

Commonwealth of Massachusetts

Executive Office of Health and
Human Services



State Innovation Model Operational Plan

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INTRODUCTION AND OVERVIEW

The Commonwealth of Massachusetts is committed to creating a health care system that provides high quality, accessible, and affordable care to all of its residents. The Commonwealth appreciates the opportunity afforded by the federal State Innovation Model grant to catalyze its transformation toward an innovative health care system that is capable of delivering health care, better value, and better health for all residents of the Commonwealth.

The Commonwealth's State Innovation Model grant activities will:

- Support public and private payers in transitioning to integrated care systems;
- Enhance data infrastructure for care coordination and accountability;
- Advance a statewide quality strategy;
- Integrate primary care with public health and other services; and
- Create measures and processes for evaluating and disseminating best practices.

During the initial implementation phase, the Commonwealth has taken important steps to implement the State Innovation Model grant, including releasing a Request for Applications for MassHealth's Primary Care Payment Reform, convening organizations participating in the Group Insurance Commission's value-based procurement strategy, engaging with stakeholders on the design of a bi-directional e-Referral system and on HIE adoption for behavioral health providers, developing a project governance structure, creating and executing a stakeholder engagement plan, developing a detailed implementation plan, and proposing an evaluation plan. The Commonwealth is pleased to share this draft of its operational plan, which provides additional detail about the Commonwealth's vision for the next three years of innovation and system transformation through the State Innovation Model grant.

A. GOVERNANCE, MANAGEMENT STRUCTURE AND DECISION-MAKING AUTHORITY

1. Governor's Office Engagement in Overseeing the Project and Implementing the Proposed State Innovation Model

In August 2012, Governor Patrick signed into law Chapter 224 of the Acts of 2012, An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation. Chapter 224 defines a clear vision for health reform in Massachusetts, including establishing an annual goal for limiting the growth of total health care expenditures, supporting the transition to alternative payments in both the public and private sectors, promoting prevention and wellness, increasing price transparency, and strengthening health information technology infrastructure.

Governor Patrick is strongly committed to transforming the health care system. When Chapter 224 was signed, Governor Patrick noted, "Today, we take our next big step forward...we are ushering in the end of fee-for-service care in Massachusetts in favor of better care at lower cost." Ultimately, Chapter 224 aims to transform the health care delivery system to become more efficient and transparent, and higher in quality.

Massachusetts' State Innovation Model (SIM) grant activities are aligned with and will support the Commonwealth's efforts to achieve the promise of Chapter 224. As Governor Patrick noted when Massachusetts was awarded the SIM grant, "In Massachusetts we believe that access to quality, affordable health care is a public good. This funding will assist us in implementing the next phase of health care reform to provide better care, better health and lower costs." In the implementation phase, the Executive Office of Health and Human Services (EOHHS) is working collaboratively with a number of agencies as implementing and strategic partners. EOHHS has provided updates on the SIM grant at cross-Administration health reform implementation meetings which are attended by staff from multiple agencies as well as the Governor's Office. At the Cabinet level, the Secretary of Health and Human Services has been active in overseeing SIM grant implementation. He has convened a public meeting to obtain stakeholder input on SIM grant activities and led discussions of the grant at internal meetings that include agency leaders.

Please see Attachment A for relevant press releases and a letter of support from the Governor for the SIM initiative.

2. Governance, Management Structure, Decision-Making Authority, and Accountability

The Massachusetts SIM project governance structure is illustrated in two diagrams below. The first diagram portrays at a high level the different functional roles played by key state agencies and personnel. The second diagram is a staffing chart identifying key staff by project.

On a day-to-day basis, project activities are coordinated across agencies at two levels. As mentioned previously, there are broad cross-Administration meetings on health reform implementation that are jointly convened by EOHHS with the Executive Office for Administration and Finance (ANF). Participants at this meeting include ANF, EOHHS, the Department of Public Health (DPH), the Department of Mental Health (DMH), MassHealth, the Center for Health Information and Analysis (CHIA), the Group Insurance Commission (GIC), the Health Policy Commission (HPC), the Executive Office of Labor and Workforce Development, the Executive Office of Housing and Economic Development, the Division of Insurance, the Health Connector, and the Governor's Office. This group meets every one to two months, and is a helpful forum for the SIM team to share updates and obtain feedback on SIM activities and strategy.

Grant administrative functions are handled in smaller interagency meetings that include the implementing agencies, namely EOHHS/MassHealth, DPH, DMH, the Executive Office of Elder Affairs (EOEA), CHIA and GIC. These meetings are convened by the SIM project director every one to two months. Since the grant award was made, EOHHS has signed Interagency Service Agreements (ISAs) where needed with implementing agencies. Specifically, EOHHS has ISAs in place with DPH, DMH, CHIA, and GIC to carry out SIM grant activities.

Since the submission of the SIM grant proposal, the state's Health Policy Commission (HPC) has been established. The HPC was created by Chapter 224 and is responsible for a number of key health reform and cost containment strategies in Chapter 224. The HPC is an important and valuable strategic partner to the

implementation of the SIM grant, particularly given its role in monitoring alternative payment methodologies, measuring the impact of health reform on cost and quality, and developing standards for alternative payment models such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). EOHHS expects to be coordinating very closely with the HPC on a number of SIM projects moving forward.

EOHHS has also used the Secretariat’s “health cluster” to discuss SIM grant activities. Health cluster meetings are convened by the Secretary of Health and Human Services and include the Commissioner of Public Health, the Commissioner of Mental Health, the MassHealth Director, and the EOHHS Director of Health Care Policy and Strategy.

Exhibit 1 below shows the SIM Project Governance Structure and Exhibit 2 shows the Project Organizational Chart.

Exhibit 1: Project Governance Structure

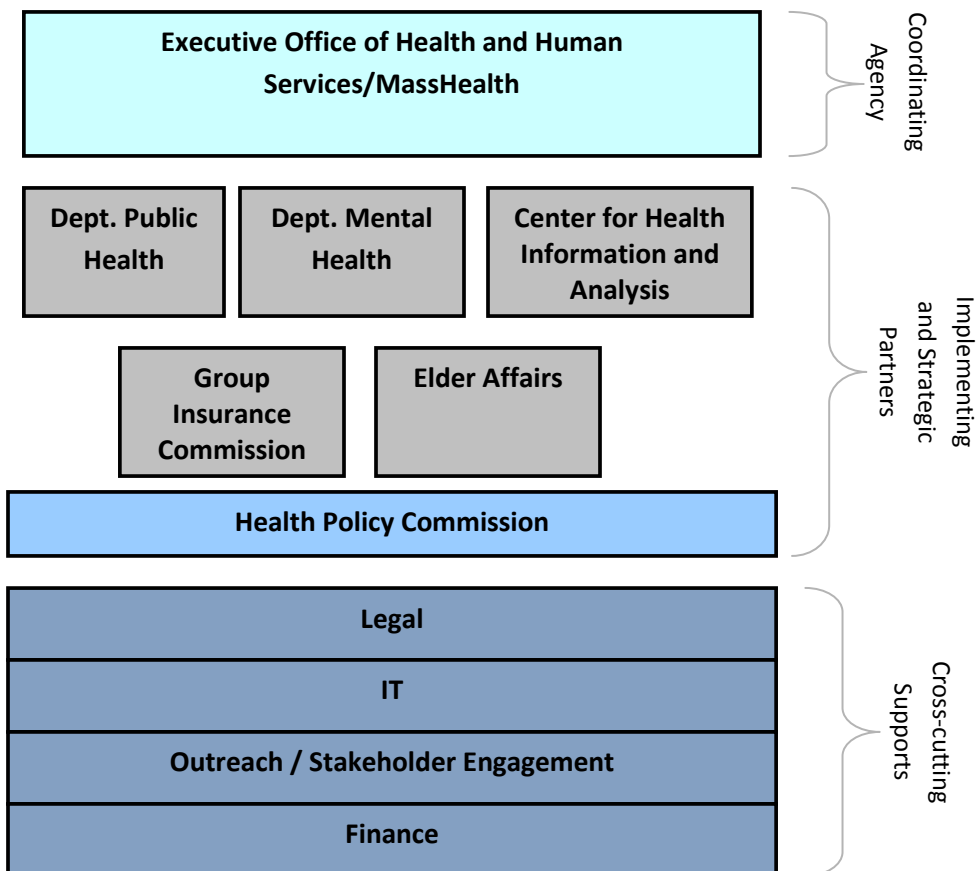
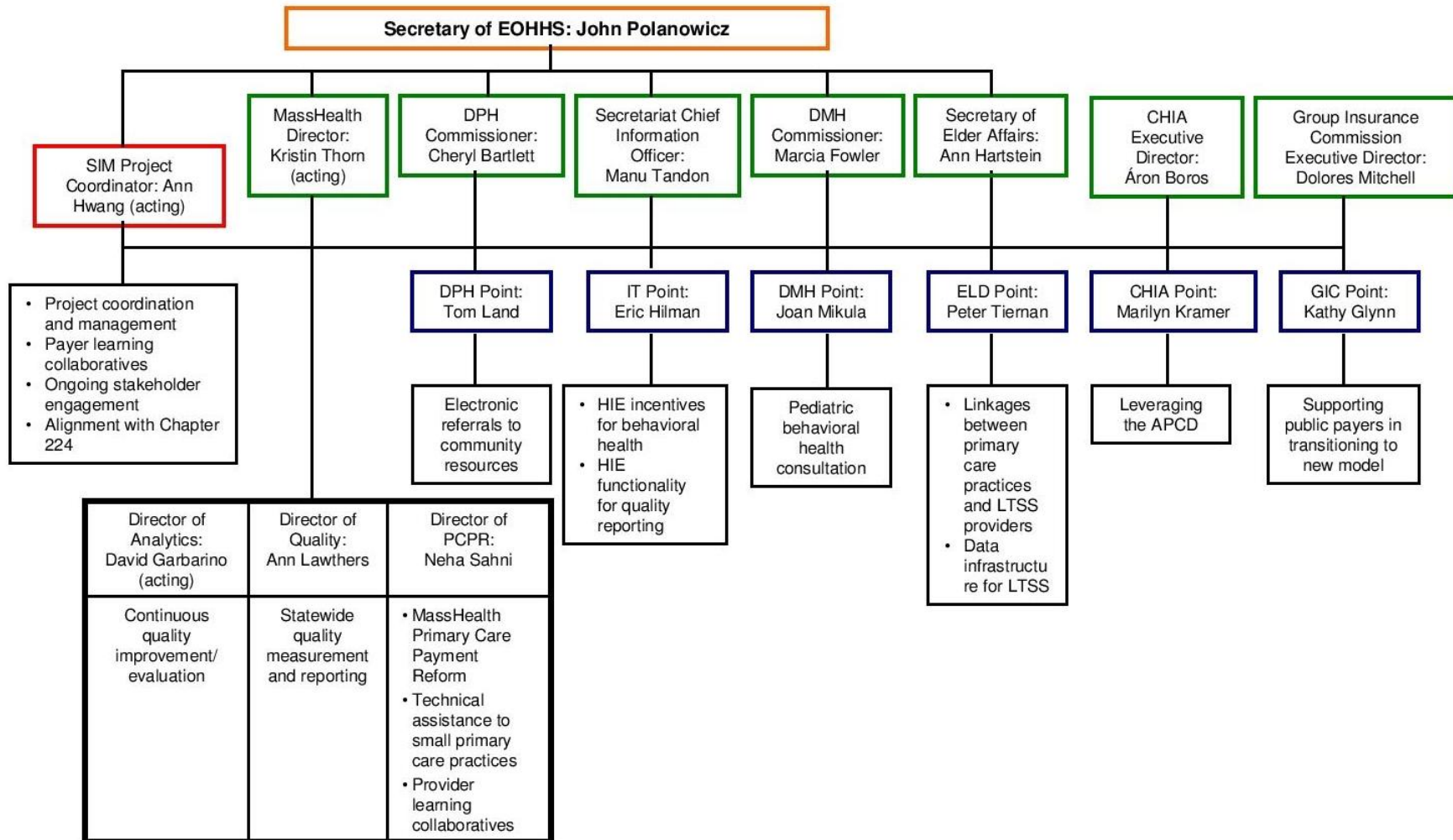


Exhibit 2: SIM Project Organization



3. Mechanisms to Coordinate Private and Public Efforts Around Key Test Model Elements

Massachusetts recognizes that coordination of private and public efforts will be essential to the success of the SIM grant and to health reform more broadly. Massachusetts is fortunate to have an actively engaged and highly informed base of interested stakeholders. Through a public and transparent process led by the Health Policy Commission, these stakeholders participate regularly in many aspects of health reform implementation, such as efforts to define patient-centered medical homes and accountable care organizations and develop a research agenda for cost trends.

Stakeholder engagement specific to the SIM project is documented in the stakeholder engagement plan. Massachusetts has established a website for SIM information, created a dedicated SIM grant email address, and established a distribution list for those who are interested in receiving updates about SIM. The Secretary of Health and Human Services hosted a public meeting on June 25, 2013 that was attended by over 50 stakeholders. The Massachusetts SIM team anticipates hosting quarterly stakeholder meetings to continue to provide updates to stakeholders and to obtain stakeholder feedback. Additional information about coordination of public and private efforts can be found in Attachment D (Stakeholder Engagement Plan) and Section H (Participant Retention Process).

4. Integration or alignment of planned transformation with existing legislative and executive authority

The Massachusetts SIM grant supports the vision laid out in Chapter 224. Chapter 224 requires public payers to move toward alternative payments and establishes specific benchmarks that MassHealth must meet. Authorities established under state law enable the Commonwealth to carry out the activities described in the grant.

B. COORDINATION WITH OTHER CMS, HHS, AND FEDERAL OR LOCAL INITIATIVES

1. Coordination Between SIM and CMS/HHS/Federal and Other CMMI Initiatives

Massachusetts has a long history of partnering with the federal government, not only in support of the state's historic coverage expansion, but also in the development and implementation of new payment and delivery models. Through participation in a number of initiatives made possible by the Affordable Care Act (ACA), the state and its providers have demonstrated a commitment to leveraging opportunities to innovate with the federal government as it supports states' payment and delivery system reform agendas. The state has also used its 1115 Demonstration and other federal funding opportunities described below to accelerate the pace of innovation.

- Massachusetts has aligned core components of its multi-payer model with the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Program. As these programs continue to evolve, they will add both momentum and scale to the state's broader transformation efforts.
- The Duals Demonstration is also aligned with this model. Integrated Care Organizations (ICOs) are encouraged to use alternative payment methodologies, including global budgets and shared savings/risk arrangements, in contracting with providers. MassHealth is committed to aligning ICO payment methodologies with the broader alternative payment strategy.
- The Delivery System Transformation Initiative (DSTI) is a three-way partnership between CMS, Massachusetts, and seven safety net hospitals that offers performance-based incentive payments to hospitals and thereby supports investments in areas such as developing PCMH models, strengthening care management, redesigning discharge processes, and improving IT and analytic capacity.
- The Pediatric Asthma Bundled Payment Pilot is designed to support the shared vision of integrated, preventive care for pediatric Medicaid patients with asthma. Eligible participants in Medicaid's PCPR Initiative would be encouraged to participate in the pilot.

- Money Follows the Person (MFP) provides support to disabled and elderly Medicaid beneficiaries living in the community. The model supported by the grant aligns with the vision in MFP of providing integrated, coordinated care in the appropriate long-term care setting. Primary care providers would be expected to coordinate with the range of appropriate LTSS providers who care for their patients, including MFP providers.
- IMPACT is an Office of the National Coordinator (ONC)-funded pilot program to improve care transitions by leveraging a health information exchange. The lessons learned from the IMPACT project will inform provider organizations participating in the state's multi-payer model. The care coordination in the model will broadly support the aims of IMPACT as well, creating a positive feedback loop.
- The CHIPRA Quality Demonstration Grant pilots several pediatric quality measures, and establishes the Child Health Quality Coalition (CHQC) to manage and promulgate that measurement. The state has already leveraged the CHIPRA measures in the SQAC process and in selecting measures for MassHealth's PCPR Initiative, and will continue to engage the CHQC as a key stakeholder in support of the expansion of quality measurement with respect to pediatric patients.
- Projects being undertaken by the Executive Office of Elder Affairs (EOEA) with support from the SIM grant also take into consideration coordination with other initiatives. For example, with regard to Aging and Disability Resource Centers (ADRCs), SIM grant funding is being utilized to automate and simplify the MDS 3.0 Section Q referral process, in which nursing facility residents signal their interest to reside in a community setting. Skilled nursing facilities (SNFs) will initiate referral with a simple web-based notification, which routes to a coordinating Aging Services Access Point (ASAP) based on geographic catchment. Depending on the resident's Medicare/Medicaid insurance status, the ASAP staff receiving the referral will route it to ADRC Options Counselors for residents whose payer is Medicare, or to Money Follows the Person (MFP) staff

where the resident's payer is Medicaid, operating MFP and the Comprehensive Screening Services Model (CSSM) programs. MFP participants who enroll in EOE's Frail Elder Waiver (FEW) program will be case-managed within the Senior Information Management System (SIMS) system. All such participants will have the option of utilizing the Physician's Portal functionality to support coordination of care with a participating Physician's Practice. In addition, all EOE home care participants may utilize Consumer Connect, providing the participant or a caregiver with a web-based window to their active LTSS community service plan. With regard to Care Transitions 3026, EOE observes an emerging interest in the Physician's Portal by Care Transitions teams engaged in Coleman-method coaching to reduce repeated hospitalizations. The Portal's presentation of selected demographic, clinical, and environmental information for consumers who are enrolled in FEW and state home care (i.e. case-managed in SIMS) seems valuable in this context and represents a new area of focus in which to expand use of this application.

- The e-Referral project at DPH is coordinating with multiple initiatives at the Office of the National Coordinator (ONC) and the Centers for Disease Control and Prevention (CDC). e-Referral is being considered as a use-case for the ONC/CDC Public Health Tiger Team (<http://wiki.siframework.org/Public+Health+Tiger+Team>) which focuses on developing structured data capture for public health. The DPH e-Referral project is also in communication with the ONC/CDC Health eDecisions work group. This work group focuses on creating standardized clinical decision support tools. e-Referral is exploring ways to collaborate and support both of these federal efforts (<http://wiki.siframework.org/Health+eDecisions+Homepage>). CDC has also asked to receive regular updates on the progress made by the e-Referral project.
- The state has issued an RFI with regard to the Medicaid Health Homes program.
- During the implementation phase, Massachusetts submitted an 1115 demonstration waiver amendment request to CMS that includes Primary Care Payment Reform.

Maintaining coordination and alignment among these initiatives will require active planning and stakeholder engagement. The state is committed to working with the relevant state and federal agencies. During the implementation period, the Commonwealth has appreciated having regular telephone conferences with its CMMI project team and having the opportunity to brief CMS about its innovation model and project activities. Massachusetts' project team looks forward to continuing to work closely with the federal government during the model testing period.

2. Coordination with Local Initiatives

Massachusetts' 2012 health care reform law recognized the importance of community and public health initiatives to achieving the Triple Aim. The Massachusetts Department of Public Health collaborates regularly with local organizations who are interested in promoting health and wellness in their communities. Through its SIM-grant funded project, DPH will be working closely with local and community-based organizations on an e-Referral system that will foster connections between primary care and community health. In addition, as part of Chapter 224, DPH is developing an innovative and groundbreaking proposal for use of prevention and wellness funds that further fosters connections between the medical system and public health.

Electronic referrals to community resources

The state is currently developing an e-Referral program that will link primary care systems to a wide variety of community resources that offer health education, physical activity opportunities, nutrition consultation, or other health-related services that take place outside of the health care setting. These linkages are designed to encourage follow-up and coordination of services. In addition, they will facilitate clinical community linkages with evidence-based self-management programs for chronic disease and for community-based health and wellness programs. At least four community resources (Tobacco Quitline, Local Councils on Aging, YMCAs and Visiting Nurses Associations) will be enabled to receive referrals and send back information about patient progress to the community health centers. This information provided by the community

resource will be added directly into the patient's electronic medical records. The Department of Public Health will be working closely with both clinical organizations and community-based organizations in creating the e-Referral tool. Although the pilot project is focused on four specific community resources, the e-Referral tool is being designed in a flexible manner so the tool can be utilized by a wider array clinical and community resources.

Prevention and Wellness Trust Fund

Chapter 224 created the Prevention and Wellness Trust Fund, a \$57 million, four-year investment in evidence-based community prevention activities, administered by DPH in consultation with the Prevention and Wellness Advisory Board.

All Fund activities must support Massachusetts' goal of meeting the health care cost growth benchmark. In addition, 75% of the funds must be distributed in competitive grants to:

- Reduce the rates of the state's most costly preventable health conditions
- Reduce health disparities
- Increase healthy behaviors
- Increase the adoption of workplace-based wellness programs
- Develop a stronger evidence base of effective prevention programs

Municipalities or regional collaborations of municipalities, community organizations, health care providers, or health plans working in collaboration with one or more municipalities, and regional planning agencies are all eligible to apply for funding. Up to 10% of the funds can be used towards supporting workplace wellness programs.

In developing a proposal for the allocation of these grant funds, DPH and the Prevention and Wellness Advisory Board are considering an innovative approach that would award a relatively small number of grants to municipalities, in partnership with community based organizations, healthcare providers, health plans, regional planning agencies and/or worksites. Grantees would undertake activities that target high priority conditions and create seamless access (such as is enabled through the e-Referral system) to all community and clinical services needed to prevent and control chronic disease and other conditions. The e-Referral tool

will play a central role in facilitating the delivery of services. By requiring that communication is bi-directional, the effectiveness of interventions can be evaluated in clinical terms.

3. Integration with Existing State Plan Amendment and Waiver Authorities

A major initiative supported by the SIM grant is the implementation of Primary Care Payment Reform (PCPR). The goal of PCPR is to improve access, patient experience, quality and efficiency through the patient-centered medical home model, which includes care coordination, care management, and better integration of primary care and behavioral health services. The payment methodology of PCPR includes a Comprehensive Primary Care Payment (CPCP), a quality incentive payment, and a shared savings/risk payment. The CPCP is a per-member-per-month (PMPM) risk adjusted payment for a defined set of primary care services and medical home activities. The shared savings/risk payment sets a target for non-primary care medical spending and allows providers to share in the savings if actual expenditures are below the target. There are also options for providers to share in a higher percentage of the savings in return for taking on the risk of sharing in losses if actual expenditures exceed the spending target. PCPR will be implemented across MassHealth's managed care programs, including both the Primary Care Clinician (PCC) program and the Managed Care Organization (MCO) program.

In June 2013, Massachusetts filed an 1115 Medicaid Demonstration waiver amendment request that included waiver authority for implementation of Primary Care Payment Reform. A procurement was issued for PCPR during the SIM implementation period.

C. OUTREACH AND RECRUITMENT

As described in the Stakeholder Engagement and Communication Management Plans (Attachment D and Section Q), the Commonwealth is engaging with multiple types of stakeholders through multiple different

avenues. In addition to broad stakeholder outreach coordinated through EOHHS, there are project-specific outreach and recruitment activities as well.

In Primary Care Payment Reform, the state will not directly reach out to beneficiaries. Rather, MassHealth through its PCPR initiative will select providers who are interested in participating in the alternative payment program through a procurement process. Each provider will be responsible for notifying and informing beneficiaries about their involvement in the program. PCPR will support and encourage provider outreach to the beneficiaries.

PCPR outreach to providers began in August of 2012 with the posting of a Request for Information (RFI) to solicit information from a broad spectrum of interested parties about advancing alternative payment methodologies. Throughout the fall and early winter, multiple meetings were held to inform all stakeholders, including interested provider groups, about the PCPR opportunity to transition to alternative payment methodologies.

Official recruitment of providers began in March of 2013 with the release of the Request for Applications (RFA) for PCPR (Attachments B and C). Following the RFA release, an additional six informational sessions were held to assist applicants.

MassHealth anticipates working closely with providers through the model testing period. Learning collaboratives and technical assistance, for example, will provide forums through which to address providers' experience with beneficiaries.

D. INFORMATION SYSTEMS AND DATA COLLECTION SETUP

The Massachusetts SIM team recognizes the importance of strengthening data collection and analytic capacity, in order to improve the coordination of care, enable accountability for the cost of care, incentivize quality, and evaluate the impact of the State Innovation Model. The team further recognizes that there will be different data collection mechanisms for different purposes, including for reporting to CMMI, self-evaluation of SIM activities, and monitoring of a multi-payer system.

For the purpose of reporting to CMMI, Massachusetts has developed worksheets to track implementation timelines and project status. Massachusetts is using both a budget tracking worksheet and its accounting system, MMARS, to track SIM grant expenditures.

For self-evaluation of SIM activities, each project team has defined milestones and is reporting project status on a regular basis to EOHHS. In addition, as appropriate, project teams have developed specific indicators related to the success of their project. These are described in more detail in the evaluation plan in Section R.

For monitoring of a multi-payer system, the Massachusetts SIM team anticipates two streams of work. The first stream is to collect and provide data needed for Primary Care Payment Reform. Primary Care Payment Reform will rely on data in the Medicaid Data Warehouse to provide timely information to providers to enable panel management as well as to implement the payment structure, which includes a capitated primary care payment as well as quality and shared savings incentives.

Details on the processes and mechanisms for data collection within PCPR have been clearly delineated in the PCPR RFA, and are summarized below.

Table 1: Data that EOHHS will provide to participants:

Type of Data	Intended Frequency	Time Period
Claims-Based Information & Enrollment Information from PCC Plan		
List of attributed Panel Enrollees (monthly)	Monthly (1st day)	Based on caseload snapshot as of 15th of previous month
Claims history	Refreshed monthly (1st day)	Includes all claims submitted by 15th of previous month
Reports based on claims history	To be determined	To be determined
Attributed Panel Enrollees with Risk Scores	Quarterly	Based on caseload snapshot as of 15th of previous month and one year history (e.g., the report available to practices on Oct. 1, 2013 would be based on claims with dates of service between July 1, 2012 and June 30, 2013 that were submitted by July 31, 2013)
PMPM utilization by type of service		Same as above

Payment Information		
Participant-specific CPCP and associated detail (Risk Score, percent of Primary Care delivered outside the Participant)	Updated every six months	EOHHS will inform each applicant of its final CPCP rate during the contracting phase. This rate will be calculated based on claims with dates of services in CY 2011 with appropriate adjustments
Participant-specific benchmark for Shared Savings calculation	Updated annually	Six-month benchmark would be provided approximately 60 days prior to the start of the benchmark period
Quality measure thresholds, benchmarks, and other parameters	Updated annually prior to the start of the program year in which they will use	

MassHealth is currently reviewing applications for participation in PCPR. In the contracting phase, MassHealth will be incorporating data sharing provisions into PCPR contracts. Model language can be found in the Model Contract that was included as part of the RFA (included as Attachment C).

The second workstream will be to monitor broader multi-payer trends in the marketplace. To do this, Massachusetts anticipates relying primarily on the All-Payer Claims Database (APCD) and working in close partnership with both the Health Policy Commission and the Center for Health Information and Analysis.

Massachusetts' APCD is designed to simplify the process by which payers submit claims data to various Massachusetts state agencies and contains a variety of information including medical, pharmacy and

dental services claims data with dates of service beginning in 2008. It also includes claims data from self-insured plans as of 2011.

Table 2: APCD Data

Provider File	Member File	Claims File	Product File
<ul style="list-style-type: none"> • Service/prescribing provider (name, tax ID, payer ID, NPI, specialty code, city, state, zip code) • Billing provider (name, payer, ID, NPI) 	<ul style="list-style-type: none"> • Personal health info (encrypted) (subscriber and member names and social security numbers) • Patient demographics (age, gender, relationship to subscriber) 	<ul style="list-style-type: none"> • Medical claims • Pharmacy claims • Dental claims • Service information (service and paid dates, paid amount, admission types, diagnosis and procedure information) 	<ul style="list-style-type: none"> • Type of product (HMO, POS, indemnity) • Type of contract (single person, family) • Coverage type (self-funded, individual, small group)

The APCD will be a powerful tool for monitoring trends in the marketplace and with the passage of Chapter 224, CHIA has been working with payers to enhance data collection such as around alternative payment methods and alternative payment contracts. Both CHIA and the Health Policy Commission will be issuing detailed cost trends reports in 2013 that will provide important baseline information about the current marketplace, in terms of health care costs, relative prices, and the current landscape of alternative payments. In addition, the Health Policy Commission has analyzed the current Massachusetts market as it relates to penetration of ACOs and PCMHs.

Moving forward, the Massachusetts SIM team anticipates working closely with both CHIA and the HPC on evaluation efforts. More information about the Commonwealth's plans for evaluation can be found in Section R.

E. ALIGNMENT WITH STATE HIT PLANS AND EXISTING HIT INFRASTRUCTURE

The Secretary of Health and Human Services, who leads the SIM grant implementation efforts, also chairs the statewide Health Information Technology (HIT) Council. The EOHHS Chief Information Officer oversees the IT aspects of SIM grant implementation and coordinates the work of the HIT Council and other state health information technology initiatives. The HIT Council is the governing body for the Massachusetts

Health Information Exchange (HIE), known as Mass HIway. EOHHS and the HIT Council work closely with the Massachusetts e-Health Institute (MeHI) in developing the capabilities of the MassHIway. The involvement of the Secretary and the CIO with the SIM grant will help ensure coordination of SIM projects with other state HIT efforts.

1. HIE Functionality for Quality Reporting

CMS has approved funding for a Quality Data Repository/Clinical Data Repository (QDR/CDR) in an IAPD approved in April 2013. This funding will be used to establish a repository and to leverage EHR connectivity to the HIE to permit the collection of quality information via the HIE. In addition, since the standards for quality data collection and storage are not mature, it is expected that there will be the need for a provider web portal to be upgraded to enable manual entry and/or file upload initially.

During the implementation period, EOHHS IT and MassHealth reached a decision that there will be a Clinical Data Repository for MassHealth patients that will be owned by MassHealth. This will be implemented in conjunction with the Quality Data Repository EOHHS IT is implementing using IAPD funding to collect population level quality data from all providers. SIM grant funding will be utilized to implement those changes necessary to MMIS to use quality data as the basis for payments and/or for research and analysis purposes.

2. MMIS Modifications for PCPR Support

Some modifications were in process at the time of the SIM grant and were being funded by IAPD operational funds. A small amount of the SIM grant will be utilized to cover additional development work being performed in the implementation period that is necessary for PCPR. The bulk of the SIM grant funds will be used to support ongoing operations and maintenance of these capabilities which are essential to the implementation of Primary Care Payment Reform.

3. Linkages Between Primary Care Practices and LTSS/Data Infrastructure for LTSS

One of the four SIM-grant funded projects under the EOE is the Physician Portal. In its Phase 1 incarnation, this application provides web-based access for primary-, acute-, or transitional-care medical professionals to a read-only view of selected information (an LTSS electronic health record) about their patients who are enrolled in the home care program (state program or Frail Elder Waiver). This information is housed in EOE's SIMS and is managed by case management and clinical assessment staff at EOE's Aging Services Access Points (ASAPs), and includes demographic, environmental, clinical, plan-of-care, service plan, functional impairment, I/ADLS, and other related assessment information. The goal of this project is to increase communication supporting coordination of care between the consumer's interdisciplinary care team, including physicians, ASAP staff, the consumer and the consumer's family. This project has no IAPD funding. The SIM grant is being used to close the funding gap to enable the implementation of their system. Phase 2 for the Physician Portal will be to integrate this system with the HIE, and to enable bi-directional communications using industry-standard data exchange formats. The Commonwealth has not yet secured funding for phase two activities.

4. Electronic Referrals to Community Resources

The Department of Public Health is implementing a bi-directional, vendor-neutral, open-source referral system. This system would enable clinical providers to send electronic referrals directly from their electronic health records (EHRs) to community services such as the Tobacco Quitline for smoking cessation and YMCAs for evidence-based weight loss programs. The DPH project has engaged an outside contractor to develop this open-source system which includes a universal translator to receive referrals and an electronic referral gateway to enable referrals to resources that do not have EHRs. The SIM grant is being used to develop the open-source software and to pilot this software in nine community health centers with a minimum of four different community resources (Tobacco Quitline, Visiting Nursing Associations, YMCAs and Local Councils on Aging). This grant is also being used to evaluate the impact of these e-Referrals on both the

use of these community-based programs as well as their impact on health process measures (e.g., blood pressure, HbA1c levels, BMI) and longer term health outcomes (e.g., reduction in heart attacks). In addition, the state is hoping to integrate this system with the HIE to enable medical/clinical providers to provide e-referrals to this group of community service providers using the EHR systems in the same manner as noted above. No other federal funding supports this program.

5. Technical Assistance to Behavioral Health and LTSS Providers

Behavioral health providers (e.g. psychologists, social workers, and counselors) and LTSS providers in general do not qualify for federal governmental EHR adoption incentive programs. Yet programs such as Primary Care Payment Reform (PCPR) emphasize the need for these types of clinicians to collaborate with primary care and other medical clinicians. During the SIM implementation period, the state is working to ascertain the adoption landscape with regard to these classes of providers in general and with respect to the participants in the PCPR program in particular. In addition, the Commonwealth is seeking to coordinate with MeHI and their efforts to engage behavioral health providers and LTSS providers. The SIM funding is currently being used to support a part-time project manager to do the initial research. Initial research suggests that the large behavioral health organizations are well on the way to implementing EHR and many have already deployed EHR systems. None have integrated with the HIE at this time. The status of the smaller providers is still unknown. EOHHS anticipates conducting similar research for LTSS providers.

The plan is to determine the EHR adoption landscape, especially as it relates to the PCPR participants. Based on findings, the state will develop an outreach/education program to encourage EHR and HIE adoption to the extent that it is necessary. In addition, the state anticipates a need for technical support to help these providers implement the technical integration and possibly support related to provider and staff training regarding usage and best practices.

These efforts are synergistic with other funds that are designed to assist providers with EHR adoption. MeHI has a “Last Mile” program funded in part by an ONC grant as well as money allocated by Chapter 224.

The SIM grant funding will support several state employees and contractors in the EOHHS IT group to coordinate, track, and manage this project. The Last Mile Program funding will be used to provide grants to EHR vendors and providers to encourage them to connect their systems with the Mass HIway HIE system.

F. ENROLLMENT ELIGIBILITY AND DISENROLLMENT PROCESSES (NOT SUBMITTED PER CMS INSTRUCTIONS)

G. MODEL INTERVENTION, IMPLEMENTATION AND DELIVERY

1. The Model to be Tested

Historically, the payment and delivery systems in Massachusetts have been grounded in a fee-for-service (FFS) structure that does not inherently promote efficiency, quality, or coordination of care. Massachusetts is fully committed to transforming its payment and delivery systems, particularly in light of the recent passage of Chapter 224. Massachusetts intends to use grant funds to accelerate the migration to a statewide multi-payer model in which providers, particularly primary care providers, assume accountability for the quality and cost of care provided to their patients across the delivery system. In this model, providers are supported by a shared savings/risk payment framework and an aligned multi-payer operational structure. The specific investments undertaken under this funding opportunity close key gaps between our current and desired health care systems by facilitating the participation of public payers in the model and building out the multi-payer operational structure.

2. Description and Purpose of the Model

The multi-payer model is based on a shared vision for primary care providers to take accountability for the quality and cost of care through a patient-centered medical home (PCMH) that includes care coordination and care management, enhanced access to primary care, coordination with community and public health resources, integration with behavioral health, and population health management. We define primary care

providers broadly to include group practices, hospital based primary care providers, and community health/mental health centers that provide primary care services. These provider organizations may be embedded in larger organizations, ranging from integrated delivery systems to independent practice associations to accountable care organizations (ACOs). This PCMH model applies to a variety of patient populations, including children, people with behavioral health conditions, and the elderly.

The model includes a common payment framework involving a shared savings/risk arrangement with quality incentives. Shared savings is an incentive structure in which providers share in the savings if the actual costs of care, for a population of patients attributed to them, fall below expected costs over a specified time period. Shared risk arrangements expose providers to liability if actual costs exceed expected costs. These arrangements incentivize providers to manage the total cost of care. Quality performance may be used as a basis for independent quality incentive payments or to determine the amount of shared saving payment and/or shared loss a provider organization may receive. The payment framework would also support delivery transformation into medical homes through per-member-per-month medical home payments, infrastructure payments, advance payment of shared savings, or capitated primary care payments.

The operational structure for this model consists of four key elements, each of which motivates investments proposed under this grant: 1) a statewide cross-payer approach to providing provider organizations with the data required for care coordination and accountability; 2) a statewide quality strategy, which aligns payers around a standard set of quality metrics and facilitates multi-payer data collection, measure calculation, and data transmission via the Health Information Exchange (HIE); 3) a robust set of public health and community-based services and strong linkages among these services and other parts of the health care delivery system; 4) a multi-payer statewide approach to learning, evaluation and dissemination of best practices. This shared operational structure minimizes the burden of participation on providers, reduces redundancy and promotes alignment of operational systems across payers.

3. Gaps Between the Current State and Proposed Model

Massachusetts has made significant progress in shifting towards the specified alternative payment model, with many major payers already participating. Medicare, MassHealth and its contracted Managed Care Organizations (MCOs), and commercial carriers are moving toward alternative payment contracts consistent with the model. The model of the PCMH has been widely adopted across the state. Medicare's ACO programs emphasize the importance of primary care and beneficiary attribution is based on the provision of primary care services by a physician. MassHealth, both through its Primary Care Clinician (PCC) Plan and its contracted MCOs, has spearheaded the Patient-Centered Medical Home Initiative (PCMHI), a multi-payer effort to establish PCMHs across the state. The Group Insurance Commission (GIC), which purchases insurance for public employees and retirees, also participates in the PCMHI and is partnering with MassHealth to develop an aligned approach in its procurement of health plan contracts. BCBS has established the Alternative Quality Contract (AQC), which emphasizes PCMH principles in holding primary care practices and the systems that employ them accountable for quality and for the total cost of care. Tufts Health Plan and Harvard Pilgrim Health Care provider contracts also emphasize PCMH principles. The recent health care reform law also supports primary care in the PCMH framework and accountability for cost and quality outcomes.

A shared savings framework is also common across several of the current initiatives in the state. Both Medicare ACO programs rely on a shared savings/shared risk approach. PCMHI includes an upside-only shared savings approach. In MassHealth's Duals Demonstration, Integrated Care Organizations (ICOs) are encouraged to use alternative payment methodologies to contract with providers, including shared savings/shared risk arrangements. The BCBS AQC includes a "global budget" arrangement, whereby provider organizations share in budget savings and share risk for budget deficits. The Tufts Coordinated Care Model also uses a form of shared savings in its contracts. In many of these models, quality performance affects the extent of eligibility for the shared savings payment.

By virtue of their size and history, public payers have the potential to catalyze significant change in the market. Massachusetts is using State Innovation Model funds to support MassHealth's development of a

payment and delivery system reform effort called the Primary Care Payment Reform (PCPR) Initiative and the GIC's effort to develop and implement an aligned approach in its upcoming health plan procurement.

To support this model, the state is also using grant funds to address several operational gaps. Many payers have recognized the need for practices to receive data on the services their patients receive in other settings. Medicare provides claims data to participating ACOs, while BCBS, Tufts, and other commercial payers have set up portals for providers to access claims data and some real-time information on emergency department (ED) visits and hospital admissions. In PCMHI, Medicaid payers provide some claims data and limited real-time information. These fragmented systems are not always able to give providers the comprehensive data needed to effectively manage care. Moreover, behavioral health providers and long-term services and supports (LTSS) providers have been largely excluded from existing health information technology (HIT) incentive payments, and many do not have electronic medical records (EMRs). Massachusetts proposes to use grant funds to strengthen the data infrastructure for care coordination and accountability, including leveraging the All Payer Claims Database (APCD) to provide cross-payer claims-based reports to practices, and providing technical assistance to behavioral health and LTSS providers to participate in the HIE.

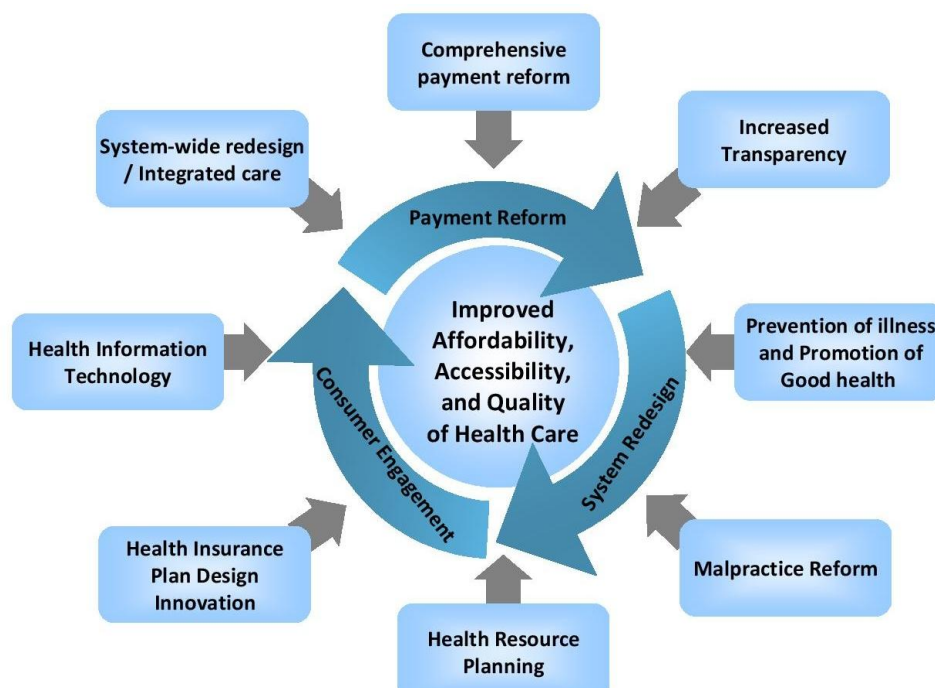
Quality measurement is a key ingredient of the specified model, and, recognizing the potential for measurement to improve outcomes and motivate excellence, the state's payers work together in several important areas. First, the Statewide Quality Advisory Committee (SQAC) represents a multi-stakeholder effort to design a standard set of quality measures. This set of measures builds upon existing measure sets such as the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measures, the Centers for Medicare and Medicaid Services (CMS) ACO measures, and quality measures in use by private payers. Second, Massachusetts Health Quality Partners (MHQP) conducts cross-payer statewide surveys of patient experience, reporting results to practices and to the public, and calculates and reports cross-payer Healthcare Effectiveness Data and Information Set (HEDIS) measures. In addition, the APCD facilitates multi-payer calculation of claims-based measures. Finally, the HIE will enable the transmission of measures of clinical quality captured by electronic health records (EHRs) as providers attain Stage 2 of meaningful use (MU). At the

same time, several gaps exist in current activities. Notably, public payers are not included in practice-level surveys, due to lack of funding. The Medicaid Management Information System (MMIS) system that covers MassHealth and the Health Safety Net requires upgrades to facilitate the analysis of quality data and its use in alternative payments. Also, some smaller and less sophisticated providers may require technical assistance in order to transition to EHRs and use the HIE.

Other key gaps addressed by this proposal are integration of public health initiatives and LTSS with the primary care system and ongoing learning and dissemination of best practices.

4. State Policy and Regulatory Levers

Exhibit 3: Levers for health care cost containment



The passage of Chapter 224 of the Acts of 2012 represents a major milestone in Massachusetts' thoughtful and collaborative approach to health reform. In 2009, the Massachusetts Health Care Quality and Cost Council (QCC), a public entity responsible for setting quality and cost targets for the Commonwealth, developed the "Roadmap to Cost Containment." This Roadmap detailed eleven strategies that have the

potential to reduce health care costs, or cost growth. In 2011, Governor Deval Patrick introduced legislation proposing a balanced and comprehensive approach to health care cost containment. Included in this legislation were many of the strategies endorsed by the QCC, including payment reform, system integration and redesign, health resource planning, and malpractice reform. In 2012, the legislature passed, and the Governor signed into law, An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation,” or Chapter 224 of the Acts of 2012. Chapter 224 sets an annual target for the growth of total health care expenditures and supports strategies to reform payments, promote integrated delivery systems, increase transparency, address market power, promote wellness, reform malpractice policy, and support health information technology.

Even prior to the recent enactment of comprehensive health care cost containment legislation, Massachusetts has undertaken a number of initiatives to advance the goals and strategies endorsed in this legislative framework. With legislation now in place, the state is poised to accelerate efforts to achieve its vision of high quality health care at lower cost, through innovation and multipayer collaboration. The legislation provides Massachusetts with important levers that support the initiatives in the SIM grant. Some of the specific levers that are most pertinent to the state’s SIM grant are described further below.

5. Payment and Delivery System Transformation

Transformation of the payment and delivery systems will be central to controlling health care costs in Massachusetts. The current system of payments for health care services is dominated by fee-for-service, which is inherently inflationary, rewards overuse of health care services, does not reward primary care, preventive care or care coordination, and contributes to administrative complexity. The current system of fee-for-service payments also facilitates a siloed delivery system, rather than integration and coordination of care.

Massachusetts is moving toward a payment system that encourages and reinforces fundamental cultural and structural changes in our delivery system, such as greater investments in primary care capacity, promotion of the right care in the right place, greater attention to prevention and wellness, better

management of chronic disease, better integration of behavioral health care, better coordination of care across care settings, and capital investments and technology diffusion based on need, evidence and quality. Global payment models have the potential to provide incentives for efficiency in the delivery of services that are missing in the fee-for-service system, while potentially driving improvements in quality through better coordination of care.

Chapter 224 promotes the adoption of payment and delivery system reforms, using a number of mechanisms. The new law positions government payers, including MassHealth and the Group Insurance Commission, as drivers of payment reform, by requiring these programs to implement alternative payment methodologies, to the maximum extent feasible, by July 1, 2014. Chapter 224 also sets out specific benchmarks for MassHealth's transition to alternative payment methodologies, requiring that, to the maximum extent feasible, MassHealth pay for health care utilizing alternative payment methodologies for no fewer than 25 percent of its enrollees that are not also covered by other health insurance coverage by July 1, 2013, for 50 percent by July 1, 2014, and for 80 percent by July 1, 2015.

Though the law does not mandate that private payers move to alternative payments, many payers have already done so and Massachusetts has engaged with these private payers in a number of ways, such as through collaboration on medical homes, health information technology, and quality initiatives. In addition, providers already participate in a number of alternative payment arrangements, including Medicare ACOs and shared savings programs, as well as alternative contracts. Chapter 224 builds on this momentum in the private market by directing the Health Policy Commission to develop processes for the certification of organizations as accountable care organizations and patient-centered medical homes. In addition, the law creates a "Model ACO" program through which organizations can be designated as "Model ACOs" and receive priority from MassHealth, the Group Insurance Commission, and the Health Connector, further promoting the shift to alternative payment structures.

6. Adoption of Health Information Technology

HIT is necessary infrastructure to improve the quality of care provided to patients and improve efficiency through better coordination of care among multiple providers, providing patients with electronic access to their provider and their own health information, and making information more readily available for population health management purposes. HIT, if it is designed with the explicit goal of supporting system redesign, has the potential to reduce unnecessary and duplicative testing, reduce the administrative burden on providers, and improve clinical quality.

Significant work to advance HIT is already underway. Chapter 305 of the Acts of 2008, an Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care, was signed into law by Governor Patrick in August 2008. It established the goal of statewide implementation of EHR in all provider settings as part of an interoperable health information exchange by the end of 2014. Massachusetts' Health Information Exchange went live in October 2012, and enables providers to more easily and securely share health information. Massachusetts also provides technical assistance and financial support to help providers in adopting electronic health records.

Chapter 224 further advances the state's comprehensive vision for development of the HIE and electronic medical records. Chapter 224 requires all providers in the Commonwealth to implement fully interoperable electronic health records systems that connect to the statewide HIE by January 1, 2017 and provides for penalties for non-compliance as well as waivers. The law also requires accountable care organizations, patient-centered medical homes, and risk bearing provider organizations to have interoperable electronic medical records by December 31, 2016.

The law provides for up to \$28.5 million in new funds over four years for providers who are not eligible for Medicare or Medicaid incentive payments and to support connection through the HIE. These statutory provisions are synergistic with SIM projects to help providers connect to the HIE, enhance the use of data for care coordination and panel management, and provide additional functionality that facilitates sharing of information between different providers or types of providers.

7. Containment of Health Care Cost Growth

Chapter 224 sets a first-in-the-nation target for controlling the growth of health care costs. The law holds the annual increase in total health care spending to the rate of growth of the state's Potential Gross State Product (PGSP) for the first five years, through 2017, and then to half a percentage point below PGSP for the next five years, and then back to PGSP.

Under the new law, the Center for Health Information and Analysis will analyze each year whether the target has been met and the Health Policy Commission will hold annual hearings on health cost trends in the Commonwealth. If the target has not been met, the HPC can require entities that have exceeded the cost growth target to create a performance improvement plan to improve efficiency and reduce cost growth.

Creating a target for health care cost growth commits all stakeholders in the Commonwealth, including government, providers, payers, and consumers, to the goal of health care cost reduction. It also commits additional resources to the careful monitoring and reporting on trends in total cost of care. For example, Chapter 224 directs HPC and CHIA to monitor trends in the health care market, including the impact of the development of accountable care organizations and other market changes on the availability and cost of health care in the Commonwealth.

Detailed reporting on cost trends, trends in the adoption of alternative payment methodologies, quality indicators, relative price, and transparency of cost and quality information for consumers will provide valuable data that will help the Commonwealth understand current trends in the market as well as the penetration and impact of different methodologies. These enhanced research and analytic capacities will be vitally important to the Commonwealth's health reform efforts, as well as for the types of evaluation that will be necessary to understand the impact of the SIM grant on the Commonwealth.

8. Promotion of Prevention and Wellness

The medical costs of people with chronic diseases account for a significant proportion of our nation's medical costs. Many chronic diseases arise and worsen because of a variety of potentially modifiable factors, including environmental conditions, socio-economic factors, and behaviors of the affected individuals. While the state has made great strides in reducing some unhealthy behaviors, there is much work still to be done. Promoting prevention and wellness will require a multi-pronged strategy, including community engagement, employer engagement, regulatory interventions, and public health campaigns.

Chapter 224 takes a number of steps to promote prevention and wellness. Most notably, the new law creates a prevention and wellness trust fund and provides the fund with \$57 million over 4 years. The funds are to be used to support the state's cost containment goals and will be awarded in a competitive award process. The Prevention and Wellness Advisory Board is considering a proposal that the funds be used to support primary care-community health linkages. These types of linkages are exemplified by the e-Referral project funded through the SIM grant, which will create bi-directional e-Referral capacity between primary care providers and community-based resources.

9. Alignment with Federal Positions

As described in Section B, the Commonwealth has worked to align its projects with federal initiatives as much as possible. More globally, Massachusetts' emphasis on controlling costs and improving quality is consonant with federal efforts in this arena. For example, the Commonwealth's model emphasizes primary care within the context of a medical home. Medicare's ACO programs emphasize the importance of primary care and even beneficiary attribution is based on the provision of primary care services by a physician. Medicare offers advance payment of shared savings to some Medicare Shared Savings Program (MSSP) participants and will transition its Pioneer ACOs to population based prospective payments.

Similarly, the state's emphasis on accountability for the total cost of care through shared savings/shared risk arrangements is also found in Medicare ACO programs. In MassHealth's Duals Demonstration, undertaken in partnership with the federal government, Integrated Care Organizations (ICOs)

are encouraged to use alternative payment methodologies to contract with providers, including shared savings/shared risk arrangements. In many of these models, quality performance affects the extent of eligibility for the shared savings payment.

10. Engagement of Stakeholders

The Stakeholder Engagement Plan, included as Attachment D, describes how the Commonwealth intends to engage with stakeholders during the SIM grant implementation and testing phase. The Stakeholder Engagement plan includes outreach to payers and providers. Payers and providers have been engaged in the SIM application and implementation phases and will continue to be engaged throughout the testing phase. Formal mechanisms for engagement come in the form of stakeholder engagement meetings, implementation team meetings, and public comment processes. The SIM team plans to continue to hold quarterly public meetings throughout the model testing period to provide updates and obtain input on overall grant implementation. In addition, each specific project also has an interested stakeholder community and there will be regular opportunities to obtain more targeted input on specific projects.

Fostering coordination and collaboration across state agencies will also be essential to the success of the SIM grant effort. EOHHS has developed a working group of implementing agencies which meets approximately monthly to discuss grant implementation activities. In addition, EOHHS is coordinating closely with a broad array of agencies across the Administration, and is utilizing an administration-wide health reform implementation workgroup as a forum to share updates and obtain feedback on SIM grant implementation activities. This workgroup is attended by the Governor's office, Administration and Finance, Housing and Economic Development, Division of Insurance, Labor and Workforce Development, Health Connector, Group Insurance Commission, Department of Public Health, Department of Mental Health, Center for Health Information and Analysis, Health Policy Commission, and EOHHS/MassHealth. These monthly meetings provide a forum for coordination around all health reform activities.

Within EOHHS, the SIM team has provided updates at internal meetings, such as the Health Cluster meeting, chaired by the Secretary of Health and Human Services and attended by the Director of Medicaid, Commissioner of Public Health, and Commissioner of Mental Health, and MassHealth leadership meetings.

Community and patient stakeholders are included in the stakeholder engagement plan.

Massachusetts is also maintaining a website and listserve to provide information about the SIM grant.

Integration of public health is also important to Massachusetts' SIM grant proposal. Specifically, the e-Referral program undertaken by DPH encourages integration of primary care and public health by facilitating the connection of clinical settings to community settings. The e-Referral workplan involves engaging multiple clinical and community stakeholders to understand how to better link patients with or at risk of chronic disease to community resources such as Chronic Disease Self-Management programs, tobacco cessation, and YMCA Diabetes Prevention Programs. Because the implementation stage is focused on developing the technical specifications for the bi-directional, open-source, vendor-neutral software, the DPH e-Referral team has already started conversations with both the clinical side and the community side to understand how referrals might be made, what types of information needs to be transmitted from the medical record to the community organization, and what types of information should be transmitted back into a patient's medical record. As part of the EOHHS IT Project Management Office project development plan, DPH staff has facilitated conversations between the various stakeholders and the IT development staff to aid in the design of the e-Referral software.

Several different offices within the DPH Bureau of Community Health and Prevention's Division of Prevention & Wellness have leveraged existing relationships to enable these conversations. There is Bureau-wide interest in using this software to facilitate these community-clinical linkages for many public health programs. The e-Referral software will not only allow DPH to track the number of referrals made to specific programs, but it will allow an evaluation of longer term health outcomes as information about the referral is embedded back into a patient's medical record. The ultimate success of the e-Referral program will depend on several factors that the DPH is already working on including stakeholder engagement, Bureau and senior DPH

leadership support, and collaborative data sharing between DPH, community programs, and the Massachusetts League of Community Health Centers.

H. PARTICIPANT RETENTION PROCESS

Providers and delivery systems across the state have committed to making the changes envisioned by the new payment and delivery system model. For PCPR, MassHealth has issued an RFA and anticipates signing contracts with participating providers. MassHealth will also be working with MCOs to amend their contracts so that participating providers are paid by MCOs in an aligned fashion. In Massachusetts' multi-payer PCMH, 46 practices including 30 community health centers (CHCs) have committed to transforming into PCMHs in the context of a shared savings model. Seven safety net hospitals have committed to taking more accountability for the cost and quality of care across settings.

Outside of Medicaid, the five Pioneer ACOs and twelve MSSP practices committed to this transformation for their Medicare members. The University of Massachusetts (UMass) Memorial Medical System, including several hospitals and multispecialty group practices, has demonstrated commitment to this model. Six practices in the UMass system, caring for over 30,000 patients, are participating in PCMH transformation programs, two of them in the state's PCMH. Over 1,600 primary care physicians are participating in the BCBS Alternative Quality Contract.

On the payer side, Blue Cross Blue Shield (BCBS) and Tufts Health Plan are also moving towards APMs that are consistent with this model. BCBS' Alternative Quality Contract (AQC) focuses on patient-centered medical home principles and encourages primary care practices and systems to increase accountability for quality and total costs of care. In alignment with the model, BCBS AQC includes an efficiency opportunity whereby provider organizations share in budget savings and share risk for budget deficits. Similarly, the Tufts Coordinated Care Plan (CCP) emphasizes a PCMH system and is moving providers to risk-based global contracts. Payers in the state are participating in processes to build the foundational structures necessary for

transformation, including the SQAC, APCD, HIE and HIT stakeholder processes, and will be included in payer learning collaboratives.

Chapter 224 further encourages the shift to alternative payment methodologies (APMs), in both the public and private sector in an effort to contain health care costs and improve quality. To do so, Chapter 224 has tasked the Health Policy Commission to develop standards and definitions for patient-centered medical homes and accountable care organizations, and to establish a model ACO program in which model ACOs are to be given priority consideration in state contracting.

Chapter 224 also requires both the GIC and MassHealth to implement alternative payment methodologies. In the context of the SIM grant, MassHealth and the GIC are developing an aligned strategy. The GIC's value based procurement strategy will include risk to providers by encouraging its health plans to contract with integrated risk bearing organizations. MassHealth's Primary Care Payment Reform will not only include members in the Primary Care Clinician (PCC) plan, but will also include the participation of MCOs.

In developing its four projects related to long-term services and supports (LTSS), the Executive Office of Elder Affairs has carefully engaged with its provider network as it expands program/business function and user community availability under the Senior Information Management System (SIMS). This grounding in careful stakeholder work will increase the likelihood of participation.

For example, the concept of the Physician Portal emerged from the Aging Services Access Point (ASAP) community, EOEA's core operating partners for its elders Home and Community-Based Services (HCBS) network. The ASAPs had recognized a value and approach to leveraging Senior Information Management System (SIMS) data into a medical community-of-practice, seeking to benefit elder consumers and patients through improved coordination of care and data quality feedback. EOEA has facilitated the application's development with its primary vendor Harmony, and has repeatedly previewed the Physician Portal with executive directors of the 27 ASAPs in Massachusetts from the concept's inception. The ASAPs are actively engaging with primary-, acute- and transitional-care providers to encourage adoption of the application. Medical professionals whose patients are active home care consumers are candidates to use this application.

The Section Q referral system, once deployed, will be used by 450 skilled nursing facility (SNF) organizations. In the next several weeks EOEA will kick-off the project with user organizations, and will introduce training, system administration, and user support processes during statewide deployment in Fall 2013.

The initiative to streamline Adult Foster Care/ Group Adult Foster Care (AFC/GAFC) clinical determinations will also be rolled out this fall. Over 200 new AFC/GAFC provider organizations will be folded into the SIMS user community as they begin to use this system, reducing time-to-clinical-determination throughout the AFC/GAFC provider community. Application access, system administration, training materials, and user support will be coordinated by EOEA.

Finally, the Caregiver Connect project has already been piloted (in an earlier phase) with families and an ASAP; once closer to deployment EOEA will reconvene a pilot group for incremental input prior to a rapid statewide deployment. Each of the 27 ASAPs will engage the families and caregivers of its state and Frail Elder Waiver (FEW) home care consumers to increase their engagement with the case management and long term services and support (LTSS) network by use of this application. Any active home care consumers, and their family, are candidates to use this application.

Similarly, DPH is working closely with the Massachusetts League of Community Health Centers, individual community health centers, as well as a variety of community-based organizations on developing the e-Referral plan, as documented in the stakeholder engagement plan included as Attachment D. DMH will be consulting with the MCPAP Pediatric Advisory Committee, which includes the MCPAP Statewide Medical Director and pediatricians from twelve pediatric practices from across the state that are enrolled in and utilize MCPAP. CHIA will be consulting with providers in the development of all-payer reports. EOHHS IT has already conducted outreach to behavioral health providers to better understand their needs as they pertain to EHR adoption and will be doing similar work with LTSS providers. Stakeholder engagement will continue to be essential to the success of SIM implementation moving forward.

I. QUALITY, FINANCIAL, AND HEALTH GOALS AND PERFORMANCE MEASUREMENT PLAN

In developing performance measures for Primary Care Payment Reform, EOHHS/MassHealth carefully selected measures that are externally validated and already in use, such as measures compiled by HEDIS, AHRQ, CMS, and private payers in Massachusetts.

These metrics focus on key areas including adult prevention and screening, behavioral health (adult and pediatric), adult chronic conditions, access (adult and pediatric), health and care coordination (adult and pediatric). While almost all of the measures are found in the CMMI Core Measure Set, in some cases PCPR required additional measures. The additional PCPR measures are all NQF endorsed measures. The PCPR measures are described in detail in Attachment E.

The selection of performance measures for PCPR considers: 1) clinical significance, 2) room for improvement, as indicated by national norms and results in high-performing organizations, 3) the expectation that measures would be responsive to the model intervention, 4) alignment with national and state initiatives, and 5) stakeholder acceptability. The Commonwealth recognizes that stakeholder support is crucial to successfully implement the SIM initiative and therefore, Massachusetts has taken steps to obtain input from payers and providers on performance measures.

The PCPR measures have been shared with payers and providers through an RFI and RFA process, and through numerous informational sessions and workgroups held during the development of PCPR, including meetings held with MassHealth's five managed care organizations (MCOs) both individually and as a group.

In addition to the work done through PCPR to align quality measures, there are additional efforts being undertaken in the Commonwealth to improve alignment. Massachusetts recognizes the importance of alignment, as many public and private payers in Massachusetts collect measures of the quality of care, as part of the implementation of innovative payment methodologies. These include measures collected by payers using alternative contracts, such as the AQC; measures required by CMS for Pioneer ACOs and the Medicare Shared Savings Program; and measures required by CMS for Medicaid and CHIP programs.

To help streamline and coordinate quality measures, legislation in 2010 established a Statewide Quality Advisory Committee (SQAC) to define a standard list of healthcare quality measures. Currently, providers submit a wide variety of quality measures to different government, trade and improvement agencies, with little to no standardization between these organizations. By creating a Standard Quality Measure Set (SQMS) for the state, the SQAC may be able to reduce provider reporting burden, ensure that the strongest quality measures are in use, and give consumers the confidence to compare provider quality from public sources. The measure set is intended for annual reporting by Massachusetts providers, and for insurance companies to use to evaluate provider quality and create tiered products.

The SQAC was established by Chapter 288, Section 54 of the Acts of 2010, as amended by Chapter 359 of the Acts of 2010. Its members represent government agencies, hospitals, medical associations, the Group Insurance Commission, employer associations, medical groups, health plans and consumer groups. The Committee members use their expertise to evaluate the measures that are statutorily mandated for inclusion in the SQMS and nominate additional quality members for consideration. SQAC members vote on individual measures to include or exclude in the SQMS. To be included, quality measures must meet a minimum threshold of practicality and validity, and meet at least one of the Committee's priority areas. In 2012, these areas included community and population health, behavioral health, and care coordination and care transitions.

Under its statutory mandate, the SQAC is required to include the following four measure sets in the SQMS: (1) Centers for Medicaid and Medicare Services' Hospital Process Measures; (2) Hospital Consumer Assessment of Healthcare Providers and Systems Survey (H-CAHPS); (3) Healthcare Effectiveness Data and Information Set (HEDIS); and (4) Ambulatory Care Experiences Survey (ACES). With the assistance of committee staff, the SQAC evaluated each of the mandated measures and assigned it either a strong, moderate, or weak level of recommendation. The same process was used to evaluate non-mandated measures, which were initially proposed by members of the public, SQAC Committee Members, or experts with knowledge of the Committee's three priority areas. The chosen measures, along with the statutorily

mandated measures, will make up the official SQMS. In addition to endorsing specific measures, the Committee will identify future quality measurement priority areas, and may choose to disseminate its recommendations to non-governmental stakeholders.

Chapter 224 continued the work of the SQAC and moved the SQAC into the Center for Health Information and Analysis. Chapter 224 provides that the SQAC will provide annual recommendations for updates to the Standard Quality Measure Set. As part of its work, the SQAC, has prepared a comprehensive inventory of all quality measures used in the Commonwealth.¹ This quality measure inventory is an important step in helping the Commonwealth understand the utilization of quality measures across different payers and lay the groundwork for further alignment.

In terms of establishment of performance benchmarks, PCPR has not yet started collecting data, and the first round of data collection is anticipated to begin in the testing phase. Providers are requested to submit performance data quarterly based on the timeframe table included in the RFA (Attachment B) and the Model Contract (Attachment C). As data comes in, PCPR will continually assess performance targets against benchmarks. Details about the calculation of quality incentive payments for both Pay for Reporting and Pay for Performance are detailed in the Model Contract included as part of the PCPR RFA.

Tables on performance measures as requested by CMS can be found as Attachment E.

J. APPROPRIATE CONSIDERATION FOR PRIVACY AND CONFIDENTIALITY

While sharing medical information between a patient's providers can improve coordination of care, making health information more accessible also raises privacy and confidentiality concerns that must be carefully considered and addressed. There are many applicable Federal and State regulations that apply. The HIT council has convened a legal and policy advisory group to address these concerns and ensure that patient consent is obtained, recorded, and respected in all applicable situations. The Behavioral Health Integration

¹https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCoQFjAA&url=http%3A%2F%2Fwww.mass.gov%2Fchia%2Fdocs%2Fg%2Fsqac%2F2013%2Fma-quality-measure-catalog-2-26-13.xlsx&ei=oU3UUfTtFbHG4APby4HwBw&usg=AFQjCNHcoYW15h6CZs5mG_SC6-jlKMO4CQ&bvm=bv.48705608,d.dmQ

Task Force has made recommendations about the sharing of behavioral health information. Chapter 224 requires that patients have the ability to opt in or opt out of health information sharing at any time. EOHHS/MassHealth has reviewed the SAMHSA confidentiality regulations and will ensure that the Commonwealth is in full compliance. Within the PCPR initiative, applicants have been informed via the RFA that they must comply with all state and federal laws and regulations relating to confidentiality and privacy. Other stakeholder input will be sought and considered during the course of SIM grant implementation.

K. STAFF/CONTRACTOR RECRUITMENT AND TRAINING

An organization chart showing the overall organization of the project is shown in Section A. Detailed descriptions of the roles of key staff by agency are found in the tables below, followed by information about the role of contractors. Newly hired staff and contractors are trained by the respective project leads. Senior staff will also provide their time in kind to support the work of the SIM grant. Additional staffing needs will continue to be refined during the implementation period.

Center for Health Information and Analysis (CHIA)

Key Personnel/Participants				
Name	Organization	SIM Role	Key Responsibilities	Email
Marilyn Kramer, Deputy Executive Director	CHIA	Principal Investigator/ Executive Sponsor	<ul style="list-style-type: none"> • Holds ultimate responsibility for APCD products • Coordinates with SIM operational senior management • Oversees delivery of APCD resources in support of development and operation of the Massachusetts model • Oversees work with payers to capture required data and improve data quality • Oversees work with providers to design provider portal functional capabilities • Approves recruitment of new staff dedicated to SIM Implementation • Approves work products • Responsible for functional quality of technical solutions 	Marilyn.Kramer@state.ma.us

Michael Cocchi	CHIA	Chief Information Officer	<ul style="list-style-type: none"> • Leads project technology development • Oversees data quality assurance and enhancement • Directs and approves APCD system architecture development and operations • Oversees system development and performance for SIM Implementation requirements • Responsible for implementation of the Master Patient Index and oversight of intake/process for the SIM Implementation data • Ensures adherence to technical standards • Executes formal reviews of overall product quality • Accountable to Executive Sponsor 	Michael.Cocchi@state.ma.us
David Netherton	CHIA	Director of Administrative Simplification	<ul style="list-style-type: none"> • Oversees project managers and a small support team of project coordinators working to advance administrative simplification • Directs activities needed to expand effective use of APCD by state agencies and CHIA business units. • Coordinates all activities of State Innovation Models Initiative (SIM) grant, the Affordable Care Act (ACA) Health Connector grant and the Group Insurance Commission validation project • Oversees documentation of initiatives related to administrative simplification, and associated cost savings and other benefits to the Commonwealth • Manages consultants and staff carrying out functions necessary to support administrative simplification • Accountable to Executive Sponsor 	David.Netherton@state.ma.us

Positions to be Filled					
Position	SIM Role	Anticipated Date of Hire	Qualifications	Salary	Recruiting strategy
CHIA Project Manager	<ul style="list-style-type: none"> Develops the formal project plan, charter, change management documents, risk mitigation plan, issues logs, project plan and communications related to SIM Coordinates build-out of provider portal hardware, software, human resources for the team preparing quarterly extracts, risk adjustment model runs and data quality reports Ensures that all project variances related to tasks and resources are identified and controlled Tracks tasks and activates related to constraints on scope, budget and schedule Manages cross-functional sub-projects, tasks and activities Accountable to the Director of Administrative Simplification 	August 2013	Minimum: Five years full-time or equivalent experience in business administration, business management or public administration, of which at least one year must have been in a management capacity; Bachelors degree or higher, Master degree preferred	To \$120,000 per annum	Expert health care consultant RFQ in process
CHIA Business Analyst	<ul style="list-style-type: none"> Develops business requirements and specifications for provider portal applications Reviews APCD documentation and identifies enhancements Develops specifications for new data elements and analytic tools Outlines requirements for reporting modules for the provider portal Accountable to Project Manager/CIO 	August 2013	Minimum: Bachelors degree or higher in business administration, business management, or public administration; graduate degree preferred.	To \$65,000 per annum	Expert health care consult; RFQ in process

CHIA Report Writer	<ul style="list-style-type: none"> Coordinates report development with SIM Implementation provider outreach activities focused on expanding accessibility and use of APCD Implements reporting routines designed in collaboration with the Database Developer and Business Analyst Assists with integrating provider feedback and implementation of enhancements in reports and online reporting modules Provides support functions related to requirements for SIM implementation and ACA Connector/Exchange projects Accountable to Project Manager/CTO 	October 2013	Minimum: Bachelor's degree or higher in health sciences or public administration; Graduate degree preferred	To \$70,000 per annum	CEO, graduate schools, professional association postings; to be followed by screening, Interviews, completion of HR process
CHIA Database Developer	<ul style="list-style-type: none"> Designs and builds relational databases Develops and supports implementation of risk adjustment and Master Patient Indexing software Leads testing, revision, enhancement, documentation and rollout of database applications Supports installation and testing of SAS code Coordinates Master Patient Indexing software and development of automated reporting processes Directs technical implementation tasks Accountable to Project Manager/CTO 	October 2013	Minimum: Bachelors degree or higher in computer sciences; Graduate degree preferred	To \$85,000 per annum	CEO, graduate schools, professional association postings; to be followed by screening, Interviews, completion of HR process
CHIA Database Analyst	<ul style="list-style-type: none"> Supports technical processes through expert knowledge of APCD data Supports development and testing of online editing Assists SIM Implementation and ACA Connector staff and consultants in use of APCD for development of the Massachusetts model Works with CHIA Subject Matter Experts in support of expanding use of the provider portal Supports data quality improvement activities Accountable to the Project Manager/CIO 	October 2013	Minimum: Bachelors degree or higher in computer sciences, business administration or public administration; Graduate degree preferred	To \$65,000 per annum	Initiated CEO, graduate schools, professional associations postings; to be followed by screening, Interviews, completion of HR process

Department of Public Health (DPH)

Key Personnel/Participants				
Name	Organization	SIM Role	Key Responsibilities	Email
Tom Land	DPH	Project Manager	<ul style="list-style-type: none"> Oversees coordination of SIM e-Referral effort with other Department-wide efforts including Prevention & Wellness Trust Fund as well as other Health Information Technology efforts in Massachusetts Approves recruitment of new staff dedicated to SIM Implementation e-Referral project 	Thomas.Land@state.ma.us
Laura Nasuti	DPH	Evaluator	<ul style="list-style-type: none"> Oversee implementation and execution of SIM grant programmatic activities including convening stakeholders, managing IT development team, responding to required grant deliverables, budget questions, RFR development Approves IT contract hires dedicated to e-Referral development Attend ONC and CDC technology work groups that tie into the e-Referral program 	Laura.Nasuti@state.ma.us

Positions to be Filled					
Position	SIM Role	Anticipated Date of Hire	Qualifications	Salary	Recruiting strategy
e-Referral Program Coordinator II	<ul style="list-style-type: none"> Assist with coordination of all aspects of the State Innovation Model e-Referral program including collaborative meetings with external stakeholders and internal staff meetings Responsible for monitoring administrative components of SIM e-Referral contracts Maintains the timeline for activities and aids with any other federal reporting requirements for the SIM award Contributes to communication efforts among members of the project including EOHHS, DPH staff, community and the community health centers. 	TBD	Minimum: Applicants must have at least (A) two years of full-time, or equivalent part-time, professional, administrative or managerial experience in business administration, business management or public administration, the major duties of which involve program management, program administration, program coordination, program planning and/or program analysis, or (B) any equivalent combination of the required experience and allowable substitutions.	\$80,000 annually	<ul style="list-style-type: none"> Disseminate job announcement through the Commonwealth's Human Resource Division network. Outreach/disseminate to area academic institutions and DMH professional network
Epidemiologist /Data Analyst	<ul style="list-style-type: none"> Works closely with the e-Referral evaluator to develop specific frameworks, logic models, and methods for conducting both process and impact evaluations of programs and interventions Works closely with Director of the Office of Integrated Policy, Planning and Management to ensure that community-clinical linkages are implemented with adequate data collection and evaluation plans to determine the value of the project 	TBD	Applicants must have at least (A) 5 years of full-time or equivalent part-time, professional, or technical experience in epidemiology, virology, immunology, bacteriology, or microbiology, and (B) of which at least two years must have been in a professional capacity or (C) any equivalent combination of the required experience, and the substitutions below.	\$85,000 annually	<ul style="list-style-type: none"> Disseminate job announcement through the Commonwealth's Human Resource Division network. Outreach/disseminate to area academic institutions and DMH professional network

Department of Mental Health (DMH)

Key Personnel/Participants				
Name	Organization	SIM Role	Key Responsibilities	Email
Joan Mikula	DMH	DMH Deputy Commissioner of Child/Adolescent Services	<ul style="list-style-type: none"> • Provide strategic guidance to project implementation activities • Serve as lead liaison to senior executive leadership of other state agencies and external key stakeholder leaders • Develop stakeholder inputs on design of sustainability plan • Develop recommendations and plan for sustainability of MCPAP beyond SIM grant 	Joan.Mikula@state.ma.us
Christina Fluet	DMH	DMH Director of Planning and Policy Development Child/Adolescent Services and SIM Project Director	<ul style="list-style-type: none"> • Oversee implementation and execution of all DMH SIM grant activities • Oversee implementation of all project planning activities and documentation • Serve as primary liaison with MCPAP staff regarding all aspects of project planning and implementation • Serve as primary liaison with SIM Project staff • Coordinate DMH SIM activities with other EOHHS SIM project partners 	Christina.Fluet@state.ma.us

Positions to be Filled					
Position	SIM Role	Anticipated Date of Hire	Qualifications	Salary	Recruiting strategy
DMH State Innovation Model Grant Project Manager	<ul style="list-style-type: none"> • Coordinate all project meetings and communications • Maintain all project planning documents and other documentation as required by DMH and EOHHS • Serve as liaison to MCPAP staff to coordinate project activities • Assist the DMH SIM Project Director in the execution of all project activities, oversight, and strategic planning 	09/01/13	<ul style="list-style-type: none"> • Bachelor's Degree required; Master's Degree in public health, psychology, social work, or related health and human services field preferred. • At least five years experience and demonstrated capacity in project management • Excellent planning and organizational skills • Excellent communication skills, both oral and written • Knowledge of the children's behavioral health service system in Massachusetts 	\$60,000 annually (.5 FTE)	<ul style="list-style-type: none"> • Disseminate job announcement through the Commonwealth's Human Resource Division network. • Outreach/disseminate to area academic institutions and DMH professional network

Executive Office of Elder Affairs (EOEA)

Key Personnel/Participants				
Name	Organization	SIM Role	Key Responsibilities	Email
Peter Tiernan	EOEA	Chief Financial Officer	<ul style="list-style-type: none">Executive Sponsor	Peter.Tiernan@state.ma.us
Joan O'Rourke	EOEA	Chief Information Officer	<ul style="list-style-type: none">Oversee implementation and execution of SIM grant activities	Joan.O'Rourke@state.ma.us
Jim Ospenson	EOEA	Business Analyst & Information Architect	<ul style="list-style-type: none">Oversee implementation and execution of SIM grant activities	James.Ospenson@state.ma.us

Executive Office of Health and Human Services (EOHHS)/MassHealth

Key Personnel/Participants				
Name	Organization	SIM Role	Key Responsibilities	Email
Ann Hwang	EOHHS	SIM Grant Director (Acting), Director of Health Care Policy and Strategy	<ul style="list-style-type: none"> Oversee implementation and execution of SIM grant activities; ensure coordination with other health reform initiatives 	Ann.Hwang@state.ma.us
Neha Sahni	MassHealth	Director of Primary Care Payment Reform	<ul style="list-style-type: none"> Oversee implementation and execution of SIM grant activities Acts as a liaison between the Steering Committee and Advisory Council; working to communicate the groups' respective priorities 	Neha.Sahni@state.ma.us
Jackie Harris	EOHHS	Director of Accounting	<ul style="list-style-type: none"> To provide effective leadership and management in the development and implementation of a consolidated HHS accounting operating model, to establish an EOHHS Accounting future state vision for the proposed operating model; develop a high level implementation plan and timeline for accounting consolidation; identify high level IT requirements for accounting systems and identify unique processes and applications across agencies. 	Jackie.Harris@state.ma.us

Key Positions to be Filled					
Position	SIM Role	Anticipated Date of Hire	Qualifications	Salary	Recruiting strategy
Health Care Innovation Program Director	The Health Care Innovation Program Director, reporting to Director of Health Care Policy and Strategy, will have overall responsibility for the success of the SIM initiative. The Program Director will communicate with and build relationships with external groups and individuals, particularly providers, payers, consumers, legislators, and federal and state officials regarding the implementation of the State Innovation Model Grant. The Director receives and responds to telephone and written requests from a variety of parties, including the legislature, and federal and state officials. The Director will maintain regular contact and communication with state and federal agencies and will provide information about program activities to interested members of the general public at meetings, conference, and public forums.	September 2013	Minimum: Applicants must have at least (A) five years of full-time or equivalent experience in business administration, business management, or public administration and (B) of which at least one year must have been in a managerial capacity	\$44,590.00-\$108,447.70	Interviews completed; awaiting completion of HR process
Assistant Director of Analytics	This position will have a day-to-day responsibility for continuous quality improvement, program monitoring, the State evaluation, and CMS' evaluation	TBD	TBD	TBD	Recruitment in process

Primary Care Payment Reform Operations Analyst	<ul style="list-style-type: none"> • Provide effective in-depth analytical support for the development, implementation and monitoring of the operational aspects of PCPR Initiative. • Develop comprehensive operations metrics that highlight performance across the Initiative, including conducting regular operations performance analysis. • Provide internal and external stakeholders with data and reporting tools to support performance and monitoring of SIM Grant activities. • Conceptualize operational needs, creatively identify options and strategies and execute complex operational analyses, drawing on multiple data sources and utilizing a broad array of technology resources 	TBD	Applicants must have at least (A) four years of full-time, or equivalent part-time, professional, administrative, supervisory, or managerial experience in business administration, business management or public administration, and (B) of which at least three years must have been in a supervisory or managerial capacity, or (C) any equivalent combination of the required experience and substitutions.	\$35,247.68 to \$85,262.46	Currently being posted
Primary Care Payment Reform Quality Management Analyst	<ul style="list-style-type: none"> ▪ Establish quality improvement goals and metrics and coordinate the monitoring and evaluation of progress towards their achievement. Provide feedback to, and maintain ongoing communication with, contracted PCPR providers regarding quality goals; evaluate the performance of each provider against established metrics. Develop contract language to enable effective oversight of PCPR providers with respect to quality. ▪ Facilitate the collection of clinical, member satisfaction, and access data; analyze the data and identify and prioritize opportunities for improvement. ▪ Serve as a quality resource for various Providers and Plans units and participating Health Plans. Facilitate coordination, communication, and collaboration among these various entities with respect to PCPR quality. 	TBD	Minimum: (A) five years of full-time/part-time professional, administrative, supervisory or managerial experience; (B) at least four years in supervisory or managerial capacity; (C) any equivalent combination of required experiences and substitutions	TBD	Recruitment in process

Additional positions filled:

Encounter data analyst, started July 15, 2013

Quantitative analyst, started June 9, 2013

Financial analyst, anticipated start September 1, 2013

Additional positions to be filled:

Technical Assistance Project Manager

PCPR Project Manager

PCPR Assistant Project Manager

Learning Collaboratives Project Manager and MassHealth Representative

Key Personnel/Participants

Name	Organization	SIM Role	Key Responsibilities	Email
Manu Tandon	EOHHS IT	Secretariat Chief Information Officer	<ul style="list-style-type: none"> Oversee all SIM IT implementation activities and ensure coordination with other IT initiatives in the Commonwealth 	Manu.Tandon@state.ma.us
Eric Hilman	EOHHS IT	Project Manager	<ul style="list-style-type: none"> Define project requirements with key stakeholders Coordinate project activities for adherence to project plan and goals Develop detailed project plans, work breakdown structures, project checklists, and budgets to meet established time frames, funding limitations and staffing availability Monitor results against established timeframes, deliverables, tasks, dependencies, and associated business and technical requirements and specifications Prepare procurement documents as required Prepare and deliver presentations and other communications to audiences internal and external to state government Coordinate with groups in state government and in quasi state agencies to align programs to achieve objectives of stated subprojects within the SIM grant program Analyze financial situation and prepare/present reports as needed 	Eric.Hilman@state.ma.us

Group Insurance Commission (GIC)

Key Personnel/Participants				
Name	Organization	SIM Role	Key Responsibilities	Email
Catharine Hornby	GIC	Deputy Director	<ul style="list-style-type: none"> • Participation and oversight of development activities for the SIM Grant, attending all meetings at which project scope, budget and personnel allocation are discussed/determined. • Review consultant proposals; assist in review and amendments to same and negotiate final terms and conditions of contractual obligations of consultant. • Support the Director of Policy & Program Management on any strategic issues requiring further definition during the administration of this grant. • Provide legal guidance and advice during the payer contracting phase to the GIC's Lead Counsel. • Attend monthly IRBO Workgroup meetings and any other meetings related to this Grant; where necessary, function as legal advisor to the GIC with regard to the agency's role and duties under the terms of the Grant. • Interact with EOHHS to assure the GIC's responsibilities and deadlines are understood and fulfilled. • Accountable to the Executive Director and has relational accountability to the Grant Director of EOHHS 	Catharine.Hornby@state.ma.us

Kathy Glynn	GIC	Director of the Policy & Program Management Department	<ul style="list-style-type: none"> • Communication and coordination with appropriate staff on all matters of import and relevance to the Value-Based Purchasing Initiative. • Liaison with EOHHS on day-to-day matters, assuring that deadlines are met and obligations under contract are fulfilled. • Support the Legal Department in the payer contracting phase, to assure that obligations under the IRBO development and the GIC's value-based health reform strategies are incorporated. • Work with the Deputy Director in review of consultant proposals; make recommendation as to best course of action on the two studies funded under this Grant. • Research ACO marketplace for key (potential) partners under the Grant. • Maintain routine communication with consultant (Mercer) via weekly phone conferences to review task list and discuss any outstanding items requiring resolution. • Communicate with payers, keeping them informed of any and all issues that impact their development of IRBO/ACO contracts. • Coordinate IRBO Workgroup activities; identify key issues coming out of monthly meetings and supervise follow-up. • Work with Consultant/s/ on a detailed workplan for each of the two studies funded under the Grant; review with the Deputy Director and Executive Director; accountable to the Deputy Director 	Kathy.Glynn@state.ma.us
Catherine Moore	GIC	Budget Director	<ul style="list-style-type: none"> • Management of budget negotiations between the GIC and its health plans during re-procurement activity. • Assessment of IRBO/ACO Development Milestones and Financial Target Measurement proposals developed by the GIC's consultant; offer recommendations and support negotiated changes/amendments to same. • Jointly with the Director of Policy & Program Management, develop IRBO/ACO financial tracking guidelines and reporting requirements to assure objective measures of success are in place and acceptable to payers. • As needed, provide assistance in the development, review and ongoing assessment of the annual Efficiency Analysis, specifically with respect to the use of CPII methodology and data. • Support the Initiatives under the SIM Grant through the provision of any budgetary data or required program financial analysis. 	Catherine.Moore@state.ma.us

Massachusetts has identified and contracted with numerous entities to help carry out SIM activities:

Key Contractors		
Name	SIM Role	State Supervisor
University of Massachusetts Medical School	UMass will be implementing a lightweight application facilitating the exchange of de-identified section Q referrals from 400 statewide nursing facilities (SNFs) to its designated ASAP Information & Referral (I&R) teams. The referral triggers the ASAP to contact the SNF to learn the resident's identity. Data regarding post-referral transition activities will be recorded using standing SIMS protocols, by ASAPs. The referral system will reduce the time to resident's first contact with transition staff and improve measurability of this quality element. At this phase, referrals will not pass through the HIE.	Joan O'Rourke, EOE
Eliassen Group	Eliassen Group will act as Business Analyst (BA) and be responsible for creation of a project vision, requirements, use case, architecture, risk analysis, and environment plan per EOHHS standards. The BA is also responsible for test plan creation and implementation and is expected to participate in all unit and integration testing of the developed code and application.	Lisa Vallier, Director of the Application Development Team at EOHHS

Harmony Information Systems, Inc	<p>Harmony will be implementing configuration and integration software enhancements to the core Senior Information Management System (SIMS) for three of four ELD SIM-grant projects.</p> <p>(1) Physician Portal will allow third party entities; caregivers, providers and physicians the ability to view predefined elements of a consumer's record via access to a secure portal. A later phase will enable bi-directional information exchange between ASAPs and medical professionals, integrating these data exchanges with the HIE. Once this functionality is completed ELD will have the capability to integrate with the HIE system and will use this to improve care coordination and consumer outcomes across the HCBS and LTSS network.</p> <p>(2) Consumer Connect, a portal enabling caregivers/ consumers in the state or FEW home care program a read-only view of selected consumer data elements in SIMS, as maintained by Case Manager. Access to this information will enhance caregiver participation in the care planning and service delivery process for home care consumers.</p> <p>(3) AFC/ GAFC Determination Streamline. Harmony will enhance SIMS to standardize and optimize clinical assessment & determination processes for Adult Foster Care/ Group Adult Foster Care (G/AFC) programs, with the goal to reduce time-to-determination for providers. Harmony's enhancements will enable data exchange of Minimum Data Set-Home Care (MDS-HC) and other application materials from existing third-party systems in use by G/AFC providers.</p>	<p>Joan O'Rourke, EOE A</p>
Hewlett Packard (HP)	<p>HP will be implementing changes to the MMIS system to implement the payment rules of the PCPR program including issuing per member per month payments, accepting all claims and only paying those for services not covered by the per member per month fee. In addition all necessary reporting will be implemented. Beginning in April further requirement gathering and analysis will be performed to define the scope of a second release of functionality to support the PCPR and SIM program.</p> <p>HP will also be implementing the changes to MMIS to accept quality data and to utilize it as part of payment processing as well as in quality improvement initiatives. The initial phase of this work will be to conduct JAD (joint application design) sessions to define specific requirements.</p>	<p>MassHealth</p>

McInnis Consulting	McInnis Consulting will act as Systems Architect (SA), Application Developer (AD), and Project Manager (PM). The SA will be responsible for creation of an e-Referral system based on the provided EOHHS standard documentation. The SA is also responsible for being available for business analysis meetings and on-going operational support of the product with the rest of the EOHHS IT Project Management team (project manager and business analyst). The AD is responsible for developing application code based on the provided set of documentation including, but not limited to, the system architecture document, the use case document and the security workbook. The AD will work directly with both the business analyst and the project manager to fully understand the high-level scope of the project and the specific user level functionality required as per the project management standardized documentation. The developer is responsible for writing code that adheres to the most recent ADA standards and is fully vulnerability tested. The developer will perform unit testing prior to release of the code to the quality assurance team. The developer will report directly to the project manager. The PM would be responsible for the overall success of the project. The PM will handle escalation of issues from team members, scheduling JAD session, status meetings and working sessions. The PM is responsible for keeping the business apprised of the project's health throughout the unified process lifecycle from inception to transition. He/she is the point person for any changes to scope or timeline and is responsible for updating the project budget as needed.	Lisa Vallier, Director of the Application Development Team at EOHHS will manage the contract.
Mercer Health and Benefits LLC	Mercer is responsible for: (1) developing rates for the Comprehensive Primary Care Payment in MassHealth's Primary Care Payment Reform Initiative; (2) incorporating risk adjustment software into the rate setting process; (3) calculating shared savings benchmarks and validating the shared savings methodology; (4) generating databooks for potential participants in MassHealth's Primary Care Payment Reform Initiative.	Neha Sahni is in charge of supervising this particular item of work David Garbarino, Director of Purchasing Strategy, is responsible for monitoring the overall contract.
Verisk Health Inc.	Verisk is responsible for customizing and calibrating their Primary Care Activity Level (PCAL) risk adjustment model to MassHealth specifications to appropriately match the services in the Comprehensive Primary Care Payment of the Primary Care Payment Reform Initiative.	Neha Sahni, Director of PCPR

Additional contractors will be procured to help support SIM activities based on the workplan included as Attachment F.

L. WORKFORCE CAPACITY MONITORING

The Commonwealth recognizes that the shift to alternative payment methodologies may place new demands on the health care workforce. Chapter 224, as well as current trends and policies in Massachusetts, drives toward an increase in arrangements such as accountable care organizations and patient-centered medical homes. Chapter 224 included several provisions that will help the Commonwealth meet its healthcare workforce needs. We focus here on two initiatives: funds in Chapter 224 to support workforce needs in the context of health reform, and the Special Commission on Graduate Medical Education.

The Health Care Workforce Transformation Fund is administered by the Secretary of the Executive Office of Labor and Workforce Development (EOLWD) in consultation with the Health Care Workforce Advisory Board. The goal of the Fund is to ensure that Massachusetts is appropriately investing in a highly skilled workforce that is equipped to provide high-quality, cost-effective care. The Fund has received \$20 million, of which \$4 million is directed to the Department of Public Health to support the Primary Care Residency Grant Program, the Health Care Workforce Loan Repayment Program, and a primary care workforce development and loan forgiveness grant program at community health centers.

Specific aims of the Health Care Workforce Transformation Fund include:

- Supporting the development and implementation of programs to enhance health care worker retention rates;
- Addressing critical health care workforce shortages;
- Improving employment in the health care industry for low-income individuals and low-wage workers;
- Providing training, educational or career ladder services for currently employed or unemployed health care workers;
- Providing training or educational services for health care workers in emerging fields of care delivery models; and
- Funding rural health rotation programs, clerkships and health preceptorships at medical and nursing schools.

In January 2013, the Health Care Transformation Fund Advisory Board held two listening sessions to provide a forum for public comment. These listening sessions were attended by 92 individuals from the health care industry, educational institutions and workforce organizations, and a total of 36 recommendations were

suggested, spanning the topics of workforce needs, training needs and requirements for soliciting proposals and awarding funds. The first application period was announced and applications are now being accepted.

In addition to the Health Care Workforce Transformation Fund, Chapter 224 also created the Special Commission on Graduate Medical Education (GME), a 13-member commission “to examine the economic, social and educational value of graduate medical education in the commonwealth and to recommend a fair and sustainable model for the future funding of graduate medical education in the commonwealth.” Among other responsibilities, the Commission is tasked with reviewing the relationship of GME to the state’s physician workforce and care delivery system, and the impact of payment and delivery system transformation on health care workforce needs. In addition, the Special Commission is charged with releasing a report with its recommendations by the end of this summer. The Commission has reviewed current estimates of projected workforce needs. These estimates range from a shortage of 7,000 primary care physicians (PCPs) in 2020 to a 45,000 PCP shortage in 2020.² Both of these models assume that the number of physicians required to care for a population is fixed.

However, the advent of new models of care, notably Patient-Centered Medical Homes (PCMHs) and Nurse Managed Health Centers (NMHCs), could change this key assumption. Dr. Mark Friedberg and Dr. David Auerbach from the RAND Corporation were invited to present to the Commission on the projected impact of new models of care on health care workforce needs. In terms of demand, changes in assumptions about the prevalence of PCMH and NMHC, as well as about the panel size with these new models of care, change results about whether there will be a shortage or surplus of certain provider types. Overall, estimates are very sensitive to changes in primary care delivery models and standard projections do not take these changing models of primary care delivery into account. Growth of PCMH and NMHC models would further affect the projected provider imbalances.

² Kirch, DG, Henderson MK, Dill MJ. Physician Workforce Projections in an Era of Reform. *Annu Rev Med.* 2012;63:435-445; The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. December 2008. Available at: <http://bhpr.hrsa.gov/healthworkforce/reports/physwfissues.pdf>. Accessed on: July 3, 2013.

Like the Special Commission on Graduate Medical Education, the Health Care Workforce Center in the Massachusetts Department of Public Health is also focusing on workforce capacity monitoring. More specifically, the Health Care Workforce Center monitors trends in access to health care providers and identifies solutions to address health care workforce shortages. The Center undertakes a range of activities related to Graduate Medical Education such as health professions data series collection, the Massachusetts loan repayment program, and research on health workforce recruitment and retention in high need areas. The health professions data series, in particular, is unique in that it provides systematic and consistent health professions data. The data series characterizes the workforce from a supply perspective and enhances the ability to identify trends and patterns in the workforce that may impact access to health care professionals and the services they provide. To date, data is being collected from various disciplines including physicians, nurse practitioners, physician assistants, pharmacists, dentists, dental hygienists, and licensed practical nurses.

M. CARE TRANSFORMATION PLANS

Support for providers is critical to the success of the model. To this end, MassHealth is establishing a provider-oriented learning collaborative, in partnership with Commonwealth Medicine, a branch of the University of Massachusetts Medical School. MassHealth and Commonwealth Medicine have substantial experience in managing provider-oriented learning collaboratives through the PCMHI, which has involved over three years of provider training and support. The Commonwealth will evolve the PCMHI learning collaboratives to expand to the additional practices that participate in PCPR, and will focus on the key elements of patient-centered medical home models, including care management for high risk members, primary care and behavioral health integration, and continuous quality improvement. The learning collaboratives will combine learning sessions by MassHealth and expert staff on particular topics and peer-to-peer learning amongst providers. The mechanism for the learning collaborative will include in-person meetings, webinars, and online tools available to providers.

The state will cooperatively work with other learning communities in the state, including the Regional Extension Center (REC) for Health Information Technology, the Qualis Health medical home community, the Massachusetts League of Community Health Centers, and others. Interaction with other learning collaboratives may include representatives from those communities presenting at PCPR sessions, MassHealth staff presenting at those sessions, joint design of learning material, joint learning sessions, sharing of tools and resources, or other mechanisms.

The content of the curriculum will largely be focused around the clinical delivery model requirements of the model we are testing, with a focus on the elements of the Primary Care Payment Reform delivery model. These include NCQA certification as a patient-centered medical home, hiring and deploying care managers in the practice to manage high cost members, forming written agreements with behavioral health providers to ensure appropriate protocols for primary care – behavioral health integration, measuring and improving performance on quality metrics, and other medical-home focused capabilities. We look forward to working with providers to determine their priorities as well.

EOHHS will also be setting up a payer-oriented learning collaborative, to foster better alignment with commercial payers in transitioning to the model. These meetings will focus on harmonizing quality measures, simplifying administrative procedures for providers, supporting the All Payer Claims Database (APCD) as a mechanism for sharing data with providers, expanding use of the Health Information Exchange (HIE) as a platform for supporting the model, and other areas. We will bring in provider feedback as appropriate, but the focus will be on promoting coordination across payers. We look forward to working with Medicare as a partner in this model as well.

N. SUSTAINABILITY PLANS

The Massachusetts model will leverage one-time-only grant funds to make investments that catalyze or accelerate transformation to an alternative delivery and payment system that is self-sustaining.

There is extensive evidence to suggest that the delivery model, payment framework and operational structure of the model can improve quality and lower cost for Massachusetts residents. Specific components of the model also have been shown to reduce costs while enhancing quality. Therefore, Massachusetts surmises that this model will not only be self-sustaining for years to come, but also reduce costs. The savings accrued from reduction of health care costs can be reinvested into the system to further improve care delivery.

Massachusetts has also demonstrated its commitment to support payment and delivery system transformation. The Commonwealth is providing funding for many health reform activities through a one-time \$225 million assessment on payers and providers, as well as additional state funds through the Health Care Payment Reform fund to support the Health Policy Commission and an Innovation Investment grant program.

1. Evidence Base for the Delivery Model

Studies related to the delivery model indicate that a strong primary care base can improve quality, reduce cost, and reduce disparities in care, especially when delivered through a PCMH. Regular primary care provider utilization is associated with improved satisfaction, better compliance, fewer emergency department (ED) visits and hospitalizations, and improved morbidity and mortality results.³ Increased availability of primary care physicians is linked to decreased admissions, ED visits, and surgeries.⁴ Evaluation of the PCMH delivery model is in the early stages, but initial results across the country suggest that PCMH have real potential to significantly lower costs associated with care, and improve quality and improve the patient experience. There are indications that PCMH may lead to decreases in hospital utilization and emergency room utilization which in turn lead to significant cost savings.

³ Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv.* 2007;37(1):111-126.

⁴ Kravet SJ, Shore AD, Miller R, Green GB, Kolodner K, Wright SM. Health care utilization and the proportion of primary care physicians. *Am J Med.* 2008;121(2):142-148.

For example, from 2004-2009 HealthPartners in Minnesota found a 39% decrease in ER visits, 24% fewer hospital admissions, reduced appointment wait time by 350% from 26 days to 1 day⁵ and a reduction of outpatients costs by \$1,282 in patients using 11 or more medications.⁶ North Carolina's Community Care model was estimated to save \$382 million⁷ while lowering ED utilizations and outpatient costs by 23% and 25% respectively.⁸ In addition, the Community Care model was estimated to save \$200 million for Medicaid beneficiaries, with significant reductions in hospital utilization for chronic conditions.⁹ Geisinger's medical home model yielded 4-7% savings over three years and 25% lower hospital admissions,¹⁰ and Washington University's site experienced a 12% reduction in hospitalizations and savings of \$217 per enrollee by using medical home tools.¹¹ A Medicaid PCMH in New York accrued cost savings of 11% overall in the first nine months and reduced hospital spending by 27% and ER spending by 35%.¹² Medical homes also improve chronic disease management and adherence to regular screening guidelines, narrow racial disparities in health outcomes¹³ and improve care processes for preventative services¹⁴ which may translate to additional savings.

The importance of promoting behavioral health integration with primary care is well documented as well. The National Institute of Mental Health estimates that in a given year, 26% of the US adult population has a mental health disorder.¹⁵ An estimated 70% of primary care visits stem from psychosocial issues.¹⁶

⁵ HealthPartners. (2009). HealthPartners BestCare: How to Deliver \$2 Trillion in Medicare Cost Savings, and Improve Care in the Process. Retrieved July 2, 2013, from HealthPartners: <http://www.healthpartners.com/files/47979.pdf>

⁶ Flottemesch T, Fontaine P, Asche S, Solberg L. *Relationship of Clinic Medical Home Scores to Health Care Costs*. J Ambul Care Manage. 2011;34(1):78-79.

⁷ Mahoney P. (2011, December 21). Our Results: Making headway on cost and quality. Retrieved July 2, 2013, from Community Care of North Carolina: <http://www.communitycarenc.com/our-results/>

⁸ Steiner BD, Denham AC, Ashkin E, Newton WP, Wroth T, Dobson LA. Community Care of North Carolina: Improving Care Through Community Health Networks. Ann Fam Med. 2008;6(4):361-367.

⁹ Wilhide S, Henderson T. Community care of North Carolina: A provider-led strategy for delivering cost-effective primary care to Medicaid beneficiaries. American Academy of Family Physicians. June 2006.

¹⁰ Maeng DD, Graham J, Graf TR, Liberman JN, Dermes NB, Tomcavage J, David DE, Bloom FJ, Steele GD. Reducing the long-term cost by transforming primary care: Evidence from Geisinger's medical home model. Am J Manag Care. 2012;18(3):149-155.

¹¹ Peikes D, Peterson G, Brown RS, Graff S, Lynch JP. How changes in Washington University's Medicare Coordinated Care Demonstration Pilot ultimately achieved savings. Health Aff (Millwood). 2012;31(6):1216-1226.

¹² Chemung County Government. (2011, April 18). Medicaid Medical Home Realizing Positive Results in First Year. Retrieved June 2, 2012 from Chemung County News: <http://www.chemungcounty.com/index.asp?pageid=105&nid=650>

¹³ Beal AC, Doty MM, Hernandez SE, Shea KK, Davis K. 2007. Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund.

¹⁴ Jackson GL, Powers BJ, Chatterjee R, Bettger JP, Kemper AR, Hasselblad V, Dolor RJ, Irvine J, Heidenfelder BL, Kendrick AS, Gray R, Williams JW. The patient-centered medical home: A systematic review. 2013;158(3):169-178.

¹⁵ Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Arch Gen Psychiatry. 2005;(6):617-27.

Behavioral health costs are also a significant driver of medical expenses, as annual medical expenses for patients with both chronic medical and behavioral health conditions are 46% more than those for patients who have chronic medical conditions only.¹⁷ Studies have shown an increase of at least 50% in access to mental health care if offered in primary care settings and in an integrated fashion.¹⁸ The Improving Massachusetts Post-Acute Care Transfers (IMPACT) model, which provided primary-care based care management for patients with depression, found significant improvements in quality and long-term associated cost savings.¹⁹

2. Evidence Base for the Payment Framework

The FFS payment model has the potential to impede high-quality comprehensive primary care practice, because FFS compensates providers based on the financial value of the care they deliver, leading to weak financial incentives for careful diagnosis and management, which are typically the responsibility of primary care, and strong financial incentives for specialty care, including care of uncertain value. Evidence suggests that shared savings and shared risk models with quality incentives can address these poor incentives and improve quality and cost outcomes. For example, the AQC includes a global budget approach with quality gates and a quality incentive payment. Significant improvements in quality have been shown and were accelerated in the second year. Spending growth also slowed compared to comparison groups (1.9% savings in the first year, 3.3% in the second, measured in per-member per-year terms). Savings were greater for providers who had no prior experience in risk contracts, with 6.3% and 9.9% savings in the first and second year respectively.²⁰ All ten of the Medicare Physician Group Practice (PGP) demonstration's sites displayed

¹⁶ Fries JF, Koop CE, Beadle CE, Cooper PP, England MJ, Greaves RF, Sokolov JJ, Wright D, the Health Project Consortium. Reducing health care costs by reducing the need and demand for medical services. *N Eng J Med*.1993;329(5):321-325.

¹⁷ Petterson SM, Phillips RL Jr, Bazemore AW, Dadoo MS, Zhang X, Green LA. Why there must be room for mental health in the medical home. *Am Fam Physician*. 2008;77(6):757.

¹⁸ Bartels SJ, Coakley EH, Zubritsky C, Ware JH, Miles KM, Areán PA, Chen H, Oslin DW, Llorente MD, Costantino G, Quijano L, McIntyre JS, Linkins KW, Oxman TE, Maxwell J, Levkoff SE, PRISM-E Investigators. Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry*. 2004; 161(8):1455–1462.

¹⁹ Unützer J, Katon WJ, Fan MY, et al. Long-term cost effects of collaborative care for late-life depression. *Am J Manag Care* 2008;14(2):95-100.

²⁰ Zirui Song, Dana Gelb Safran, Bruce E. Landon, Mary Beth Landrum, Yulei He, Robert E. Mechanic, Matthew P. Day and Michael E.

significant improvements in the quality metrics, with all ten groups achieving benchmark performance on 30 of the 32 measures by the end of the five year program. The number of groups earning shared savings bonuses increased over time, with two practices gaining a bonus in the first year, four in the second year, and five in the third year.²¹

3. Evidence Base for the Operational Structure

The theory of action, outlined below, is based on the experience of payers nationally and within the state implementing shared savings models in the context of a medical home.

Table 3: Theory of Action

Input	Intervention	Actions	Results
<ul style="list-style-type: none"> ▪ Incentives for providers to redesign practices to take accountability for cost and quality of care ▪ Provision of timely, accurate data through a statewide IT infrastructure ▪ Connections to public health and community resources ▪ Statewide quality strategy ▪ Learning collaboratives and technical assistance 	<ul style="list-style-type: none"> ▪ Practices are redesigned. Providers coordinate care across settings and provide care management; connect and manage relationships with other resources; use enhanced data; provide patient-centered care; promote integration of behavioral health services and techniques 	<ul style="list-style-type: none"> ▪ Providers and patients reduce inappropriate underutilization and overutilization of services ▪ Patients receive care in appropriate settings (e.g., in primary care office instead of ED) ▪ Patient behavior is promoted through patient-centered care and use of behavioral health techniques 	<ul style="list-style-type: none"> ▪ Improved patient outcomes and quality of care ▪ Improved efficiency and lower costs for practices

While this operational framework has not been evaluated as a whole, the various components of a united data strategy, statewide quality strategy, integration of public health and community resources with primary care, and learning and collaboration have significant evidence bases to support the approach the

Chernew. The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending And Improved Quality. Health Aff July 2012 10.1377/hlthaff.2012.0327.

²¹ Medicare Physician Group Practice Demonstration. (August 2008), available at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf.

state has recommended. In addition, for each of the specific projects, the Commonwealth has identified a sustainability pathway and evidence-base.

4. Evidence Base and Sustainability Mechanisms for Specific Components of the Model

Investment Area 1: Supporting Public Payers in Transitioning to the Model

i. MassHealth's Primary Care Payment Reform

The purpose of the PCPR Initiative is to support primary care delivery transformation by giving primary care providers greater flexibility and resources to deliver care in the best way for their patients. This initiative will be available to providers who are in MassHealth's managed care networks, including the PCC Plan and MCOs. MassHealth anticipates supporting these PCPR Initiative participants by providing timely data, targeted technical assistance, and some sub-grant funding to support care coordination, cost management, and other innovations consistent with the proposed model. The proposed MassHealth PCPR model is designed to support primary care delivery through practices that are consistent with a PCMH with integrated behavioral health services.

Payments would be calculated pursuant to three distinct payment methodologies: first, a CPCP, a risk-adjusted per-member-per-month payment for a defined set of primary care and behavioral health services; second, a quality incentive payment; and third, a shared savings/risk payment. MassHealth would continue to pay FFS for non-primary care services, but the shared savings payment is an incentive to coordinate those services as well. Participants would not be responsible for paying claims for non-primary care services.

The CPCP would give practices added flexibility to provide the right kind of care at the right time and in the right setting. This payment model may support expanding the care team, offering phone and email consultations, allowing group appointments, targeting appointment length to patient complexity, leveraging community health workers, etc., while allowing a range of primary care practice types and sizes to participate and to operationalize behavioral health integration.

The purpose of the shared savings/risk payment is to reward participants for improving the efficiency of care provided to patients in the context of improved quality. Participants must meet defined quality standards to be eligible for shared savings payments.

Sustainability: Most costs, including consulting and actuarial support, paying for quality metric reporting, upgrading IT systems, and providing technical assistance are one-time expenses associated with helping MassHealth and providers transition into this program. Ongoing staff costs will be covered to the extent required after the demonstration phase by the state.

Evidence base: Comprehensive payments for primary care have been supported by a number of health policy experts.²² When tested in commercial settings, this approach has generated promising results. For example, the Qliance Medical Group in Seattle operates on a per member per month payment for primary care services delivered in a medical home model, and has seen 11% cost reductions, 62% reductions in emergency department visits, and 26% reductions in hospital days.²³ A similar approach is being piloted in the Capitol District Physicians Health Plan with 13,000 commercial lives, with an evaluation in process.²⁴

ii. Group Insurance Commission

The Massachusetts Group Insurance Commission (GIC) manages health plans for state and certain municipal employees and retirees, with approximately 400,000 covered lives. In the fall of 2012, the GIC began re-procuring all of its health plans for the five year period beginning July 1, 2013 to encourage the implementation of alternative payment methodologies aligned with the proposed multi-payer model and consistent with Chapter 224.

²² A. H. Goroll, R. A. Berenson, S. C. Schoenbaum, et al, Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, *Journal of General Internal Medicine*, March 2007 22(3)410-15.

²³ Bruce Japsen. "More Care Up Front for \$54 a Month". *New York Times*. May 21, 2012. <http://www.nytimes.com/2012/05/22/health/directprimary-care-providers-extend-concierge-services.html?pagewanted=all>; Jane Anderson. "Direct Primary Care Practice Model Eyed to Trim Health Care Spending". *Internal Medicine News*, October 14, 2010. [http://www.internalmedicine.com/index.php?id=2049&type=98&tx_ttnews\[tt_news\]=17683&cHash=da03e20e36](http://www.internalmedicine.com/index.php?id=2049&type=98&tx_ttnews[tt_news]=17683&cHash=da03e20e36).

²⁴ Ash AS, Ellis RP. Risk-adjusted Payment and Performance Assessment for Primary Care. *Medical Care*. 2012;50(8):643–653.

Sustainability: The funds requested are supplemental to regular expenses of the GIC and of the health plans. Once the initial transformation is underway, the GIC and the plans have sufficient resources to continue the transformation.

Investment Area 2: Data Infrastructure

i. Leveraging the All-Payer Claims Database

All-payer reports could help providers better manage their patient panel and ensure that patients are receiving effective, efficient, high-quality, coordinated care. Existing tools for patient panel management are fragmented by payer, leaving physicians with incomplete data around areas for improved care within their panel. We propose creating a portal so that large and small provider groups can access data and/or reports for patients attributed to them, thereby creating “all payer” reports for their practices. The budget also includes resources for CHIA to analyze how providers are using the portal, data, and reports, and refine products accordingly.

Sustainability: Ongoing supports for the provider portal to the APCD are expected to be lower than set-up costs. These costs could potentially be funded through user fees.

Evidence base: Historically, payers have sent physicians “profiles” or “scorecards” based on claims data which have resulted in reductions in utilization.^{25,26} Some payers use disease registries, which also have been shown to reduce costs and improve outcomes.²⁷ Profiles and registries are typically generated from a single payer’s claims data, with the result that providers receive reports in mixed frequencies and formats. Fragmented reporting makes it difficult for providers to understand their progress in managing their patient panel as a whole.

²⁵ Balas, J. Effect of Physician Profiling on Utilization. J Gen Intern Med.1996;11(10):584-590.

²⁶ Berwick, DM. Coltin KL. Feedback Reduces Test Use in a Health Maintenance Organization. JAMA. 1986;225:1450-1454.

²⁷ Larsson S, Lawyer P, Garellick G, Lindahl B, Lundstrom M. Use of 13 Disease Registries in 13 Countries Demonstrates Potential To Use Outcome Data to Improve Health Care’s Value. Health Aff. 2012;31(1): 220-227.

ii. HIE Technical Assistance to Behavioral Health and LTSS Providers

Behavioral health providers are not eligible for Medicare and Medicaid HIT incentive payments.

Grant funding would be used to offer technical assistance with HIE adoption to behavioral health and LTSS providers involved in the PCPR program. Primary care providers and partner behavioral health providers would access the assistance in conjunction with the PCPR program. LTSS providers involved with the PCPR participants would also be eligible for assistance.

Sustainability: Technical assistance will be provided to assist providers with HIE adoption. Once this is completed, on-going funding will not be necessary.

Evidence base: The evidence supporting the importance of primary care–behavioral health integration is discussed in the section titled “Evidence Basis for the Delivery Model” of the project narrative.

Additionally, a pilot program in Missouri’s Medicaid program demonstrates that behavioral health integration relationships supported by electronic information exchange mechanisms can produce dramatic cost savings.²⁸ The Substance Abuse and Mental Health Services Administration (SAMHSA) has documented extensively the lack of EMR systems in mental health and substance abuse providers, which has hindered appropriate primary care – behavioral health integration.²⁹

iii. Data Infrastructure for LTSS

EOEA maintains a case management system for the individuals receiving their services (the Senior Information Management System – SIMS). The robust business functionality embodied in SIMS supports an efficient network of LTSS providers supporting elder home and community-based services, binding together EOEA, its regional elder care agencies (Aging Services Access Points, or ASAPs), and their sub-

²⁸ Michelle Seslar. Improved Outcomes, \$24M net savings delivered via Missouri Behavioral Health Integration. The Advisory Board on June 20, 2012. <http://www.advisory.com/Research/Technology-Insights/The-Pipeline/2012/06/Improved-outcomes-24M-net-savings-delivered-via-Missouri-behavioral-health-integration>.

²⁹ Clark HW. Strategic Initiative #6: Health Information Technology, Electronic Health Records and Behavioral Health. Substance Abuse and Mental Health Services Administration. October 1st, 2010. <http://www.samhsa.gov/about/siDocs/healthIT.pdf>.

contracted providers to record consumer information, to determine eligibility and need, and to authorize and invoice for home care services.

In this investment, a module will be added to this system to enable the system to receive and distribute information from clinical assessments, such as data from the minimum data set (MDS) and Adult Foster Care and Group Adult Foster Care assessment information. A separate module and SIMS business process will allow Skilled Nursing Facilities (SNFs) to signal to ASAP staff that they have a Section Q referral, which would be routed to ADRC Options Counselors or to MFP Transition Coordinators. Such data exchange will build operational efficiencies and increase coordination of care by enabling secure exchange of information among providers.

Sustainability: The development of these functionalities in the system infrastructure is a onetime cost and does not need further funding for sustainability. EOEA will work with providers to assure the timely and continued use of these functionalities in their system.

Investment Area 3: Statewide Quality Strategy

i. HIE Functionality for Quality Reporting

Massachusetts will upgrade the MMIS system used by MassHealth and other public payers to enable it to incorporate quality data, use that data in alternate payment systems, and export that data to statistical and analytic software. In addition, this investment includes funding for some technical assistance to providers in using the HIE for the transmission of quality data and for some stakeholder engagement to ensure that the HIE functions effectively and is used for this purpose. Quality data flowing through the HIE will be aligned with CMS' and the ONC's 33 MU standards and rely on federal standards for data format and reporting to the maximum extent possible.

Sustainability: Funds support one-time expenditures to upgrade systems and assist providers in transitioning to new systems.

ii. Statewide Quality Measurement and Reporting

Massachusetts plans to expand existing multi-payer work in the areas of measurement and improvement of patients' experiences and clinical quality to include MassHealth and Medicare. This would allow MassHealth and Medicare to be included in practice level surveys and reporting on patient experience and clinical quality.

Sustainability: Absent new funding, Medicaid and Medicare will not be included in these surveys and calculations after 2016; however, this measurement will be of particular value during the grant period because both Medicaid and Medicare will be making profound programmatic and payment changes during the period. The state may also elect to continue to fund participation after the grant period.

Evidence base: Patients with better care experiences are more engaged and adherent³⁰ and have better health outcomes^{31,32} all HEDIS measures are well-supported by evidence. All-payer information can reveal actionable system problems, such as delays in returning test results and gaps in communication that have broad quality and efficiency implications.

Investment Area 4: Integrating Primary Care With Other Services and Resources

i. Electronic Referrals to Community Resources

Massachusetts proposes to develop a public domain version of an e-Referral system that links clinical settings to a wide variety of community resources. Massachusetts proposes to develop a generalized, vendor-neutral data exchange for two-way communication between providers and community resources. The resulting software will be developed as a public domain product available to all Departments of Health. Significant technical assistance will be provided to install the system in three

³⁰ DiMatteo, MR. Enhancing patient adherence to medical recommendations. JAMA. 1994; 271: 79-83.

³¹ Greenfield S, Kaplan S, Ware JE Jr., Expanding patient involvement in care. Effects on patient outcomes. Annals of Internal Medicine. 1985;(102):520-528.

³² Stewart, MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995; 152:1423-1433.

community health centers per year for three years. More limited technical assistance will be offered to enable other sites to link themselves to same community resources.

Sustainability: Software development will be a one-time cost. The cost of providing assistance to pilot sites is a one-time cost associated with the grant. To the extent it deems necessary, the state will support technical assistance as the project is scaled.

Evidence base: The preponderance of evidence supports the effectiveness of quitlines to reduce tobacco use.³³ Having access to an easy one-click referral process can double the number of patients doctors refer to quitlines.³⁴ Related research showed that tobacco intervention systems (which included referrals to the state quitline) increased the likelihood of self-reported quitting by 40% and decreased the likelihood of primary care office visits for smoking related illnesses 35 by 4.3%.³⁵ Similar results can be cited for chronic disease self-management programs,³⁶ sustained physical activity programs,³⁷ strength training for seniors,³⁸ and the use of visiting nurses to reduce health care costs.³⁹ Yet, there is no generalized system for making referrals to these programs from clinical settings. Currently, the vast majority of community referrals throughout the United States rely on paper reports to update providers about services delivered to their referred patients.⁴⁰

ii. Access to Pediatric Behavioral Health Consultation

The Massachusetts Child Psychiatry Access Project (MCPAP) supports access to mental health services for children by providing access to telephone-based physician-to-physician consultations between

³³ Fiore, MC, et al., Treating Tobacco Use and Dependence: 2008 Update-Clinical Practice Guideline, U.S. Public Health Service, May 2008, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.

³⁴ Op. cit.

³⁵ Op. cit.

³⁶ Bodenheimer T, Lorig K, Holman H, and Grumbach K. Patient Self-management of Chronic Disease in Primary Care. JAMA. 2002;288(19):2469-2475.

³⁷ Marcus B, Bock BC, Pinto BM, Forsyth LA, Roberts MB, and Traficante RM. Efficacy of an individualized, motivationally-tailored physical activity intervention. Annals of Behavioral Medicine. 1998;20(3):174-180.

³⁸ Seguin R and Nelson ME. The benefits of strength training for older adults, American Journal of Preventive Medicine. Volume 25, Issue 3, Supplement 2, Pages 141-149, October 2003.

³⁹ Rogers J, Perlic M, Madigan EA. The effect of frontloading visits on patient outcomes. Home Healthcare Nurse. 2007;25(2):103-109.

⁴⁰ Op. cit.

a pediatrician and psychiatrist, and access to a referral network for community resources for the mental health treatment of children. By enhancing the ability of pediatricians to address children's mental health needs, this service mitigates the shortage of child psychiatrists. MCPAP has been operating in Massachusetts since 2005, supported by state funding. Pediatricians attest to the significance of MCPAP in giving them confidence to provide appropriate mental health treatment to their patients. Grant funding would be used to support enhancements to MCPAP that would allow real-time access to psychiatrists via telephone. It would also enhance MCPAP's ability to meet the substance abuse needs of adolescents.

Sustainability: Depending on outcomes, enhanced MCPAP services could potentially be supported by a combination of funds, including as part of a capitated payment arrangement.

Evidence base: The MCPAP program has been rigorously evaluated and found to be significantly effective in improving access for children in Massachusetts. Ninety-five percent (95%) of children in Massachusetts see a pediatrician who uses MCPAP services. Data indicates that pediatricians primarily consult MCPAP psychiatrists for diagnostic assistance, information about resources in the community, and medication questions. Over 90% of pediatricians agreed or strongly agreed that MCPAP consultations were useful. Perceptions of adequate access to child psychiatrists jumped from 5% to 33% over the course of the program. Additionally, the percentage of primary care providers that felt they could adequately meet the needs of children with psychiatric problems rose from 8% to 63%.⁴¹

iv: Linkages Between Primary Care Practices and LTSS Providers

In this investment, modules will be added to the SIMS system to enable new communities, including caregivers and family members (Caregiver Connect), and their primary care physicians (Physician Portal), to access key information from SIMS. EOEA will work with the current SIMS system to create and approve view-only access to relevant SIMS data to these audiences. Relevant data will be tailored to the needs of

⁴¹ Sarvet B, Gold J, Bostic JQ, Masek BJ, Prince JB, Jeffers-Terry M, Moore CF, Molbert B, Straus JH. Improving Access to Mental Health Care for Children: The Massachusetts Child Psychiatrist Access Project. *Pediatrics*. 2010;126(6):1191-1200.

each new user group. Future enhancements could include extending the view-only model to an end-to-end information sharing system, where authorized caregivers and physicians' offices could securely add information (feedback, corrections, commentary, questions) to the consumer's status and plan for long-term community care.

Sustainability: The costs of licenses are the only ongoing costs. If SIMS access is deemed valuable, then users will be willing to cover these costs after the initial grant-funded year.

Evidence Base: Several Aging Services Access Points (ASAPs) in the state have collaborated and conducted focus groups with primary-care medical practices in order to refine the dataset to be viewed by physicians. In addition, a prototype of the proposed functionality for caregivers was piloted and serves as proof-of-concept for functionality and other operational processes.

Investment Area 5: Evaluation and Dissemination

i. Learning Collaboratives

Massachusetts would expand on the existing multi-payer learning collaborative program in PCMH. The state would establish two "tracks" of learning collaboratives – payer and provider. The payer-oriented track would focus payers' efforts on aligning payment models and quality reporting standards, sharing best practices in communicating data to providers, and working together to promote delivery system transformation. The provider-oriented track would focus on diffusing and sparking the uptake of established best practices in areas such as: the medical home model, developing infrastructure, patient education and engagement, and promoting high-quality, evidence-based care.

The state will make every effort to design the learning collaboratives for maximum impact. The design for the provider track will encourage active participation. Each provider will be encouraged to set goals, test new practices, measure results, as well as share thoughts and ask questions at meetings. The design for both tracks will emphasize other evidence-based principles for the effective design of learning collaboratives such as: integrating evaluation into learning, recruiting key opinion leaders, using learning

collaborative communities to form coalitions to support change, and developing toolkits and technical support to provide practical guidance to organizations.⁴² We invite CMMI to collaborate with us on the design of the learning collaborative.

Sustainability: To the extent required after the grant period, learning collaboratives will be supported by a combination of state funds, private payer funds, and fees on participating provider organizations.

Evidence base: Evaluations of health disparities collaboratives, collaboratives undertaken a decade ago with CHCs and focused on specific clinical topics, showed significant and lasting changes in processes of care and, in some significant areas, changes in outcomes as well.^{43,44} The collaboratives also reduced racial disparities in outcomes. Furthermore, some of the barriers these collaboratives confronted—such as the lack of alignment of payment systems and limitations in data availability—are addressed by the current model. The state will also build on lessons learned from 18 months of experience with the state’s PCMH learning collaboratives, which have collected quality and cost data from participants along with practice satisfaction surveys on learning collaborative elements.

ii. Technical Assistance to Small Primary Care Practices

Massachusetts aims to include all primary care practices in delivery system transformation. While the key elements of patient-centeredness and accountability clearly pertain to practices of all sizes, specific investments and approaches may be needed for small practices to participate fully in all aspects of the model. This investment would provide technical assistance to primary care practices seeking to participate in alternative payment models, notably PCPR. This assistance might encompass consulting support, access to analytical or web-based tool, and access to experts. Technical assistance could support

⁴² Christina T. Yuan, Ingrid M. Nembhard, Amy F. Stern, John E. Brush, Jr., Harlan M. Krumholz, and Elizabeth H. Bradley. Blueprint for the Dissemination of Evidence-Based Practices in Health Care. The Commonwealth Fund, May 2010. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/May/1399_Bradley_blueprint_dissemination_evidencebased_practices_ib.pdf.

⁴³ Landon BE, Hicks LS, O’Malley AJ, et al. Improving the management of chronic disease at community health centers. *N Engl J Med*. 2007;356:921–34.

⁴⁴ Chin MH. Quality Improvement Implementation and Disparities. *Med Care* 2011 49: S65-S71.

practices in activities such as achievement of NCQA accreditation, population health management, behavioral integration, claims based analytics, and practice transformation.

Sustainability: At the end of the grant period, this technical assistance program will end. It is intended to support the transition of the market, and will not be required after the grant period.

Evidence base: Nationally, over one-third of primary care physicians practice in one or two doctor practices (state data not available).⁴⁵ These physicians may also systematically care for sicker patients, and display significantly different care patterns than larger practices.⁴⁶ Smaller practices have made up a smaller share of participants in the AQC and the Medicare ACOs to date.

O. ADMINISTRATIVE SYSTEMS AND REPORTING

1. Programmatic and Financial Oversight of the Cooperative Agreement

The EOHHS Director of Accounting is responsible for financial oversight of the cooperative agreements. The Director of Accounting meets regularly with the Acting SIM Grant Director to ensure that all programmatic and financial oversight requirements are being met. An Administrative Checklist is used to track progress on all administrative issues.

P. IMPLEMENTATION TIMELINE FOR ACHIEVING BENEFICIARY PARTICIPATION AND OTHER METRICS

The Commonwealth's SIM grant includes multiple workstreams carried out by different teams. In order to coordinate and track these multiple project workstreams, the SIM team has developed a detailed workplan for all SIM grant activities that identifies the "owner" of each action item, specific milestones, and a timeframe for milestone completion. The Commonwealth's detailed workplan showing the major projects

⁴⁵ Center for Studying Health System Change. "Proportion of Physicians in Solo / Two-Physician Practices Drops". <http://www.hschange.org/CONTENT/942/> August 16th, 2007.

⁴⁶ Jonathan D. Ketcham, Laurence C. Baker and Donna MacIsaac. Physician Practice Size And Variations In Treatments And Outcomes: Evidence From Medicare Patients With AMI. Health Aff January 2007 vol. 26 no. 1 195-205.

within the SIM initiative is included as Attachment F. To foster collaboration and develop optimal sequencing, project teams also provide verbal updates on their project status at in-person SIM team meetings. This fosters alignment in strategy and timeline across implementing agencies.

Quarterly project status reports identify key tasks and milestones that have been completed on schedule as well as tasks and milestones that are at risk. For items at risk, the Acting SIM Grant Director will work with the project lead to identify a mitigation strategy. This mitigation strategy will define specific actions to be taken to assure completion in a timeframe that does not compromise other tasks and milestones.

Q. COMMUNICATION MANAGEMENT PLAN

The Stakeholder Engagement Plan (Attachment D) encompasses internal/external stakeholder identification and definition of project communication approaches – including communication methods and timing. The objective of the communication plan is to detail who needs specific information, when they need it, and how information will be communicated. To communicate relevant programmatic and financial information, the SIM model will primarily rely on a series of standing, regularly scheduled internal and external meetings, as follows:

Internal Meetings

- i. Cross-Administration Health Reform Implementation meetings --monthly
- ii. Project team meetings – monthly
- iii. Programmatic and financial oversight team meetings – every two weeks
- iv. Presentations at Health Cluster, EOHHS Leadership, and at agency leadership meetings on an as needed basis

External Meetings

- v. Project meetings with CMS team –biweekly
- vi. Stakeholder engagement meetings – quarterly
- vii. In addition, each agency will hold their own stakeholder engagement meetings as described in the stakeholder engagement plan

Other Communication Methods

- Mass.gov website

- Listserve

R. EVALUATION PLAN

The Commonwealth has established an initial design for the SIM grant evaluation that draws upon existing processes for data collection and reporting, including many that were created as part of Chapter 224. The SIM team intends for the SIM evaluation and these other efforts to be complementary and mutually reinforcing. This synergy is particularly important, as it will ensure that the Commonwealth will be able to track continued progress after the end of the grant's evaluation period.

At a high level, the evaluation has four broad aims:

1. To assess statewide progress toward accountable care in terms of the prevalence of new care delivery and payment models and the state's overall performance on cost and quality measures.
2. To examine the impact of specific care delivery and payment models with an eye to identifying those models and design elements that are most effective.
3. To assess the progress and impact of each specific investment funded under the SIM grant.
4. To meet CMS' objectives for the SIM grant evaluation.

The Commonwealth's proposal to address the first two aims is described below, and the response to Aim 3 is described in a subsequent section. The Commonwealth looks forward to working with CMS and its contractor during the upcoming months to understand CMS' objectives (Aim 4), so that they can be built into the evaluation plan and addressed in full. It is anticipated that there will be significant overlap between Aims 1-3 and Aim 4.

1. Assessing statewide progress toward accountable care and examining the impact of specific care delivery and payment models

Aims 1 and 2 encompass a range of more specific research questions, including the following:

- What share of providers and patients are covered by new delivery models, such as patient-centered medical homes and accountable care organizations?

- What are the characteristics of these new models?
- What are the characteristics of the providers and patients that are covered?
- What share of payers and providers participate in alternate payment methods (APMs)?
- To what extent do these APMs entail per-member per-month payments, pay-for quality, shared savings (upside only or upside/downside), bundled payments, global payments, and/or global budgets?
- What are the characteristics of the payers and providers that participate in APMs?
- What determines the decision to participate?
- What are the effects of new delivery models on cost, quality, access, and patient experience?
- Are effects immediate, or do they take time?
- Are the effects more pronounced for particular models, types of provider organizations, or groups of patients?
- What are the effects of APMs on cost, quality, access, and patient experience? Do the effects correspond directly to the financial incentives created by the model?
- Are effects immediate, or do they take time?
- Are the effects more pronounced for particular models, type of provider organizations, or groups of patients?
- To what extent do new delivery models and payment systems have unintended or unexpected effects?
- What are stakeholders' perspectives on system transformation and the federal and state policies needed to support it?
- What are best practices and lessons learned?

From a research perspective, the “gold standard” for evaluation design in many respects would be to conduct a randomized experiment. However, for many reasons, such an experimental design is not practical. Therefore, we propose that the evaluation consist of a careful examination of trends in statewide measures with a comparison of trends in key outcome measures between patients affected by new delivery models or payment systems and similar patients who are covered by more traditional delivery models or payment systems.

This high-level analysis will be complemented with the analyses of specific SIM investments, discussed below. The statewide evaluation will be a mixed-method evaluation drawing upon existing and new data sources, including the following sources:

Health Policy Commission Cost Trends Report and Other Reports. Under Chapter 224, the Health Policy Commission produces an annual report that examines health care cost trends in the Commonwealth, including trends by payer, type of service, and share of costs covered by insurance/individuals. Moreover, in order to

formulate a balanced assessment of the state's progress toward affordable, high-quality care, the report also covers statewide trends in measures of quality, access, population health, and patient experience. The first annual report will be released in December 2013, with supplementary analyses to be published in the late spring of 2014. Starting in December 2014, this report will also feature focused analyses of the impact of health system change, including new delivery and payment models, on cost and quality outcomes. In preparation for the 2013 report, the HPC has engaged a contractor to analyze cost trends using data from the APCD.

Center for Health Information and Analysis Reports, All-Payer Claims Database, and Other Data. For several years, the Center for Health Information and Analysis (CHIA, formerly the Division of Health Care Finance and Policy) has prepared a series of reports on health care costs and quality including reports on premiums, total medical expenditure, and provider price variation based on data submitted by payers, as well as reports on hospital performance, health insurance coverage and access, and other topics. These reports will continue throughout the grant period and beyond.

In addition to its reports, CHIA also collects a variety of data that may be useful to the evaluation. Most importantly, the APCD offers Massachusetts a system that supports information exchange between stakeholders, and creates a key element of the evaluation's foundation. The APCD includes data from commercial payers, MassHealth, and Medicare. Data through 2011 are available at the time of this writing; data through 2012 will be released in December 2013; and data releases will be annual thereafter. Funded in part by the SIM grant, CHIA is both taking steps to enhance the analytic quality of the data (adding master patient and master provider management) and to make it more widely available. Chapter 224 broadened the guidelines for data release, and CHIA plans to create a provider portal later in the grant period.

CHIA also collects and houses other data on hospital use and insurance coverage and oversees the Statewide Quality Advisory Committee.

Cross-Payer Practice-Level Data on Quality and Patient Experience. Massachusetts Health Quality Partners has collected and published practice-level data on HEDIS quality measures, including patient experience measures. Historically, these measures have included patients with commercial insurance only. With the benefit of SIM funding, the Commonwealth hopes to provide similar data for patients with public insurance (MassHealth and Medicare) for the 2014 and 2015 data period.

Case Study of Transformation to the Statewide Model. While quantitative data on progress and outcomes are an essential component of the evaluation, Massachusetts' proposed design for the SIM evaluation also includes a qualitative case study to inform CMS' multi-state evaluation and to inform the state's ongoing transformation to accountable care. This case study would consist of document review and stakeholder interviews designed to surface motivations, consequences (intended and otherwise), key drivers of impact, best practices, and lessons learned. In addition to yielding information that is available in no other way, stakeholder interviews also offer more rapid feedback on progress and impact than other data sources.

Physicians, nurses, practice administrators, case managers, and other providers play a critical role in the success of delivery system transformation. For this stakeholder group, the proposed case study will likely include not only interviews but also either a provider survey or provider focus groups on similar topics. In this way, the evaluation will acquire more systematic data on provider perspectives.

The table below relates research topics to the likely analytic design, state-sponsored research efforts outside of SIM, and main data sources.

Table 4: Overview of the Proposed Design for the Evaluation of Statewide System Transformation

Research Question	Analytic Design	Related State Research Efforts	Data Sources
Prevalence of new delivery & payment models, including characteristics of covered practices and	Within-state before/after	HPC development of standards & payment models – conducting some background research	Administrative data compiled by HPC; APCD

patients			
Performance on cost measures	Within-state before/after	CHIA cost trend reports HPC cost trends report 2013	Payer and provider reporting compiled by CHIA; APCD
Performance on measures of quality, access and patient experience	Within-state before/after	HPC cost trends report 2013 (quality and access chapter)	Quality & patient experience measures
Impact of specific care delivery & payment models (quantitative)	Within-state cross-sectional and before/after	HPC cost trends report 2014 & special studies	Practice-level quality & patient experience measures
Provider and payer perspectives on new models		<i>To be initiated under SIM grant, pending CMS approval</i>	Expert interviews Provider focus groups and/or surveys

2. Assessing the progress and impact of specific investments

In addition to addressing Aims 1 and 2, the SIM team recognizes the importance of tracking the progress and impact of each specific investment. Evaluation activities for specific projects are described below.

Evaluation of Primary Care Payment Reform

The roll-out of Primary Care Payment Reform will require a robust evaluation effort to understand its impact and MassHealth will be conducting ongoing evaluations of all enrolled clinics. These evaluations will be based on milestones such as those in the Request for Applications but also incorporate metrics that will help MassHealth monitor the health of the program as a whole. MassHealth is in the process of procuring an analytics product that will help support this effort by providing both internal and clinic-facing analytical capabilities as well as a series of monthly reports.

Evaluations will cover a broad range of programmatic goals aligned with achieving better care, lower costs, and better health. From a program standpoint, MassHealth will be primarily assessing three categories of measures: execution of transformation and implementation plans, patient quality and safety, and the financial viability of the PCPR program on a cost-per-patient basis. Emphasis will also be placed on designing

metrics that are staged to align with the expected phases of clinical transition. Evaluation may include contract management, site visits, clinical support, and data sharing.

Evaluation of Value-Based Purchasing Strategy

During this implementation phase, the GIC completed the negotiations and contract agreements with all six of its payers and those contracts included language on the IRBO/ACO financial oversight and budget monitoring requirements and targets that will be essential to health payment reform success. The GIC will evaluate the success of these contracts by monitoring how closely each health plan adheres to specific IRBO development targets (with an associated first deadline of 9/30/13). With respect to payer coordination and communication, the GIC is evaluating the success of monthly workgroup meetings and bi-weekly phone conferences with payers by getting direct, routine feedback from those payers on the overall success of their efforts.

For both the ACO Efficiency Study and the Provider Practice Variation Study, the metrics for evaluation of success will be (a) whether action can be completed prior to the end-of-implementation deadline; and (b) ability to secure (or procure) services of an experienced consultant capable of completing the work entailed in both studies or sub-contracting with other vendors to assist with the same.

In the testing phase, the evaluation of progress for the first grant study, the ACO Efficiency Study, is partly dependent on assuring - during the preliminary discussions with a consultant and/or the documentation requirements and interviews during procurement - that the consultant has the requisite knowledge and experience with ACO development in the Massachusetts marketplace as well as Episode Treatment Group methodology, to be able to develop a credible and well-grounded quantitative study that can link to existing CPII data and efficiency measurement. This level of knowledge and experience will be important to developing a study tool for comparative analysis of ACO vs. non-ACO efficiency in the delivery of health care. The metrics that will be used to evaluate this study will be (a) completion by 1/1/14 of outreach to the CPII efficiency data aggregator and GIC's health plans; (b) the number and sufficiency of ACOs who are used as

pilot sites and non-ACOs used as the control group; and (c) how effective the study tool has proven, during the initial roll-out.

For the second grant study, the Provider Practice Variation Study, progress will be dependent upon the ability of the consultant(s) to engage the providers participating in alternative payment contracts, as well as patients, as the study parameters are being designed. It is especially important that patients from traditionally underserved populations be included early in the process, to secure their input on the fundamentals of the study approach, survey techniques and content. The metrics that will need to be used for this study's evaluation are to be determined and are dependent on the ultimate study design.

Evaluation of Leveraging the All-Payer Claims Database

Design, testing and evaluation of the model for leveraging the APCD for improved care coordination include two principal metrics: (1) number, category and percentage of practices accessing reports from the APCD provider portal; and (2) provider utilization of practice profile reports as measured by frequency of access to the APCD provider portal and reports downloaded.

Empirical measures associated with portal sustainability will be gathered through user surveys and/or engagement with participating providers to document mechanisms having the potential to lower operational costs, and to evaluate the feasibility of user fees. CHIA will verify its operating assumption that larger practices will prefer a direct connection to data with access to analytic tools while smaller practices will want analytics prepared as practice profile reports.

Impact of the use of APCD data on provider practice and effective utilization of patient information will be evaluated through correlations between cost and quality performance of practices accessing APCD information as compared with quality performance of similar practices not accessing data through the provider portal.

CHIA is responsible for gathering, maintaining and providing access to claims data through staff that possess an intimate knowledge of the APCD. Where special expertise is needed, as with configuration of the

Master Data Management, web services design, and stakeholder engagement and outreach, such tasks will be undertaken by contractors supervised by state employees.

Performance evaluation and reporting will utilize an array of methods including internal weekly reporting, self-evaluation, client response, issue tracking, operations monitoring, systems optimization, and continuous process improvement.

The aim of developing an innovative data infrastructure to deliver data across payers and providers is to enhance patient management. CHIA has produced an internal project charter for this work that specifies key deliverables, required resources and evaluation metrics, and will collaborate with EOHHS and the federal evaluator to ensure that reporting requirements are met.

Ongoing project monitoring and periodic reporting will encompass evaluation and sharing of best practices associated with reducing utilization costs and improving patient outcomes.

Evaluation of HIE Technical Assistance to Behavioral Health and LTSS Providers

EOHHS IT will track the number of behavioral health and LTSS providers who have connected to the Mass HIway, by monitoring the number of signed provider agreements and number of providers who have actually completed the technical work and are exchanging clinical transactions. In addition, EOHHS IT will communicate with behavioral health providers and their medical partners participating in Primary Care Payment Reform to track adoption and usage of electronic health records and understand the impact of usage on the care delivered. To the extent feasible and consistent with privacy concerns, usage will be tracked using the technology.

Evaluation of HIE Functionality for Quality Reporting

To evaluate implementation of the Data Repository, EOHHS IT will monitor project milestones and will also track utilization of the QDR. With respect to using the HIE for quality data, the plan is to monitor the number of providers capable of submitting quality data once the technical infrastructure is in place, and the

number of submissions that are made using this capability as compared to other means.

Evaluation of Electronic Referrals to Community Resources

As part of strategic performance monitoring, DPH will be receiving encounter-level data from the participating Community Health Centers (CHCs) from the Massachusetts League of Community Health Centers' Community Health Information Association Data Repository and Visualization Systems (CHIA DRVS). This encounter-level data will be used to evaluate process, interim, and health outcome measures.

Because DPH already has an existing infrastructure for strategic performance monitoring with the Massachusetts League of CHCs through CHIA DRVS data extracts, it will be a natural extension of the existing population health management initiative to include real-time data being received from the bi-directional e-referral system. Initially, the focus of the feedback reports will aim to increase the total number of electronic referrals. Over time, the focus of the feedback report will expand to not just count the number of referrals being made, but will explore the quality of the referral (did the patient actually participate in an intake or initial visit, how many visits did the patient have with the community resource) and finally to determine whether the referral could be associated with improvements in health and reductions in costs. This real-time performance monitoring of the bi-directional e-referral system will allow DPH to not only assess the basic use of the system, but also determine whether referrals result in the creation of effective clinical-community linkages.

In terms of evaluation, the bi-directional e-referral system, as implemented in the selected CHCs, will be evaluated on a quarterly basis by examining process measures (e.g., successful installation, number of referrals made), interim measures (e.g., number of visits to a community program, number of pounds lost, attempted smoking quits), and health outcomes (e.g., diagnoses of pre-diabetes reversed, hospitalizations avoided due to decreased heart attacks). Ultimately, a ROI for this referral system will be calculated by estimating the cost-savings for the CHCs associated with averting certain health outcomes such as cardiac-related hospitalizations.

Initially, the evaluation would focus on process measures such as successful integration of the referral system into three community health centers and four community settings (i.e., Massachusetts Tobacco Quitline, Association of Massachusetts YMCAs, local Councils on Aging, and local and regional VNAs). During the initial phase, success would be measured by the count and types of EMRs that successfully transmitted information to the universal-translator and by the count and types of community resources that are able to receive the necessary referral information via the universal translator.

After the CHCs have demonstrated being able to submit a referral electronically and receive information back into the EMR, the next stage of evaluation would be on interim measures. First, DPH will evaluate the quality of the referrals to each site. The proportion of patients who were contacted and the proportion who participated in the referral activity will be calculated. Next, DPH would look at changes in certain lab results (e.g., hemoglobin A1c), and changes in office-based measures (e.g., weight, blood pressure) that have been associated with future positive health outcomes. Reporting on interim measures and associating interim measure changes with use of the electronic referral system will aid in demonstrating the association of electronic referrals to both the health outcome measures and ROI calculations.

The final evaluation piece for the bi-directional e-referral system will be to link use of the referral system to health outcome measures and subsequent calculation of ROI. Health outcome measures will be shorter-term health measures that could be evaluated within the period of this grant, assuming successful implementation of the referral system. The cardiovascular health effects of tobacco cessation have been demonstrated within 18 months of smoking cessation and with a positive return on investment within a similar period. A preliminary list of outcome measures can be found in Table 6.

Table 5. Potential Outcome Measures

Suggested Process Measures	
# of CHCs enabled to send electronic referral	# of unique EMR platforms enabled to send electronic referrals
# of community resources enabled to receive electronic resources	# of community resources that can successfully return information about the referral
# of electronic referrals made	# of referrals that had information returned and embedded into the EMR
Suggested Interim Measures	
Proportion of referrals where patient is contacted	Proportion of referrals where patient engages in referred activity
# of visits to evidence-based program(s)	# of pounds lost since electronic referral initiated
# of attempted smoking quits	Hemoglobin A1c values
Blood pressure	Fasting LDL values
Suggested Health Outcome Measures	
Pre-diabetes diagnosis reversed	Prevented incidents of CVD
Reduction in primary care ill-visits	Prevented ED visits

Evaluation of Access to Pediatric Behavioral Health Consultation

The primary goals of the DMH/MCPAP Component of the SIM project are to: restore MCPAP Hub capacity to full-time coverage; increase utilization of MCPAP; increase pediatric primary care providers' capacity to meet the substance use needs of their pediatric patients; develop strategies for MCPAP sustainability and inclusion in primary care-behavioral health integration models; and evaluate the impact of MCPAP on primary care provider capabilities and utilization.

Through the SIM Project, DMH will build upon the encounter, utilization, and satisfaction data currently collected to include additional data points to measure progress towards these goals. Progress will be assessed at quarterly intervals using data collected by the Massachusetts Behavioral Health Partnership (MBHP), the MCPAP Hub teams, and DMH to assess Hub psychiatry coverage and response time, and primary care practice and provider-within-practice utilization. PCP substance use capabilities (knowledge, skills, and

confidence) and satisfaction with MCPAP services will be measured annually. Additionally, DMH will engage key experts in primary care-behavioral health integration to assess the feasibility of the sustainability strategy developed through the project.

The DMH-MCPAP Project Team will establish a structured process for on-going monitoring of project implementation activities. This will include regular meetings, communications, and updates among Project Team members, including consultants (e.g., Substance Abuse Consultant) and with project committees (Sustainability Steering Committee, Substance Use Steering Committee, Evaluation Steering Committee) and ad hoc advisory groups (e.g., Utilization Advisory Group). Clear expectations regarding roles, timelines and deliverables will be established. Timelines and progress towards development of deliverables will be monitored. Success of the project lies in the team's success in engaging key leaders from the public sector (e.g., EOHHS, MassHealth, DPH) and health care and behavioral health systems (including payers and providers). DMH will seek regular input from all project participants and key informants and will use this input to shape the project implementation schedule and deliverables.

Examples of key metrics that will be used to measure the success of the Project include:

1. Percentage of pediatricians in the state accessing MCPAP services.
2. Perceived improved access to child psychiatrists as reported by pediatricians
3. Percentage of MCPAP calls responded to within 15 minutes, half an hour, same-day;
4. Satisfaction surveys from pediatricians;
5. Pediatricians' perceived confidence in adequately meeting the needs of adolescents with substance abuse problems.

These metrics will be refined and expanded upon as part of the detailed evaluation plan that will be developed by the end of the SIM Project Implementation Phase (ending 9-30-13).

Evaluation of Linkages Between Primary Care Practices and LTSS Providers

The projects undertaken by EOEa include reporting provisions, as follows:

- Physician portal: 2 new standard reports have been defined and will be implemented by fall 2013: users per medical organization, and consumers per medical organization. Standard web analytics have also been installed to better understand user behavior on the portal website.
- GAFC streamline: existing reports will provide operational metrics on assessments, time-to-determine, determinations per provider, and more. The SIMS data warehouse (Harmony Advanced Reporting (HAR)) or the HCBS Explorer will provide additional data, based on AFC/GAFC applicants' clinical status, functional impairment, informal supports, and needs assessment.

Evaluation metrics for this project include process measures such as numbers of users and views, and user satisfaction and suggestions derived from qualitative interviews, SIMS Support pattern analysis derived from routine user and organization support, and focus groups.

Evaluation of Learning Collaboratives

Evaluation of learning collaboratives will include measures of provider engagement, such as percent of members attending meetings; percent of members testing new practices in response to collaborative meetings; and rating of participant experience through participant surveys.

Evaluation of Technical Assistance to Small Primary Care Practices

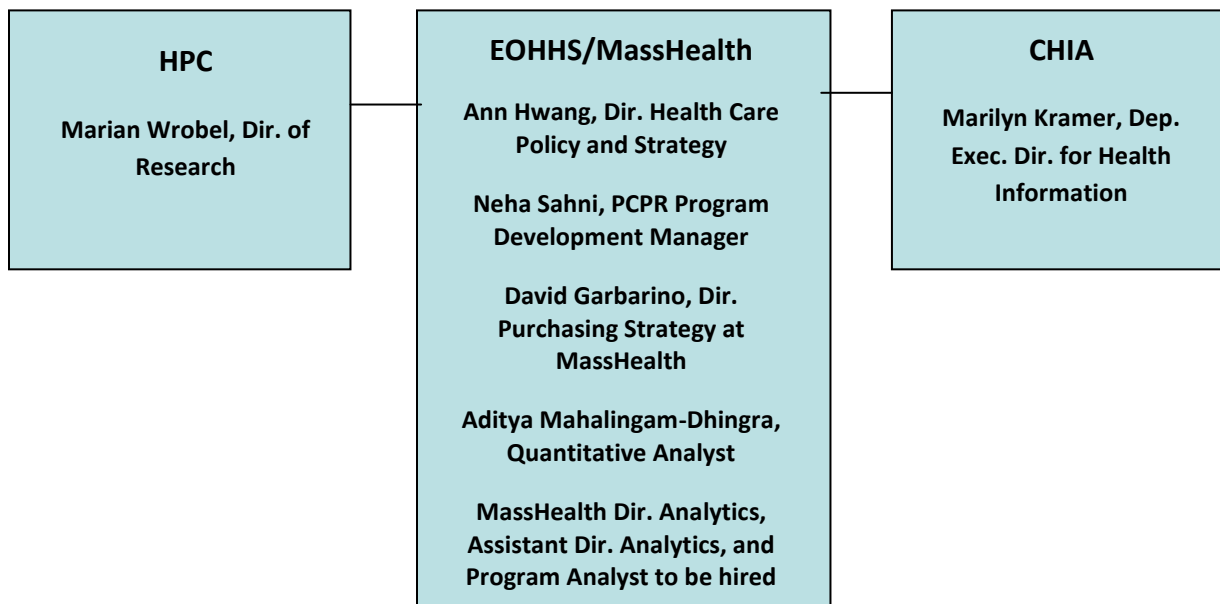
Evaluation metrics will include: satisfaction scores of small practices participating in technical assistance programs and performance of participating providers in PCPR.

4. Operational Plan for the Evaluation

The grant application had proposed that the evaluation effort be led by the MassHealth Director of Analytics, to be supported by an Assistant Director of Analytics, a Quantitative Analyst, and a Program Analyst. As the MassHealth Director of Analytics position is now vacant, the Massachusetts SIM team has developed an interim organizational structure for evaluation. Massachusetts has also been working aggressively to hire the necessary staff, including a recent hire into the Quantitative Analyst position. The interim organizational

structure leverages key analytic expertise across state agencies, and will ensure coordination of SIM evaluation efforts with other related initiatives.

Exhibit 4. Evaluation Team Structure



Key members of the state’s project staff will meet in-person with representatives of the Innovation Center and their evaluator to understand their goals for the evaluation, analytic approach, and reporting requirements. Following this meeting, the State evaluation team will refine its plan for data collection, performance reporting, and continuous quality improvement. One component of this plan will be to ensure consistency/avoid duplication between CMS’ evaluator, the state’s evaluator (to be procured), and related research efforts underway at the HPC, CHIA, and elsewhere. This plan will include a work plan that will set milestones and establish dependencies. This plan would be shared with CMS for review and input.

Once the evaluation requirements and work plan are defined, Massachusetts will solicit proposals for a contractor to conduct an in-state evaluation, using a mixed-method quasi-experimental approach. As part of the meeting with CMS described above, the state will discuss the appropriate scope for the in-state evaluation to ensure that it is appropriately coordinated with the Innovation Center evaluation and with other

work within the state, notably the HPC's work related to cost trends and examining the impact on health system change.⁴⁷

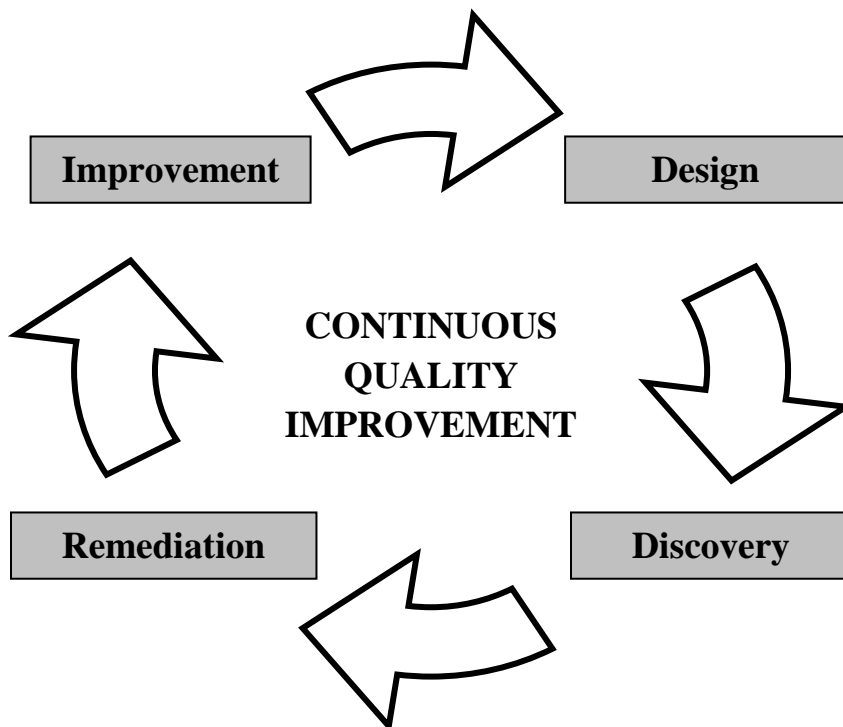
Supervised by the coordinator of the state's evaluation team, the state evaluator will produce all reports and metrics required by CMS.

Many new systems and processes will change rapidly over the SIM period, thus, it will be important to actively evaluate and review their performance and impact on quality. In the case of private payers and providers, most continuous quality improvement (QI) occurs within the organization; however, the multi-payer initiative is able to further QI by convening payers to set priorities and agree on common measures, collecting and analyzing data, and establishing forums for disseminating best practices and identifying needed systemic changes. Moreover, some types of improvement will require multi-payer action, such as regulatory and policy changes or investment in shared technology.

For the process of statewide transformation, the data collection and continuous quality improvement (CQI) plan will establish structured plans for continuous learning, adoption of best practices, and other performance improvement. Throughout the project, *discovery*, *remediation*, and *improvement* will occur via ongoing reporting and analysis and multiple statewide mechanisms, including regular reports and other dissemination mechanisms.

⁴⁷ HPC is in process of engaging a contractor to analyze cost trends in APCD. We anticipate that this work will begin in August.

Exhibit 5. Continuous Quality Improvement



S. FRAUD AND ABUSE PREVENTION, DETECTION, AND CORRECTION

Massachusetts would be interested in working with the federal government to secure waivers of certain provisions of the anti-kickback statute (42 U.S.C. section 1320a-7b(b)) and other laws that could present unintended barriers to the implementation of innovative payment and care delivery models. Interactions with HHS to date, particularly with the ATP team, have indicated that there may be impediments to facilitating access to such waivers for states. Our model has been carefully designed such that such waivers would not be necessary. However, the flexibility provided by such waivers could significantly support scaling of the model, particularly if the model advances in future years to align with ACO standards to be defined by the Health Policy Commission, which may encompass more complicated relationships between providers. We look forward to working with our provider community to define a more detailed waiver request as needed.

Within the PCPR RFA, MassHealth included the following language:

Each participant must comply with all applicable Massachusetts and federal laws and regulations, as may be amended from time to time; such compliance includes but shall not be limited to compliance with all applicable federal laws and regulations designed to prevent fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq), and the anti-kickback statute (42 U.S.C. section 1320a-7b(b)).

T. RISK MITIGATION STRATEGIES

Proactive analysis and communication are essential to risk mitigation. The Implementation Team has identified risks that may occur over the course of the project. The Massachusetts model incorporates three distinct phases to address project risk – Risk Identification, Risk Assessment and Risk Control.

- **Risk Identification** focuses on identifying initial risks and maintains a centralized repository of project risks that is continuously updated
- **Risk Assessment** establishes the context of the risk, analyzes risks, and evaluates and prioritizes each risk. Risks are evaluated in terms of both likelihood of occurrence and potential impact
- **Risk Control** selects appropriate mitigation strategies, identifies contingency plans, and monitors and updates risk status

Because the SIM initiative builds on a multi-year process of stakeholder engagement and existing market innovations, the likelihood of success of this project is high. However, we have identified several key risk areas and mitigation strategies:

Financial sustainability

The state will be leveraging one-time funds to make investments that catalyze transformation to an alternative delivery and payment system that is self-sustaining. While the state has developed an evidence-based sustainability model, the key cost and revenue assumptions will need to be regularly revisited.

Schedule risks

The SIM initiative is a multi-year, multi-stakeholder initiative and coordination is imperative to the success of the project. Therefore, development of a viable timeline and workplan that coordinates activities across agencies and builds in flexibility for anticipated delays is crucial.

Technical risks

Many projects could face technical challenges such as difficulty in developing or configuring the necessary IT components or resolving technical or regulatory hurdles.

State staffing, procurement process delays

The implementation and testing phase timelines need to allow adequate time to accommodate state staffing and procurement processes. Delays in these processes may significantly impact the outcome of the initiative.

Stakeholder engagement

Ongoing support from the stakeholder community, including providers, payers, advocacy groups, consumers, legislators, and others will be essential to the success of this model.

Variation in capacity across delivery system

Massachusetts has many provider organizations committed to transformation. However, some segments of the delivery system, such as providers in small practices, behavioral health providers and LTSS providers, may be less ready to contemplate transformation to the new model. Appropriate measures will need to be taken to engage these groups. The grant includes investments targeted at these segments, such as grants and technical assistance programs.

Information technology risks

A shared information technology infrastructure, including the statewide APCD and HIE, is a key component of this model. Specific risks related to the implementation of information technology infrastructure include the timeliness of systems improvements.

Table 6: Risk Assessment and Mitigation

Risk	Impact	Probability	Mitigation/Response
Schedule risks	High	Med	<ul style="list-style-type: none"> • Mobilize the project team quickly • Develop clear project timelines and implementation plans • Maintain open channels of communication and proactive risk assessment
Technical risks	High	Low	<ul style="list-style-type: none"> • Undertake careful planning of technical specifications
State staffing, procurement delays	High	High	<ul style="list-style-type: none"> • Regular check-ins that include program and administrative staff to troubleshoot issues
Information Technology Risks	Med	Med	<ul style="list-style-type: none"> • Careful project management to meet project milestones
Financial sustainability	Med	Med	<ul style="list-style-type: none"> • Regularly revisit key cost and revenue assumptions
Stakeholder engagement	Med	Med	<ul style="list-style-type: none"> • Conduct regular stakeholder engagement meetings • Maintain open channels of communication
Variation in capacity across delivery system	Med	Med	<ul style="list-style-type: none"> • Target interventions to high risk groups • Allow for different levels/tiers in the model to encourage participation of a range of providers

Risk Control

Throughout the testing phase, project leads will continuously and proactively monitor project areas that may be susceptible to cost, schedule, or performance deviations to minimize risks. Each team member will be responsible for identifying risks. Open communication and early risk identification are emphasized as risk mitigation strategies.