operations and Implementation

The State will use a robust internal implementation team to ensure the DSRIP program towards its goals at outlined in STC 57. The team will include, but not be limited to:

- ACO program and contract management team
- CP program and contract management team
- Statewide Investments program and contract management team
- MassHealth operations team

The State will develop an internal steering committee that will make recommendations to the Assistant Secretary for MassHealth on policy and programmatic decisions related to the DSRIP program. This steering committee will include representation from several MassHealth teams involved in the design and implementation of the DSRIP program.

Committee members will meet regularly and will solicit feedback from the DSRIP Advisory Committee on Quality and other stakeholders as needed. While the steering committee will provide timely information and consultation, ultimate decision-making power rests with the Assistant Secretary for MassHealth.

6.2 Advisory Functions

6.2.1 DSRIP Advisory Committee on Quality

The State will establish a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities as set forth in STC 71.² The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement, and clinical data used in performance improvement initiatives, quality and best practices. Final decision-making authority will be retained by the State and CMS, although all recommendations of the Committee will be considered by the State and CMS. The Committee will be made up of:

- Representatives from community health centers serving the Medicaid population
- Clinical experts in behavioral health, substance use disorder and long term services and supports. Clinical experts are physicians, physician assistants, nurse practitioners, licensed clinical social workers, licensed mental health counselors, psychologists, or registered nurses who satisfy two or more of the following criteria:
 - Five years of patient care in the relevant area of expertise
 - Experience managing clinical programs focused on the relevant patient populations

² Note STC 71 called the Committee the “DSRIP Advisory Committee.” State has decided to re-name it as the “DSRIP Advisory Committee on Quality” for clarification purposes.

- Service on national or statewide advisory committees or panels for relevant topic areas
- Advocacy members: consumers or consumer representatives, including at least one representative for people with disabilities and, separately, at least one representative for people with complex medical conditions

At least 30% of members must have significant expertise in clinical quality measurement of hospitals, primary care providers, community health centers, clinics and managed care plans. Significant expertise is defined as not less than five years of recent full time employment in quality measurement in government service, at managed care plans, at health systems, or from companies providing quality measurement services to above listed provider types and managed care plans.

To minimize risk of conflicts of interest, no more than three members may be directly employed by Massachusetts hospitals, MassHealth ACOs, or Community Partners. To further minimize conflicts of interest, no CEO, CFO, COO, or CMO of a Massachusetts hospital, MassHealth ACO, or Community Partners will be appointed to the Committee. Additionally, any members whose affiliated organizations have financial interests in performance target setting for quality measures must recuse themselves when the Committee is discussing performance target setting. Finally, potential conflicts of interest will be considered when selecting Committee members to try to minimize such conflicts.

6.2.2 Independent Assessor

The State will identify an Independent Assessor with expertise in delivery system improvement to assist with DSRIP administration, oversight, and monitoring as set forth in STC 70. The Independent Assessor will provide an added, ongoing layer of review and monitoring. The State and the Independent Assessor will concurrently review ACOs', CPs', and CSAs' Full Participation Plans, Budgets, Budget Narratives, and Semi-Annual Progress Reports to ensure compliance with the STCs and DSRIP Protocol. Preliminary ACO and CP Participation Plans and the Budgets and Budget Narratives for the Preparation Budget Period will not be subject to review by the Independent Assessor. The Independent Assessor shall make recommendations to the State regarding approvals, denials or recommended changes to Participation Plans, Budgets, Budget Narratives, and Semi-Annual Progress Reports, but final decision-making authority regarding all approvals, denials or requests for modifications rests with the State. However, the State will carefully consider the Independent Assessor's recommendations. The State has the authority to change Independent Assessors at the State's discretion.

In contrast, the Independent Evaluator is charged with reviewing the DSRIP program as a whole (see Section 6.4). At the midpoint and conclusion of DSRIP, the Evaluator will undertake a midpoint assessment and summative evaluation, respectively, which will seek to determine the effectiveness of the DSRIP program in relationship to its goals. To accomplish such reviews, the Evaluator will use a quantitative and qualitative approach. These reviews may include evaluating the work of the Independent Assessor.

6.3 Stakeholder Engagement

6.3.1 Independent Consumer Support Program

The State will create Independent Consumer Support Program to assist beneficiaries in understanding their coverage models and in the resolution of problems regarding services, coverage, access, and rights. The Independent Consumer Support Program will assist beneficiaries to navigate and access covered services in accordance with STC 62.

6.3.2 State Public Outreach for ACO Program

The State aims to facilitate a seamless transition to the new care model for MCO and ACO enrollees and will do so through the State Public Outreach for ACO Program in accordance with STC 68.

6.3.3 State Reporting to External Stakeholders and Stakeholder Engagement

The State will compile public-facing annual reports of ACO, CP, and statewide investments performance. The report will provide relevant information on the State's progress under the DSRIP program, as determined by the State. Annual public meetings will be held to engage stakeholders on the DSRIP program at large, and allow for discussion, comments, and questions. MassHealth will also post information related to the DSRIP program online. The public will be encouraged to contact MassHealth to provide comments and feedback throughout the Demonstration through a dedicated e-mail address.

6.4 Evaluation of the Demonstration

The State will procure an Independent Evaluator to conduct a mid-point assessment and final evaluation of the DSRIP program per STCs 69 and 84. The State may utilize the same Independent Evaluator for the Demonstration under STC 84 as it does for the DSRIP program under STC 69.

6.4.1 Requirements for Midpoint Assessment of Performance and Interim Evaluation

The Independent Evaluator will conduct a midpoint assessment and an interim evaluation of the DSRIP program, in accordance with STCs 69(a) and 84. The midpoint assessment will evaluate the program to determine whether the investments made through the DSRIP program are contributing to achieving the demonstration goals as described in STC 57, and which areas need improvement (e.g., conduct rapid cycle evaluations). Specifically, the quantitative findings will be used to report on progress towards reaching goals, and qualitative findings will be used to understand additional implementation issues. The results from the midpoint assessment will help to develop an interim evaluation of the DSRIP program. The State may focus on issues identified in the assessment and interim evaluation report and may implement changes where necessary. For example, if the interim evaluation reveals that the administration of the flexible services program is too burdensome or not robust enough, then the State may identify potential adjustments to the program, and implement them accordingly with appropriate communication with ACOs and CPs.

Despite the schedule set forth in STC 69(a), the State has agreed to provide the midpoint assessment through December 2019 and to submit the interim evaluation to CMS by the end of June 2020. The State will provide the draft evaluation design of the overall waiver (including initial proposals for evaluation of the DSRIP program) to CMS in March 2017. The State will provide the proposed design for the interim DSRIP evaluation to CMS for review by June 30, 2018.

6.4.2 Final Evaluation

In contrast to the interim evaluation, the final evaluation will provide a summative overview of the DSRIP program over the five year demonstration period, and evaluate whether the investments made through the DSRIP program contributed to achieving the demonstration goals as described in STC 57. The Independent Evaluator will also be responsible for completing the final evaluation of the DSRIP program in accordance with STCs 69(b) and 84(f).

6.5 CMS Oversight

6.5.1 State Reporting to CMS

The State will compile quarterly and annual reports to submit to CMS consistent with sections IX and X of the approved STCs as part of the broader 1115 demonstration reports. These reports will include an account of all DSRIP payments made in the quarter or year, respectively and include insights and updates from the progress reports collected from ACOs, CPs, and CSAs. The State and CMS will agree upon a reporting template for quarterly and annual reports by the start of the demonstration for the quarterly report and by December 2017 for the annual report. The State and CMS will also use a portion of the Monthly Monitoring Calls for March, June, September, and December of each year for an update and

discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.

6.5.2 Process for Review, Approval, and Modification of Protocol

The State will work collaboratively with CMS for the review and approval of the DSRIP Protocol. As set forth in STC 58(c), the State may modify the DSRIP Protocol over time, with CMS approval. Reasons for modification may include but are not limited to:

- State decision to change programmatic features that are codified in the Protocol (e.g. change the structure of the outcomes-based payment funding stream for CPs)
- State decision to modify State Accountability Targets during the demonstration period, if the targets are no longer appropriate, or that targets were greatly exceeded or underachieved

State will submit the modification request to CMS, which will have 90 calendar days to review and approve. If CMS does not approve the Protocol, the State and CMS will work collaboratively together to align on appropriate modifications and a timeline for prompt approval.

Appendix A: Description of ACOs and CPs

Accountable Care Organizations

To achieve Massachusetts' DSRIP goals as described above, the State is transitioning a significant portion of the delivery system from a fragmented, fee-for-service model to one where providers come together in new partnerships to take financial accountability for the cost and quality of care for populations of members. Massachusetts is launching a new Accountable Care Organization program, has designed three ACO payment models that respond to the diversity of the state's delivery system, and intends to select ACOs across all three models through a competitive procurement.

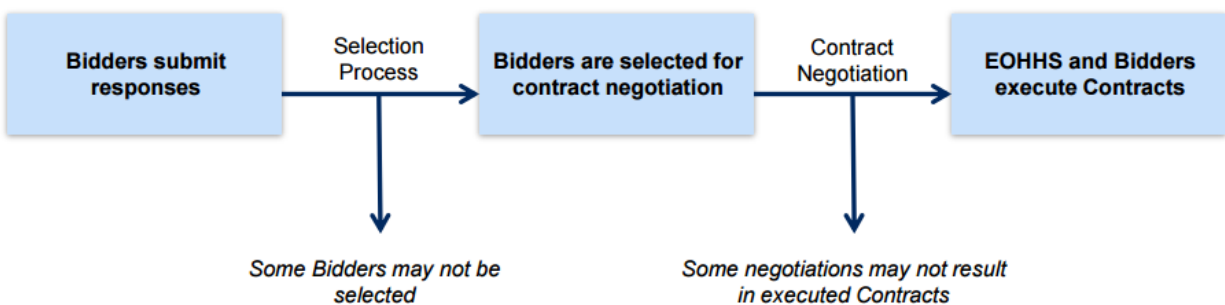
ACO contracts will have an initial term of five-years and will include significant requirements for ACOs to ensure care delivery in line with the state's delivery system goals, including but not limited to requirements to screen members and connect them to appropriate settings of care; requirements to proactively identify at-risk members, complete comprehensive assessments, and provide them with appropriate care management activities; and requirements to work with Community Partners to integrate behavioral health, LTSS, and medical care. Massachusetts' three ACO models are described in Section 1.

Procurement Process

Massachusetts intends to select ACOs across all three ACO models as part of a single, competitive procurement. Bidders may bid on more than one model, but a bidder may be selected for, at maximum, one ACO model. The State may re-open the procurement at any time if, in the State's determination, the State has not received sufficient responses, or to otherwise meet the State's delivery system goals.

Bidders will submit responses to the State's procurement by the deadline, after which the responses will be evaluated by the State. The State will select successful ACO bidders to enter into contract negotiation. Through contract negotiation, the State intends to reach successful contract execution with a set of ACOs; although not all ACOs selected for negotiation may ultimately execute contracts with the State (e.g., if an ACO ultimately chooses not to accept final contract terms or rates). The graphic below shows an example process flow:

Example process flow for procurement: for illustration purposes only:



The State's current anticipated procurement timeline is as follows:

- Request for responses was posted in September 2016
- Bidders' responses are due mid-February 2017
- Target contract execution in August 2017

- Contracts will be effective the date they are executed, and will have an operational start date (i.e., the date on which members can enroll in ACOs) in December 2017

Further information on the ACO procurement can be found online at the State's public procurement website, www.commbuys.com.

Community Partners

Community Partners will support members with complex BH and LTSS needs, in coordination with ACOs and other managed care entities, as determined by the State. The focus populations of MassHealth members for the CP program may include, for example, (1) members with diagnoses of serious mental illness and/or substance use disorder who have significant utilization of acute services such as ER visits, inpatient stays, detoxification stays, medication assisted treatment for SUD or co-occurring chronic medical conditions; and/or (2) members with claims for MassHealth State Plan LTSS of more than \$300 per month over at least 3 consecutive months.

MassHealth will selectively procure the following two types of CPs, BH CPs and LTSS CPs (see Sections 1 and 4.3 for additional descriptions of the CP Models).

- **BH CP Model overview:** MCOs and ACOs will delegate comprehensive care management responsibility to the BH CP for enrollees of the BH CP with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD). BH CPs will be required to coordinate care across the full healthcare continuum, including physical and behavioral health, LTSS and social service needs. Because BH CPs will be expected to have experience supporting members with LTSS needs, members with both complex BH and LTSS needs as assigned to a BH CP. BH CPs will be required to meet certain training obligations (e.g., training in person-centered planning, cultural competency, accessibility and accommodations, independent living and recovery principles, motivational interviewing, conflicts of interest and health and wellness principles) and coordination requirements (e.g., providing enrollees with at least two choices of LTSS service providers, assisting the member in navigating and accessing needed LTSS and LTSS-related services, identifying LTSS providers that serve or might serve the member, and coordinating and facilitate communication with LTSS providers) to ensure their capability to support members with both complex BH and LTSS needs.
- **LTSS CP Model overview:** ACOs and MCOs will conduct comprehensive assessments, convene the care teams, and provide care planning and coordination for physical and behavioral health services to enrollees assigned to a LTSS CP. The LTSS CP will review the comprehensive assessment results with the LTSS CP assigned members as part of the person-centered LTSS care planning process and will inform the member about his or her options for specific LTSS services, programs and providers that may meet the member's identified LTSS needs. The LTSS CP is expected to be an integral part of the member's care team, as requested by the member. LTSS CPs may also have the opportunity to participate in an enhanced supports model (anticipated to begin in year 2), where responsibility for the comprehensive assessment and care management will be delegated by the ACO/MCO to the LTSS CP.

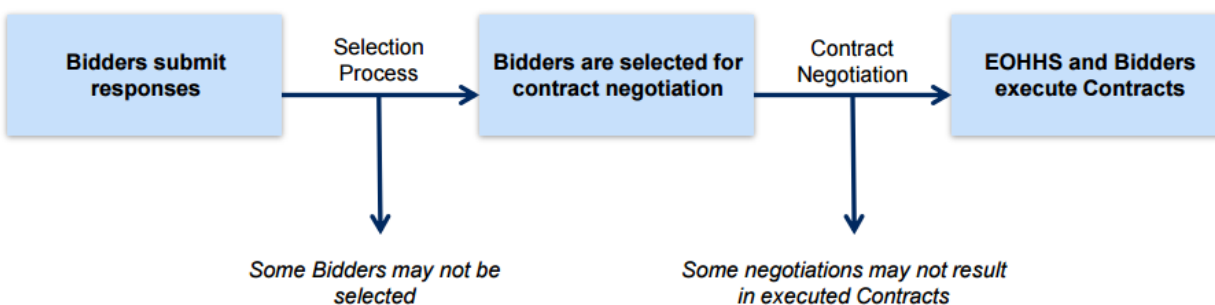
CPs will not be able to authorize services for members under either model.

Procurement Process

MassHealth intends to select BH and LTSS CPs across the State through a competitive procurement. ACOs (and other managed care entities as determined by the state) will be required to partner with CPs in all the regions or services areas in which the ACO operates.

Bidders will submit responses to the State's procurement by the deadline, after which the responses will be evaluated by the State. The State will consider any bid submitted by any entity that meets the minimum bidder qualifications of the procurement. The State will select successful CP bidders to enter into contract negotiation. Through contract negotiation, the State intends to reach successful contract execution with a set of CPs; although not all CPs selected for negotiation may ultimately execute contracts with the State (e.g., if an CP ultimately chooses not to accept final contract terms or rates). The graphic below shows an example process flow:

Example process flow for procurement: for illustration purposes only:



The State's current anticipated procurement timeline is as follows:

- Request for responses will be posted in February/March 2017
- CP responses are due end of May 2017
- Target contract execution in November 2017
- Contracting between CPs and ACOs & MCOs is targeted to be completed by January-February 2018
- CPs begin enrolling members in June 2018

Further information on the CP procurement can be found online at the State's public procurement website, www.commbuys.com.

Relationships between ACOs and CPs

Massachusetts has established a framework for ACOs and CPs to form and formalize their relationships. This framework is set forth in the model contracts for ACOs, and Massachusetts intends to similarly incorporate this framework in its model contracts for CPs. The framework delineates areas of delegated and shared responsibility between ACOs and CPs, as follows:

Delegated responsibility to BH CPs

ACOs must maintain agreements with BH CPs. These agreements will require the BH CP to support the ACO's care coordination and care management responsibilities, including:

- Working together to improve coordination and integration of BH services and expertise into care, including activities such as but not limited to:
 - Identifying BH providers that serve or might serve enrollees, and coordinating between the ACO and those providers
 - Assisting the ACO's members to navigate to and access BH and related services
 - Facilitating communication between members and providers
 - Coordinating with staff in state agencies that are involved in member care
 - Facilitating members' access to peer support services
- Working together to perform outreach and enrollment for members who are eligible for BH CPs
- Providing care management to BH CP-enrolled members, including designated care coordinators/clinical care managers, documented treatment plans, comprehensive transition management, health promotion, and other activities
- Collaborating and establishing mutual policies and procedures to ensure alignment, information sharing, appropriate sign-off, issue resolution, and communication
- Performance measurement and management, including the ACO and CP working together to evaluate performance on key process measures (e.g., outreach and enrollment) and outcome measures (e.g., the state's accountability score measures)

Delegated responsibility to LTSS CPs

ACOs must maintain agreements with LTSS CPs. These agreements will require the LTSS CP to support the ACO's care coordination and care management responsibilities, including:

- Working together to improve coordination and integration of LTSS and expertise into physical and behavioral health care, including activities such as but not limited to:
 - Identifying LTSS providers that serve or might serve enrollees, and coordinating between the ACO and those providers
 - Assisting the ACO's members to navigate to and access LTSS and related services
 - Facilitating communication between members and providers
 - Coordinating with staff in state agencies that are involved in member care
 - Providing support during transitions of care for the ACO's members
- Providing information and navigation to LTSS for the ACO's members
- Collaborating and establishing mutual policies and procedures to ensure alignment, information sharing, appropriate sign-off, issue resolution, and communication

- Performance measurement and management, including the ACO and CP working together to evaluate performance on key process measures (e.g., outreach and enrollment) and outcome measures (e.g., the state’s accountability score measures)

Exhibit A1 below details the entities performing the comprehensive assessment, care planning and service authorization functions related to LTSS and the target populations for such functions.

Exhibit A1: LTSS Comprehensive Assessment, Care Planning and Service Authorization

Activity	Entity Performing Activity	Population
Care Needs Screening	ACO or MCO	ACO and MCO enrollees
Comprehensive Assessment	ACO or MCO	ACO and MCO enrollees assigned to a LTSS CP or with LTSS needs as specified by EOHHS
LTSS segment of Care Planning	ACO or MCO	ACO and MCO enrollees with LTSS needs as specified by EOHHS who are not assigned to LTSS CPs
	LTSS CP	ACO and MCO enrollees assigned to a LTSS CP
Service Authorization	<i>Before LTSS becomes covered services and included in TCOC:</i>	
	MassHealth	ACOs and MCOs enrollees, including LTSS CP engaged enrollees
	<i>After LTSS become covered services and are included in TCOC (~year 3):</i>	
	Accountable Care Partnership Plan	Accountable Care Partnership Plan enrollees, including LTSS CP engaged enrollees
	MCO	MCO-Administered ACO and MCO enrollees, including LTSS CP engaged enrollees
	MassHealth	Primary Care ACO enrollees, including LTSS CP engaged enrollees

Shared responsibility between ACOs and CPs

Agreements will codify responsibilities of ACOs and CPs and describe additional requirements, including:

- Member assignment to a CP (as applicable)
- Care team roles and participation
- Performance expectations and any associated financial arrangements (beyond DSRIP)
- Shared decision-making and governance
- IT systems and data exchange, including quality and cost reporting

Beyond delineation of roles and responsibilities, contracts between ACOs, CPs, and MCOs must include conflict resolution protocols to handle disputes between the relevant parties. As ACOs and MCOs will not be paying CPs for services provided, a substantial portion of disputes will likely center around member referrals and care plans. If the member believes that the care he or she is receiving is unacceptable, the member will have access to formal grievance processes through the ACO, MCO, and CP entities. Additionally, the member can contact MassHealth’s Ombudsman Patient Protection Program, which is established to explicitly help members work through such issues. Throughout Year 1, the State will monitor disputes as they arise, and at year conclusion, will determine if further conflict resolution protocols are needed.

Appendix B: Description of Statewide Investments Initiatives

Student Loan Repayment

The student loan repayment program will repay a portion of a student's loan in exchange for at least a two year commitment (or equivalent in part time service) to work as a (1) primary care provider at a community health center or (2) behavioral health professional (e.g., Community Health Worker (CHW), Peer Specialist, Recovery Support Specialist, or Licensed Clinical social worker) in a community setting (e.g., community health center, community mental health center) and/or at an Emergency Service Program (ESP), and/or at any entity participating in a CP or CSA. This program hopes to reduce the shortage of providers and incentivize them to remain in the field long-term. Additionally, increased numbers of providers available to ESPs will help support diversionary strategies to reduce Emergency Department utilization and increase appropriate member placement in other settings.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the impact of the student loan repayment program on their practice and institutions. Awardees' accountability will be ensured through primary care providers' and behavioral health professionals' attestations that they have remained in the required placement for a minimum of two years or the equivalent in part time service. If a provider fails to fulfill the minimum requirement, the State will determine the appropriate recourse, which may include recoupment of funds paid by the State for student loans.

State Management

The State will select the recipients of the awards, and will conduct robust monitoring and assessment of the semi-annual progress reports including reviewing the awardees' progress, successes, and challenges.

Primary Care Integration Models and Retention

The State will implement a grant program that provides support for community health centers and community mental health centers, and/or any entity participating in a CP or CSA to allow their primary care and behavioral health providers to engage in one-year projects related to accountable care implementation, including improving care coordination and integrating primary care and behavioral health. These projects must support improvements in cost, quality and member experience through accountable care frameworks and will also serve as an opportunity to increase retention of providers. Community health centers, community mental health centers, and/or entities participating in a CP or CSA will be the primary applicant and will partner with primary care and behavioral health providers to apply for this funding.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select the recipients of this funding, and will conduct robust monitoring and assessment of the semiannual progress reports by reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or

renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Investment in Primary Care Residency Training

In order to increase the number of physicians receiving residency training in community health centers, the State will use DSRIP funding to help offset the costs of community health center and community mental health center residency slots for both community health centers, community mental health centers, and hospitals. Community health centers, community mental health centers, and hospitals will be eligible to apply for this funding.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State that detail the project's progress towards goals and pre-approved accountability measures (e.g., the number of providers remaining in the CHC for the length of the residency program), challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select the recipients of this award, and will conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures.

Workforce Development Grant Program

The State's payment reform initiatives will introduce new demands and shifting responsibilities for the healthcare workforce. The State will use DSRIP funding to support a wide spectrum of health care workforce development and training to allow for providers to more effectively operate in a new health care system. Entities participating in payment reform (ACOs, Community Partners, and CSAs), or entities in support of ACOs, CPs, and CSAs (e.g. training programs) are eligible to apply for funding.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

State will select the awardees, and will conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Technical Assistance

The State will procure vendors to provide technical assistance (TA) to ACOs, CPs and CSAs in a range of knowledge domains in order to help with the implementation of evidence-based interventions. TA may be provided in multiple forms, including but not limited to: individual consultation, learning collaboratives, tools and resources, and webinars. Providers participating in payment reform (ACOs, Community Partners, and CSAs) may be eligible to apply for funding.

Technical assistance may be available in areas such as, but not limited to:

- (1) **Education:** Education on delivery system reform topics, such as governance requirements, shared savings and shared losses; network development; quality and financial management analytics; assistance with health care literacy; and other topics.
- (2) **Actuarial and Financial:** Actuarial consulting to support participation in payment models. Baseline education and readiness assessments that address financial business process changes, patient attribution, budgeting, practice management systems, and other needs.
- (3) **Care Coordination/Integration:** Technical assistance to support, establish, and improve care coordination/integration best practices, including best practices around incorporating community health workers and social workers into practice, among other areas
- (4) **Performance Management:** Technical assistance to support program improvements, project management and provider performance management
- (5) **Health Information Technology:** Consultations to provide insight into what HIT investments and workflow adjustments will be needed to achieve goals regarding data sharing and integration across the delivery system (e.g., establishing clinical or community linkages through an e-Referral system)
- (6) **Accessible and Culturally Competent Care:** Training and support materials to promote best practices for accessibility and for culturally competent care for individuals with limited English proficiency; diverse cultural and ethnic backgrounds; physical, developmental, or mental disabilities; and regardless of gender, sexual orientation, or gender identity.
- (7) **Chronic Conditions Management:** Training, support, and technical assistance on utilizing and implementing evidence-based interventions to manage chronic conditions, among other areas.
- (8) **Behavioral Health Care Treatment and Management:** Training, support, data analytics, and technical assistance in caring for patients with behavioral health needs in the community, among other areas
- (9) **Population Health and Data Analytics:** Training, support, and technical assistance in analyzing data (e.g. raw claims extracts from The State, clinical quality data from EHRs) to help providers make evidence-based decisions, among other items

Awardee's Obligations

ACOs, CPs, and CSAs will be eligible to apply for technical assistance. Interested ACOs, CPs, and CSAs will submit a comprehensive TA plan as part of their application, which will be subject to modification and approval by the State. Any TA resources to support the plan must not overlap with TA supported through other funding sources (e.g., federal, state, private sector). Awardees will be required to submit a semiannual progress report discussing the progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

Vendor's Obligations

Vendors will work in collaboration with the State, ACOs, CPs, and CSAs to provide TA in a way that optimizes allocated TA resources and supports sustainable TA infrastructure. Vendors will also be required to submit documentation covering the same topics discussed in the awardees' semiannual progress report.

State's Management

The State will procure qualified vendor(s) for each TA category. A vendor may be approved for multiple categories. To be considered a qualified vendor, the vendor must demonstrate expertise and capacity for the categories for which it is applying, as well as meet other eligibility criteria set by the State.

The State will conduct robust monitoring and assessment of progress reports submitted by the awardees and TA vendors, which will include reviewing progress, successes, challenges, and accountability measures. Awardee and TA vendor accountability will be based on meeting pre-determined accountability measures, which will focus on whether the awardee was able to meet its technical assistance goals, or whether the vendor provided appropriate TA. If the goals are not met, or performance is inadequate, the State, in consultation with the awardee and/or vendor, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Alternative Payment Methods (APM) Preparation Fund

The State will use DSRIP funding for an Alternative Payment Methods (APM) Preparation Fund, which will offer two years of support to providers that are not yet ready to participate in an APM, but want to take steps towards APM adoption. Funds can be used to develop, expand, or enhance shared governance structures and organizational integration strategies linking providers across the continuum of care. Massachusetts' providers seeking to move towards ACOs or APMs but that are not participating as a MassHealth ACO; and behavioral health providers, BH CPs, LTSS providers and LTSS CPs seeking to enter into APM arrangements with MassHealth managed care entities will be eligible to apply for funding. Funds may also be used to raise awareness about APM among providers not yet engaged in a MassHealth ACO, CP, or CSA.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select recipients of this funding, and conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Enhanced Diversionary Behavioral Health Activities

The State will use DSRIP funding to support investment in new or enhanced diversionary strategies or infrastructure to help place members with behavioral health needs in the least restrictive, clinically most appropriate settings and to reduce the incidence of members who are boarded in a hospital emergency

department waiting for admission into acute inpatient treatment or diversion to a community setting. Strategies for investment may include:

- Workforce Development
- Urgent care and intensive outpatient program (IOP)
- Community-Based Acute Treatment (CBAT) for adults
- ESP/Mobile Crisis Intervention (MCI) Teams with specific focus on placement in the EDs
- Crisis Stabilization Services (CSS)
- Telemedicine and Tele-psychiatry
- Peer Support models
- Discharge navigation services
- Web-based portal for navigation and data collection of ED boarding and available bed placement
- Care coordination software to better manage members who are boarded in the ED and to prevent such events

ACOs, CPs, CSAs, primary care providers, ESPs, community mental health centers, acute care hospitals, community health centers, psychiatric hospitals, advocacy organizations, provider organizations, vendors, and MCOs may be eligible to apply for funding. ACOs, CPs, or CSAs receiving funding must demonstrate that activities supported through this statewide investment are not duplicative with activities supported through other available funding.

Awardee's Obligations

Awardees will submit a semiannual progress report discussing the project's progress to date including activities and progress towards the reduction of ED boarding, goals and accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select recipients for this funding, and conduct robust monitoring and assessment of the semiannual progress and annual reports. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Improved accessibility for people with disabilities or for whom English is not a primary language

The State will use DSRIP funding to help providers offer necessary equipment and expertise at their facilities to meet the needs of persons with disabilities, or of those for whom English is not a primary language.

Funding would be available to help providers purchase items necessary to increase accessibility for members with disabilities, for accessible communication assistance, and for development of educational materials for providers regarding accessibility for members with disabilities. The State will tailor some of these materials specifically for providers treating members who are vision-impaired, deaf and hard of hearing, or for whom English is not a primary language. Applicants will be required to demonstrate that training is not duplicative of that received under the Technical Assistance statewide investments funding stream.

The State may also utilize this funding to support development of directories or other resources to assist MassHealth members find MassHealth providers by preferred accessibility preferences and to assist providers in identifying the accessibility preferences of their patients.

Awardee's Obligations

Awardees will be required to submit semiannual progress reports to the State discussing the project's progress towards goals and pre-approved accountability measures, challenges and plans to address those challenges, and expenditures to date.

State's Management

The State will select funding recipients, and conduct robust monitoring and assessment of the semiannual progress reports through reviewing progress, successes, challenges, and accountability measures. Awardees' accountability will be evaluated by whether the projects were completed, and whether performance on the accountability metrics, set out prior to the project's implementation, was adequate. If the project was not completed, or performance on the metrics was inadequate, the State, in consultation with the awardee, will determine appropriate recourse, which may include corrective action plans, termination from the investment program, barring providers from applying for future Statewide Investment funding, recoupment of funds, or other contract management activities (e.g., working collaboratively with the awardee to identify and implement new strategies to meet the project goals, or renegotiating the awardee's responsibilities or the project's goals to achieve partial success, as appropriate).

Appendix C: Example Calculation of State DSRIP Accountability Score by Accountability Domain for BP 4

The following example demonstrates how the State DSRIP Accountability Score will be calculated for Budget Period 4. There are five steps to calculate how much at-risk funding the State earns in a given BP:

- **Step 1:** Calculate the MassHealth ACO/APM Adoption Rate Score
- **Step 2:** Calculate the Reduction in Spending Growth Score
- **Step 3:** Calculate the Overall Statewide Quality and Utilization Performance Score
- **Step 4:** Using the three scores calculated in Steps 1 through 3 to calculate the State DSRIP Accountability Score
- **Step 5:** Use the State DSRIP Accountability Score to determine earned at-risk funds

Step 1: Calculate the MassHealth ACO/APM Adoption Rate Score for BP 4

For the ACO/APM Adoption Rate score, the State will earn a 100% score for a given Budget Period if the State meets or surpasses the target for that Budget Period. If the State does not meet the target, then it will earn a 0% score for that Budget Period.

For BP 4, the State must have at least 40% of MassHealth ACO-eligible members who are enrolled in or attributed to ACOs or who receive services from providers paid under APMs, as shown below:

EXHIBIT A2 – Target ACO/APM Adoption Rates, BP 4

Target ACO/APM Adoption Rates						
DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
% of MassHealth ACO-Eligible Lives Served by ACOs/ Covered by APMS	NA	25%	30%	35%	40%	45%

For the purpose of this example, assume that the State has a 42% ACO/APM adoption rate in BP 4. Therefore, the State receives an accountability domain score of **100%** in this category.

Step 2: Calculate the Reduction in Spending Growth Score for BP 4

In accordance with STC 67(g), the State will calculate its performance on reduction in state spending growth compared to the trended PMPM, and the domain score will be determined according to a gap-to-goal methodology for each budget period, as follows:

- If Actual Reduction < (50% * Reduction Target), then Measure Score = 0%
- If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
- If Actual Reduction ≥ (50% * Reduction Target) AND < (Reduction Target), then Measure Score is equal to: (Actual Reduction - (50% * Reduction Target)) / (Reduction Target - (50% * Reduction Target)) OR the simplified version,

$$\frac{\text{Percent of reduction target achieved} - 50\%}{100\% - 50\%}$$

For BP 4, the Reduction Target is 1.1% off of trended PMPM, as shown in below.

EXHIBIT A3 – Reduction Targets for ACO-Enrolled PMPMs, BP 4

Reduction Targets for ACO-Enrolled PMPMs						
DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
% Reduction Target in ACO-enrolled PMPM vs. trended PMPM	NA	NA	NA	0.25% off of trended PMPM	1.1% off of trended PMPM	2.1% off of trended PMPM

For the purpose of this example, assume that the State’s Actual Reduction is 0.9% in BP 4, which is roughly 82% of the Reduction Target, as show below:

$$\begin{aligned} \text{Percent of reduction target achieved} &= \\ \frac{0.9\%}{1.1\%} &\approx 82\% \end{aligned}$$

Thus, to calculate this State accountability domain score:

$$\frac{82\% - 50\%}{100\% - 50\%} = 64\%$$

Therefore, the State receives an accountability domain score of **64%** in this category.

Step 3: Calculate the Overall Statewide Quality and Utilization Performance for BP 4

In accordance with STC 67(h), the State will annually calculate the State performance score for each quality and utilization domain by aggregating the performance scores of all ACOs on a member-month weighted basis. Weighting varies by Budget Period, as shown below:

EXHIBIT A4 – ACO Quality Domain Weights

ACO Quality Domain Weights			
Quality Domain		Domain Weight: BP 1	Domain Weight: BP 2-5
1	Prevention & Wellness	20%	10%
2	Chronic Disease Management	20%	15%
3	Behavioral Health / Substance Use	25%	15%
4	Long Term Services and Supports	10%	5%
5	Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	25%	20%
6	Avoidable Utilization	0%	20%
7	Member Care Experience	0%	15%

STEP 3(a): Scoring for all Domains Except Avoidable Utilization

For all domains except avoidable utilization, domain scores for BP4 are calculated using the following steps:

- Calculate the aggregate domain scores for BP 1-3
- Calculate the pooled aggregate domain scores across the three Budget Periods
- Calculate the aggregate domain scores for BP 4 (our example year) and run a weighted t-test to compare pooled aggregate domain scores from BP 1-3 against the BP 4 populations

Domain score calculations for other Budget Periods would follow a similar methodology.

1. Calculate the aggregate domain scores for BP 1-3

Assume there are two ACOs (ACO 1 and ACO 2) with 10,000 and 20,000 members, respectively, for all Budget Periods. Assuming ACO 1 receives a score of 30% and ACO 2 receives a score of 40% in the Prevention and Wellness domain for BP 1, the aggregate domain score for BP1 is:

$$\left(30\% \times \frac{10,000}{10,000 + 20,000}\right) + \left(40\% \times \frac{20,000}{10,000 + 20,000}\right) = 36.7\%$$

This step is repeated for all quality domains in BP 1-3 (see Exhibit 5 for detail).

2. Calculate the pooled aggregate domain scores for BP 1-3

The pooled aggregate domain score is then calculated by taking the weighted average of aggregate domain scores across a given range of budget periods. Using Prevention and Wellness again as the example, assume that the aggregate domain score for BP 1, BP 2 and BP 3 are 36.7%, 46.7% and 70%, respectively. The pooled aggregate domain score would be:

$$\left(\text{Agg. Domain Score}_{BP1} \times \frac{\text{ACO Pop}_{BP1}}{\text{Total Pop}_{BP1-3}}\right) + \left(\text{Agg. Domain Score}_{BP2} \times \frac{\text{ACO Pop}_{BP2}}{\text{Total Pop}_{BP1-3}}\right) + \left(\text{Agg. Domain Score}_{BP3} \times \frac{\text{ACO Pop}_{BP3}}{\text{Total Pop}_{BP1-3}}\right)$$

$$\left(36.7\% \times \frac{30,000}{90,000}\right) + \left(46.7\% \times \frac{30,000}{90,000}\right) + \left(70\% \times \frac{30,000}{90,000}\right) = 51.1\%$$

EXHIBIT A5 – ACO Aggregate and Pooled Aggregate Domain Scores, BP 1-3

Budget Period	BP 1			BP 2			BP 3			BP 1-3
	ACO 1	ACO 2	Total	ACO 1	ACO 2	Total	ACO 1	ACO 2	Total	Total (BP 1-3)
Number of members	10,000	20,000	30,000	10,000	20,000	30,000	10,000	20,000	30,000	90,000
DSRIP Quality Domains	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	Pooled Aggregate Domain Score (BP 1-3)
Prevention & Wellness	30	40	36.7	40	50	46.7	60	75	70.0	51.1
Chronic Disease Management	50	40	43.3	60	50	53.3	70	60	63.3	53.3
Behavioral Health / Substance Use	60	70	66.7	60	70	66.7	60	70	66.7	66.7
Long Term Services and Supports	60	60	60.0	50	60	56.7	60	70	66.7	61.1
Integration (PH, BH, LTSS, SS)	40	50	46.7	50	60	56.7	60	70	66.7	56.7
Member Care Experience	40	40	40.0	50	60	56.7	60	70	66.7	54.4

3. Calculate the aggregate domain scores for BP 4 and run weighted t-test

After calculating the BP 4 aggregate domain scores using the same method utilized to calculate BP 1-3 domain scores (see above), the State will run a stratified Wilcoxon test (i.e. the van Elteren test) to compare each aggregate domain score from BP 4 against its related pooled aggregate domain score from BP 1-3. The p-value from this test will indicate whether each BP 4 quality domain score is statistically better (receives 100% score), statistically worse (receives 0% score) or not statistically different (receives 100% score) from previous years.

EXHIBIT A6 – Stratified Wilcoxon test of BP 4 Aggregate Scores and BP 1-3 Aggregate Pooled Scores

Budget Period	BP 1-3	BP 4			Stratified Wilcoxon test		
	Total (BP 1-3)	ACO 1	ACO 2	Total (BP 4)	Testing BP 4 aggregate domain scores against BP 1-3 pooled aggregate domain scores		
Number of members	90,000	10,000	20,000	30,000			
DSRIP Quality Domains	Pooled Domain Score (BP 1-3)	ACO 1 Domain Score	ACO 2 Domain Score	Aggregate Domain Score	Result	DSRIP Domain Score	Weight
Prevention & Wellness	51.1	60	75	70.0	Statistically BETTER	100%	10%
Chronic Disease Management	53.3	70	60	63.3	Statistically BETTER	100%	15%
Behavioral Health / Substance Use	66.7	60	70	66.7	NOT statistically significant	100%	15%
Long Term Services and Supports	61.1	40	60	53.3	Statistically WORSE	0%	5%
Integration (PH, BH, LTSS, SS)	56.7	60	70	66.7	Statistically BETTER	100%	20%
Member Care Experience	54.4	60	70	66.7	Statistically BETTER	100%	15%

STEP 3(b): Scoring for Avoidable Utilization

In accordance with STC 67(j), the State’s performance on avoidable hospital utilization will be evaluated on two measures:

- Potentially preventable admissions (3M’s PPA measure)

- Hospital all-cause readmissions (NQF #1789)

These measures will be calculated using the following methodology:

- If Actual Reduction < (50% * Reduction Target), then Measure Score = 0%
- If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
- If Actual Reduction ≥ (50% * Reduction Target) AND < (Reduction Target), then Measure Score is equal to: (Actual Reduction - (50% * Reduction Target)) / (Reduction Target - (50% * Reduction Target)) OR the simplified version,

$$\frac{\text{Percent of reduction target achieved} - 50\%}{100\% - 50\%}$$

Reduction Targets vary by budget period, as shown below:

EXHIBIT A7 – Avoidable Utilization Reduction Targets

Avoidable Utilization Reduction Targets						
DSRIP Budget Period	Prep Budget	BP 1	BP 2	BP 3	BP 4	BP 5
PPA Reduction Targets	Reporting Only	Reporting Only	3%	7%	12%	15%
Readmissions Reduction Targets	Reporting Only	Reporting Only	3%	9%	15%	20%

For the purpose of this example, assume that the State achieves a 12% PPA Reduction in BP 4, which gives the State a PPA Reduction score of 100%.

Also assume that the State achieves a 13% Readmissions reduction BP 2, which is roughly 87% of the Reduction Target, as show below:

$$\text{Percent of reduction target achieved} = \frac{13\%}{15\%} \approx 87\%$$

Thus, the Readmissions Reduction Score is:

$$\frac{87\% - 50\%}{100\% - 50\%} = 74\%$$

The average of the PPA Reduction Score and the Admissions Reduction Score yields the overall Utilization score:

$$\frac{100\% + 74\%}{100\% + 100\%} = 87\%$$

Therefore, the State receives an accountability domain score of **87%** in this category.

STEP 3(c): Calculating the Overall Statewide Quality and Utilization Performance

To calculate the overall Statewide Quality and Utilization performance, we multiply the domain scores from BP 4 and the weights from BP 4 and obtain the sum:

EXHIBIT A8 – Calculating the Statewide Quality and Utilization Score for BP 4

DSRIP Quality Domains	Domain Score	BP 4 Weight	Weighted Domain Score
Prevention & Wellness	100%	10%	10%
Chronic Disease Management	100%	15%	15%
Behavioral Health / Substance Use	100%	15%	15%
Long Term Services and Supports	0%	5%	0%
Integration (PH, BH, LTSS, SS)	100%	20%	20%
Member Care Experience	100%	15%	15%
Avoidable Utilization	87%	20%	17%
Statewide Quality and Utilization Score for BP 4 =			92%

Step 4: Calculate the Overall State DSRIP Accountability Score for BP 4

The State will calculate the State DSRIP Accountability Score by multiplying the Score for each State DSRIP Accountability domain by the associated weight and then summing the totals together.

For this example, the State achieved the following domain scores in BP 4:

- MassHealth ACO/APM Adoption Rate: **100%**
- Reduction in State Spending Growth: **64%**
- ACO Quality and Utilization Performance: **92%**

Thus, the State DSRIP Accountability Score for BP 4 is **86.6%**, as demonstrated in the table below:

EXHIBIT A9 – Calculating the Overall State DSRIP Accountability Score

Example Calculation of State DSRIP Accountability Score for BP 4				
DSRIP Accountability Domain	Domain Weight	State Domain Score	State Accountability Calculations	DSRIP Score
MassHealth ACO/APM Adoption Rate	20%	100%	20% x 100% =	20%
Reduction in State Spending Growth	25%	64%	25% x 64% =	16%
ACO Quality and Utilization Performance	55%	92%	55% x 92% =	50.6%
State DSRIP Accountability Score =				86.6%

Step 5: Determine At-Risk Funds Lost and Earned for BP 4

As noted above, the amount of at-risk State expenditure authority varies by Budget Period. For Budget Period 4, the amount at-risk is \$41.25M.

EXHIBIT A10 – Percent of State DSRIP Expenditure Authority At-Risk, BP 4

Percent of State DSRIP Expenditure Authority At-Risk					
DSRIP Budget Period	Prep BP and BP 1	BP 2	BP 3	BP 4	BP 5
DSRIP Expenditure Authority	\$637.5M	\$412.5M	\$362.5M	\$275M	\$112.5M
% of Expenditure Authority At-Risk	0%	5%	10%	15%	20%
Actual Expenditure Authority At-Risk*	\$0M	\$20.625M	\$36.25M	\$41.25M	\$22.5M

To calculate how much at-risk funding the State has earned for BP 4:

$$\begin{aligned}
 &BP\ 4\ amount\ at-risk \times BP\ 4\ State\ DSRIP\ Accountability\ Score \\
 &\$41.25M \times 86.6\% = \$35.7M
 \end{aligned}$$

To calculate how much at-risk funding the State has lost for BP 4:

$$\begin{aligned}
 &BP\ 4\ amount\ at-risk - BP\ 4\ at-risk\ funding\ earned \\
 &\$41.25M - \$35.7M = \$5.55M
 \end{aligned}$$

Therefore, the State earned **\$35.7M** and lost **\$5.55M** of the \$41.25M at-risk in Budget Period 4.

Appendix D: Measure Tables

ACO Measure Slate

#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In				
								R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
Prevention & Wellness												
1	Well child visits in first 15 months of life	Percentage of ACO attributed members who turned 15 months old during the measurement period and who had 6 or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life.	H	NCQA – Health Plan	1392	NCQA Quality Compass	Yearly	R	P	P	P	P
2	Well child visits 3-6 yrs	Percentage of ACO attributed members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	H	NCQA – Health Plan	1516	NCQA Quality Compass	Yearly	R	P	P	P	P
3	Adolescent well-care visit	Percentage of ACO attributed members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetricianand gynecology (OB/GYN) practitioner during the measurement period.	H	NCQA – Health Plan	N/A	NCQA Quality Compass	Yearly	R	P	P	P	P
4	Weight Assessment / Nutrition Counseling and Physical Activity for Children/Adolescents	Percentage of ACO attributed members 3 to 17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement period: (1) body mass index (BMI) percentile documentation, (2) counseling for nutrition, and (3) counseling for physical activity.	H	NCQA - ACO	24	NCQA Quality Compass	Yearly	R	P	P	P	P
5	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to ACO attributed members (up to age 65) between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of attribution to the ACO.	H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
6	Postpartum Care	Postpartum Care: The percentage of deliveries of live births to ACO attributed members (up to age 65) between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.	H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
7	Oral Evaluation, Dental Services	Percentage of ACO attributed members under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	American Dental Association on behalf of the Dental Quality Alliance	2517	EOHHS benchmarks derived fromnationally and state/locally available data	Quarterly	R	R	P	P	P
8	Tobacco Use: Screening and Cessation Intervention	Percentage of ACO attributed members ages 18 to 64 who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	H	American Medical Association on behalf of the Physician Consortium for Performance	28	EOHHS benchmarks derived from nationally and state/locally available data	Yearly	R	R	P	P	P
9	Adult BMI Assessment	Percentage of ACO attributed members ages 18 to 64 who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement period	H	NCQA - ACO	N/A	NCQA Quality Compass	Yearly	R	P	P	P	P

10	Immunization for Adolescents	Percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday. The measure will calculate a combination rate using Combo-1. [2017 HEDIS Spec will be updated Oct 2016 to include HPV vaccine.]	H	NCQA - ACO	1407	NCQA Quality Compass	Yearly	R	P	P	P	P
Chronic Disease Management												
11	Controlling High Blood Pressure	Percentage of ACO attributed members 18 to 64 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement period, based on age/condition-specific criteria	H	NCQA - ACO	18	NCQA Quality Compass	Yearly	R	P	P	P	P
12	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 to 64, for ACO attributed members with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
13	Asthma Medication Ratio	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA - Health Plan	1800	NCQA Quality Compass	Quarterly	R	P	P	P	P
14	Comprehensive Diabetes Care: A1c Poor Control	The percentage of patients 18 to 64 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	H	NCQA - Health Plan	59	NCQA Quality Compass	Yearly	R	P	P	P	P
15	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 ACO attributed member months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272	NCQA Quality Compass	Quarterly	R	P	P	P	P
Behavioral Health / Substance Abuse												
16	Developmental Screening for behavioral health needs: Under Age 21	Percentage of ACO attributed members under age 21 screened for behavioral health needs using an age appropriate EOHHS approved developmental screen	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
17	Screening for clinical depression and documentation of follow-up plan: Age 12+	Percentage of ACO attributed members age 12 to 64 screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	H	CMS	418	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
18	Depression Remission at 12 months	Percentage of ACO attributed members age 18-64 with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months (Defined as PHQ-9 score less than 5). Or a response to treatment at 12 months (+/- 30 days) after diagnosis or initiating treatment. (Patient Health Questionnaire-9 (PHQ-9) score decreased by 50% from initial score at 12 months (+/- 30 days).	H	Minnesota Community Measurement (also adapted by CMS and NCQA)	710	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

19	Initiation and Engagement of AOD Treatment (Initiation)	Percentage of ACO attributed members ages 13 to 64 diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	C	NCQA - ACO	4	NCQA Quality Compass	Quarterly	R	P	P	P	P
20	Initiation and Engagement of AOD Treatment (Engagement)	Percentage of ACO attributed members ages 13 to 64 diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	C	NCQA - ACO	4	NCQA Quality Compass	Quarterly	R	P	P	P	P
21	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for ACO attributed members ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA - ACO	576	NCQA Quality Compass	Quarterly	R	P	P	P	P
22	Follow-up care for children prescribed ADHD medication - Initiation Phase	Percentage of ACO attributed members 6 to 12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	C	NCQA - ACO	108	NCQA Quality Compass	Quarterly	R	P	P	P	P
23	Follow-up care for children prescribed ADHD medication - Continuation Phase	Percentage of ACO attributed members 6 to 12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	C	NCQA - ACO	108	NCQA Quality Compass	Quarterly	R	P	P	P	P
24	Opioid Addiction Counseling	Percentage of ACO attributed members ages 18 to 64 with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
Long Term Services and Supports												
25	Assessment for LTSS	Percentage of ACO attributed members (up to age 65) with an identified LTSS need with documentation of an age appropriate EOHHS-approved assessment.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
Integration												
26	Utilization of Behavioral Health Community Partner Care Coordination Services	Percentage of ACO attributed, BH CP-eligible members (up to age 65) who had at least one Behavioral Health Community Partner care coordination support during the measurement period.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
27	Utilization of Outpatient BH Services	Percentage of ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R

28	Hospital Admissions for SMI/SUD Population	Risk-adjusted percentage of ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD who were hospitalized for treatment of selected mental illness diagnoses or substance use disorder (regardless of primary or secondary diagnosis)	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
29	Emergency Department Utilization for SMI/SUD Population	Risk-adjusted ratio of observed to expected ED visits during the measurement period, for ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD for a selected mental illness or substance use disorder that is either the primary or secondary diagnosis	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
30	Emergency Department Care Coordination of ED Boarding Population	Percentage of patients boarding in the ED for whom a referral was made by the ED to the PCP or Community Partner (CP) upon discharge. Boarding defined as ≥ 48 hours in the ED.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
31	Utilization of LTSS Community Partners	Percentage of ACO-attributed, LTSS CP-eligible members (up to age 65) who received at least one LTSS CP support during the measurement period	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
32	All Cause Readmission among LTSS CP eligible	Percentage of ACO attributed, LTSS CP eligible members (up to age 65) who were hospitalized and subsequently readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
33	Social Service Screening	Percentage of ACO attributed members (up to age 65) who were screened for social service needs.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
34	Utilization of Flexible Services	Percentage of ACO-attributed members (up to age 65) recommended by their care team to receive flexible services support that received flexible services support.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
35	Care Plan Collaboration Across PC, BH, LTSS, and SS, Providers	Percentage of ACO attributed members (up to age 65) identified for care management/care coordination with documentation of a care plan that: - is developed by/shared with primary care, behavioral health, LTSS, and social service providers, as applicable - addresses needs identified in relevant assessments/screenings - is approved by member (or caregiver, as appropriate).	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

36	Community Tenure	Measure will assess ACO's ability to support and retain member placement in the community. Measure under development:	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
		Potential examples include:										
		1. Percentage of ACO attributed members who transitioned to the community from an LTC facility and did not return to a facility during the subsequent 12 months period.										
		2. Percentage of Days in Community for members with at least one index discharge from a LTC facility: (Total Eligible Days – Total Institutional Care Days)/Total Eligible Days										
		3. Average or median days of community tenure for ACO attributed members with an index discharge (during the measurement year) from a long term stay institution to a community setting who were admitted to a long term stay institution within 180 day period following the index discharge.										
Note: Community setting definition should follow CMS HCBS Final Rule 2249-F and 2296-F.												
Avoidable Utilization												
37	Potentially Preventable Admissions	Risk-adjusted ratio of observed to expected ACO attributed members who were hospitalized for a condition identified as "ambulatory care sensitive"	C	3M	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	P	P	P	P
38	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO attributed members (up to age 65) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	CMS*	1789*	EOHHS benchmarks derived from baseline data	Quarterly	R	P	P	P	P
39	Potentially Preventable Emergency Department Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO attributed members ages 18 to 64 per 1,000 member months.	C	3M	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
Member Experience			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P

* CMS specifications as documented in NQF #1789 will be utilized with changes to the age range (up to age 64 rather than 65 and above) and the insured population (Medicaid rather than Medicare)

BH CP Quality Measure Slate. Measures will be calculated for those CP eligible members engaged with the CP												
#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In				
								R = Reporting, P = Pay-for-Performance.				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to ACO/MCO/health plan enrollees (any age) between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of assignment to the BH CP.	C	NCQA	1517	NCQA Quality Compass	Quarterly	R	R	P	P	P
2	Annual primary care visit	Percent of CP-engaged members who had an annual primary care visit in the last 15 months	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Chronic Disease Management												
3	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO/MCO/health plan enrollees with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
4	Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA	1800	NCQA Quality Compass	Quarterly	R	R	P	P	P
5	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 ACO/MCO/health plan member months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272	NCQA Quality Compass	Quarterly	R	R	P	P	P
III. Behavioral Health / Substance Use Disorder												
6	Initiation and Engagement of AOD Treatment (Initiation)	The percentage of ACO/MCO/health plan adolescent and adult members with a new episode of AOD who received the following: <u>Initiation of AOD Treatment</u>	C	NCQA	4	NCQA Quality Compass	Quarterly	R	R	P	P	P
7	Initiation and Engagement of AOD Treatment (Engagement)	The percentage of ACO/MCO/health plan attributed adolescent and adult members with a new episode of AOD who received the following: <u>Engagement of AOD Treatment</u>	C	NCQA	4	NCQA Quality Compass	Quarterly	R	R	P	P	P
8	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for ACO/MCO/health plan enrollees ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576	NCQA Quality Compass	Quarterly	R	R	P	P	P
9	Follow-up After Hospitalization for Mental Illness (3-day) by BH CP	Percentage of discharges for BH CP-enrolled members ages 21 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had a face-to-face encounter with a BH CP within 3 days of discharge	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In				
								R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
IV. Member Experience												
A. Access			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Participation in Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Quality and Appropriateness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
E. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
F. Social Connectedness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
G. Self Determination			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
H. Functioning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
Self Reported Outcomes			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
J. General Satisfaction			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
V. Integration												
12	Social Service Screening	Percentage of CP-engaged members who were screened for social service needs	H	EOHHS	N/A		Quarterly	R	R	P	P	P
13	Utilization of Flexible Services	Percentage of ACO-enrolled, CP-engaged members (up to age 64) recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	P	P	P
14	Utilization of Outpatient BH Services	Percentage of ACO/MCO/health plan enrollees that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A		Quarterly	R	R	P	P	P
VI. Avoidable Utilization												
15	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO/MCO/health plan enrollees CP CP-engaged (up to age 64) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
16	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO/MCO/health plan enrollees CP-engaged ages 18 to 64 per 1,000 member months.	C	3M	N/A		Quarterly	R	R	P	P	P
VII. Engagement												
17	BH Comprehensive Assessment /Care Plan in 90 Days	Percentage of ACO/MCO/health plan-enrolled, BH CP assigned members with documentation of a comprehensive assessment and approval of a care plan by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to BH CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
11	Rate of Care Plan Completion	Percentage of ACO/MCO/health plan-enrolled, BH CP assigned member who had a completed care plan during the measurement period	H	EOHHS	N/A		Quarterly	R	R	P	P	P

LTSS CP Quality Measure Slate. Measures will be calculated for those CP eligible members engaged with the CP												
#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In				
								R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Well child visits 3-6 yrs	Percentage of ACO/MCO enrollees 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	C	NCQA	1516	NCQA Quality Compass	Quarterly	R	R	P	P	P
2	Adolescent well-care visit	Percentage of ACO/MCO enrollees 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A	NCQA Quality Compass	Quarterly	R	R	P	P	P
3	Oral Evaluation, Dental Services	Percentage of ACO/MCO enrollees under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Member Experience												
A. Service Delivery			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Choice and Control/Consumer Voice			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Effectiveness/Quality of Care			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
III. Integration												
6	Utilization of Flexible Services	Percentage of ACO-enrolled, CP-engaged members (up to age 64) recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	P	P	P
7	Social Service Screening	Percentage of CP-engaged members who were screened for social service needs	H	EOHHS	N/A		Yearly	R	R	P	P	P
8	Annual primary care visit	Percent of CP-engaged members who had an annual primary care visit in the last 15 months	C	EOHHS	N/A		Quarterly	R	R	P	P	P
IV. Avoidable Utilization												
9	All Cause Readmission	Risk-adjusted ratio of observed to expected ACO/MCO enrolled, CP-engaged members (up to age 64) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
10	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO/MCO enrolled, CP-engaged members ages 18 to 64 per 1,000 member months.	C	3M	N/A		Quarterly	R	R	P	P	P
V. Engagement												
11	LTSS Care Plan in 90 days	Percentage of ACO/MCO enrolled, LTSS CP assigned members with documentation of a LTSS care plan that is approved by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to LTSS CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
5	Rate of Care Plan Completion	Percentage of ACO/MCO -enrolled, LTSS CP assigned member who had a completed care plan during the measurement period	H	EOHHS	N/A		Yearly	R	R	P	P	P

CSA Quality Measure Slate												
#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In				
								R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Well child visits 3-6 yrs	Percentage of CSA members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	C	NCQA	1516	NCQA Quality Compass	Yearly	R	R	P	P	P
2	Adolescent well-care visit	Percentage of CSA members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A	NCQA Quality Compass	Quarterly	R	R	P	P	P
3	Oral Evaluation, Dental Services	Percentage of CSA members under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Behavioral Health												
4	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for CSA members ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576	NCQA Quality Compass	Quarterly	R	R	P	P	P
III. Member Experience: Wraparound Fidelity Index Short Form (WFI-EZ) - Caregiver Form												
A. Your Experiences around Wraparound			Form	TBD	N/A			R	R	P	P	P
B. Satisfaction			Form	TBD	N/A			R	R	P	P	P
C. Outcomes			Form	TBD	N/A			R	R	P	P	P
IV. Avoidable Utilization												
6	Hospital Admissions for SMI/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI and/or SUD who were hospitalized for treatment of selected mental illness diagnoses or substance use disorder (regardless of primary or secondary diagnosis)	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
7	Emergency Department Utilization for SMI/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI and/or SUD who utilized the emergency department for a selected mental illness or substance use disorder that is either the primary or secondary diagnosis	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
V. Engagement												
8	CSA Comprehensive Care Plan in 90 Days	Percentage of CSA members with documentation of a care plan and approval of care plan by primary care clinician or designee and member or legal authorized representative as appropriate . Expected attainment = 70% or above	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P