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EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID

Section 1115 Demonstration Project Amendment and Extension Request

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Executive Summary

MassHealth (Massachusetts' Medicaid and Children's Health Insurance Programs) provides health coverage to more than 1.8 million Massachusetts residents and is key to maintaining the Commonwealth's overall level of coverage at over 96 percent, the highest in the nation. At the same time, MassHealth's spending has grown unsustainably and, at more than \$15 billion, MassHealth spending is now almost 40 percent of Massachusetts' budget. While the Commonwealth has taken necessary steps to slow short-term growth in MassHealth by improving program integrity and implementing operational improvements, MassHealth must fundamentally alter its course in order to ensure the long-term sustainability of the program. MassHealth's basic structure has not changed in 20 years; a predominantly fee-for-service payment model leads to care that is often fragmented and uncoordinated. Massachusetts also faces a burgeoning opioid addiction epidemic, and continued fragmentation between primary and behavioral health care among MassHealth members. Over the past year, MassHealth has undertaken an extensive public stakeholder engagement and policy development process to devise strategies to address each of these challenges, in order to move forward with implementation.

MassHealth's 1115 demonstration provides an opportunity for Massachusetts to restructure MassHealth to emphasize value in care delivery, and better meet members' needs through more integrated and coordinated care, while moderating the cost trend.

The current demonstration is authorized through June 30, 2019, with a key portion of the demonstration – the Safety Net Care Pool (SNCP), which includes payments to providers through such programs as the Health Safety Net, Delivery System Transformation Initiatives and Infrastructure and Capacity Building grants –authorized only through June 30, 2017. If Massachusetts does not reach an agreement to restructure the Safety Net Care Pool prior to the end of June 2017, it will lose federal authorization for over a billion dollars in expenditures each year. MassHealth proposes to amend its current demonstration and to begin an early five-year extension of the entire demonstration starting July 1, 2017. This request for an amendment and five-year extension of the current demonstration will support a value-based restructuring of MassHealth's health care delivery and payment system, and includes a proposal for \$1.8 billion of Delivery System Reform Incentive Program (DSRIP) investments over five years to transition the Massachusetts delivery system into accountable care models. A new five-year extension will provide an opportunity for successful implementation far beyond what an amendment affecting only the final two years of the current demonstration agreement would allow.

The proposed demonstration extension's goals are to: (1) enact payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improve integration among physical health, behavioral health, long-term services and supports, and health-related social services; (3) maintain near-universal coverage; (4) sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals; and (5) address the opioid addiction crisis by expanding access to a broad

spectrum of recovery-oriented substance use disorder services. This proposal describes each of these goals, and the strategies to achieve them.

MassHealth's Accountable Care Approach

MassHealth is transitioning from fee-for-service, siloed care, into integrated accountable care, as providers form accountable care organizations (ACOs). ACOs are provider-led organizations that are held contractually responsible for the quality, coordination and total cost of members' care. This shift from fee-for-service to accountable, total cost of care models at the provider level is central to the demonstration extension request and to the Commonwealth's goal of a sustainable MassHealth program.

The demonstration offers providers the opportunity to form and participate in ACOs via three different model designs that encompass a range of provider capabilities.

- **Model A ACO/MCO** is an integrated partnership of a provider-led ACO with a health plan. Members will enroll in Model A ACOs, which will serve as their health plan as well as their provider network. Model A ACOs are responsible both for administrative health plan functions (such as claims payment and network development), and for coordinated care delivery for the full range of MassHealth managed care organization (MCO) covered services. Both MCOs and Model A ACOs will be paid prospective capitation rates and will bear insurance risk for enrolled members' costs of care.
- **Model B ACO** is an advanced provider-led entity that contracts directly with MassHealth and may offer Members preferred provider networks that deliver well-coordinated care and population health management although MassHealth's entire directly contracted provider network (and contracted managed behavioral health "carve-out" vendor) will be available to Model B ACO members. At the end of the performance period, MassHealth will share savings and losses with the ACO based on the total cost of care the ACO's attributed members incur.
- **Model C ACO** is a provider-led ACO that contracts directly with MassHealth MCOs. Members enroll in MCOs, and the MCO serves as their health plan and is responsible for contracting provider networks and paying providers for MCO covered services for these members. MCO members will be attributed to Model C ACOs, based on primary care relationships. At the end of each performance period, each MCO will share savings and losses with the ACO based on the total cost of care for the MCO's enrolled members who are attributed to the ACO. MassHealth will set parameters to foster alignment across payers at the ACO level, while still allowing flexibility for Model C ACOs and MCOs to negotiate many contract provisions.

These three ACO models move MassHealth providers from a primarily fee-for-service system that pays for *volume* to one that rewards *value*. ACOs are accountable and at financial risk for the total cost of members' care as well as meeting quality measures across multiple domains.

MassHealth's MCOs will be key partners in the implementation of these new models of care; ACOs are complementary to MassHealth's managed care approach. For Model A and C ACOs, the MCO will be the insurer, paying claims and working with ACO providers to improve care delivery and coordination. MCOs also have a significant role in supporting ACO providers on improving care. For example, MassHealth's upcoming MCO re-procurement will include expectations for MCOs to contract with ACOs. MCOs will be expected to help determine which care management functions are best done at the provider versus at the MCO level. In addition, MCOs will be expected to support providers in making the shift to accountable care through provision of analytics and reports for population management, and MCOs may also help ACOs determine how best to integrate behavioral health (BH) and long-term services and supports (LTSS) Community Partners (described below) into care teams.

In addition, MCOs will assume expanded responsibility for the delivery and coordination of LTSS. Following its MCO re-procurement (released in late 2016, launching in late 2017), MassHealth will transition LTSS into a set of services for which MCOs will be responsible. This expansion of MCOs' scope of responsibility will be implemented over time and modeled on MassHealth's existing One Care program (its demonstration program for dual-eligible members ages 21-64). Similar to One Care, key objectives of this integration are to improve the member experience, quality, and outcomes. MCOs will be required to adopt a person-centered approach to care, invest in community-based LTSS with an emphasis on keeping care in the community versus institutional settings, and to support independent living principles. Over time, including LTSS in the MCOs' scope of services will align financial incentives for the MCOs to leverage community-based LTSS and behavioral health services and to ensure a preventative and wellness based approach to medical services for members with disabilities and LTSS needs. Critical to the success of this model, MCOs will be required to demonstrate competencies in the independent living philosophy, Recovery Models, wellness principles, cultural competence, accessibility, and a community-first approach, consistent with the One Care model. MCOs will also be required to demonstrate compliance with the new Medicaid Managed Care regulations and to demonstrate meaningful supports and processes for providers to improve accessibility for members with disabilities, including ensuring full compliance with the Americans with Disabilities Act (ADA). An MCO must demonstrate competencies and readiness in these areas before it takes on accountability for LTSS.

To ensure that ACOs and MCOs have sufficient stability in their populations to support member-driven, person-centered care planning and services, MassHealth will implement a 12-month enrollment period for members. When a member is enrolled into an MCO or ACO, they will have 90 days to change among a managed care organization or an ACO or to enroll in the current Primary Care Clinician (PCC) Plan. After the initial 90 day period, members may disenroll only for specified reasons during the remainder of the 12-month period. Disenrollment reasons will be aligned with federal regulations. Members enrolled in the PCC Plan may choose to enroll in an MCO or ACO at any time for any reason.

Through this transition to value-based care delivery and payment, MassHealth remains committed to preserving and improving the member experience. The member experience today – especially as it

relates to coordination of care across a range of varied providers, including behavioral health and community-based providers of long-term services and supports, culturally and linguistically appropriate care, and accommodations and competency to support individuals with disabilities – varies across the state. MassHealth will set clear care delivery and contractual expectations for ACOs. In addition, MassHealth is committed to continuing robust requirements for member rights and protections. Current policies and procedures for member protections will remain in place for the PCC Plan and the MCOs, including existing appeals and grievance procedures. Members in ACO models also will have access to ACO-specific grievance processes as well as an external ombudsman resource. MassHealth will ensure that members have adequate access and choice in networks, and will continue to require that MCOs and ACOs (as appropriate according to the model type) have provider networks that comply with all applicable managed care rules.

Overall, the quality, experience, and cost of care for members will be improved through integrated, managed care options. MassHealth will encourage members to choose comprehensive, coordinated, and managed models of care, including through benefit and co-payment structures. Certain benefits will be available through an ACO or MCO but will no longer be available, or will be limited, in the PCC Plan (e.g., chiropractic services, orthotics, eye glasses, and hearing aids). In addition, differential co-pays will be structured (lower copays for members enrolled in MCO/ACO options) to encourage enrollment in more coordinated models of care.

Community Partners and integration of behavioral health, long-term services and supports and health-related social services

A major focus of MassHealth’s restructuring approach and an explicit goal of this waiver demonstration is the integration of physical health and behavioral health for individuals with a range of behavioral health needs. This includes a focus on creating a system of behavioral health treatment that improve health outcomes, experience and coordination of care across a continuum of behavioral health services, reduces health disparities, and incorporates recovery principles for children, youth, and adults with a range of mental health conditions and/or substance use disorders. A variety of strategies – including ACO approaches; the role of certified Behavioral Health Community Partners; contractual expectations for managed care plans, the Massachusetts Behavioral Health Partnership, and ACOs; and other payment model adjustments – will further this goal and will strengthen approaches already existing in the Commonwealth.

In addition, the care delivery and payment approaches outlined below improve integration of the health care delivery system with LTSS, as well as strengthening linkages to social services, to meet the holistic health care needs of members. MassHealth will define a specific approach for care delivery integration, which will be built into contractual requirements. In addition, MassHealth will actively track and monitor progress for care delivery integration over time and make disbursement of DSRIP dollars contingent on achieving specific milestones for integration.

MassHealth envisions creating the formation of care teams and strengthening their engagement with members throughout the demonstration period, specifically through:

- Formation of interdisciplinary care teams, which include a member's primary care provider (PCP), behavioral health clinician, and LTSS representative (as needed) working from one integrated care plan for the member
- Seamless, person-centered care coordination for members with complex BH, LTSS and social needs
- Inclusion of community-based BH providers with expertise across the entire care continuum of BH treatments and services, from emergency and crisis stabilization through intensive outpatient, community-based services
- Inclusion of community-based LTSS providers on the interdisciplinary care teams, which demonstrate expertise in all LTSS populations including elders, adults with physical disabilities, children with physical disabilities, members with acquired brain injury, members with intellectual or developmental disabilities, and individuals with co-occurring behavioral health and LTSS needs

MassHealth will employ a tiered approach for outlining its expectations for care delivery integration based on the complexity of the member's needs. For members with complex BH and LTSS needs, ACOs will be required to have formal relationships with BH and LTSS Community Partner organizations. These organizations will be certified by MassHealth, will have experience in serving a broad range of MassHealth members and will demonstrate expertise in care management and coordination, reducing health care disparities, and promoting member recovery, resilience, and independence. For all members, MassHealth will reference national best practices to advance wellness, prevention, recovery, and integrated care and will build these expectations and standards into the ACO procurement and contractual requirements. The standards will also require ACOs to ensure delivery of integrated care to children and youth, including coordinating with Early Intervention and Children's Behavioral Health Initiative (CBHI) services, and collaborating with providers of these services. To promote access to BH treatment, MassHealth will maintain its long-standing policy of not requiring members to get referrals for outpatient behavioral health services, allowing them to self-refer to outpatient treatment.

Reflecting the importance of addressing social determinants of health in improving the health of MassHealth members with the most complex needs, the Commonwealth proposes providing DSRIP funds to ACOs to work with social service providers to address members' health-related social needs. ACOs will receive funding designated for "flexible services" to address social determinants through the DSRIP program. Additionally, MassHealth intends to expand the Community Support Program for People Experiencing Chronic Homelessness (CSPECH) to serve chronically homeless adults in all of its managed care plans.

Delivery System Reform Incentive Program (DSRIP) Investments

Throughout an extensive public stakeholder process, MassHealth received considerable encouragement from stakeholders to adopt a program that would help providers make the transition to new delivery and payment systems. In response, MassHealth requests authority for \$1.8 billion in transitional investments over five years in the form of a Delivery System Reform Incentive Program (DSRIP).

DSRIP funding will be used to support providers in building infrastructure and care coordination capabilities for delivery system reform. Providers must adopt MassHealth's ACO model or become a BH or LTSS Community Partner in order to receive DSRIP funding, and DSRIP funding will include a clear performance accountability framework. DSRIP funds will be used for three primary purposes:

- 1) To fund ACO infrastructure and variable costs as well as defined, flexible services to allow ACOs to address the social determinants of health
- 2) To support infrastructure, capacity building and variable costs (e.g, direct costs of care coordination) for BH and LTSS Community Partners to facilitate improved integration of physical health, behavioral health, LTSS and health related social services
- 3) To fund a set of investments to more efficiently scale up statewide infrastructure necessary for reform compared to provider-specific investments (e.g., targeted health care workforce development, access to medical and diagnostic equipment for persons with disabilities, new or enhanced diversionary levels of care to address BH emergency department (ED) boarding challenges)

As part of receiving authority for \$1.8 billion in DSRIP investments, MassHealth will commit to a set of performance metrics over five years addressing total cost of care, quality, member experience, care integration, and provider adoption of value-based payment models. MassHealth will hold ACOs and Community Partners accountable for their contribution toward system restructuring through increased expectations for care delivery and participation in ACO models.

In addition, a significant portion of the DSRIP investment will be directed toward community-based providers of behavioral health care and long-term services and supports who become Community Partners. DSRIP investments for ACOs will be contingent upon an ACO partnering with BH and LTSS Community Partners. This approach – both the level of investment for community-based BH and LTSS providers and the explicit requirement for ACOs to partner with these entities – is unprecedented and is an essential part of MassHealth's commitment to investing in a robust, community-based system for BH and LTSS. Furthermore, specific DSRIP investments will be allocated to address health-related social needs.

DSRIP is a time limited investment opportunity to move the Massachusetts delivery system forward. As such, MassHealth expects that costs associated with enhanced care delivery expectations after the five-year DSRIP program will be managed within the total cost of care budget for ACOs.

Safety Net Care Pool (SNCP) Redesign

MassHealth also proposes to restructure its payments to providers under the SNCP, as required in the October 2014 waiver extension agreement with CMS. DSRIP will replace existing programs focused on delivery system reform, including Infrastructure and Capacity Building grants and the Delivery System Transformation Initiatives (DSTI) program, which currently provide incentive payments for seven hospital systems to undertake delivery system reform activities. Providers that participate in MassHealth's ACO and Community Partner (CP) programs will instead become eligible for significant

investment and transition funding through DSRIP over the five-year demonstration term. This consolidation of delivery system reform funding into DSRIP will fully align SNCP funding with MassHealth's broader accountable care strategies and expectations.

In addition to the time-limited DSRIP investment, MassHealth will continue to provide necessary and ongoing funding support to safety net providers through a new stream of Safety Net Provider payments. This approach will expand the pool of eligible providers receiving funding support under the SNCP and also restructure payments to providers that currently receive DSTI funding. This revised funding structure will clearly distinguish needed ongoing operational support for safety net providers from transitional delivery system reform funding through DSRIP. The combination of DSRIP and SNCP payments will create a gradual glide path over the five-year demonstration term to a more sustainable level of safety net provider funding. Whereas DSRIP funding will support providers in making the transition to a more sustainable care delivery and payment model, ongoing Safety Net Provider funding will ensure that Medicaid financing is sustainable for providers serving a very high proportion of MassHealth and uninsured patients.

An important feature of these restructured Safety Net Provider payments is that they will be closely aligned with MassHealth's new value-based incentive model by linking an increasing portion of the funds (up to 20 percent by year 5) to outcome measures that mirror ACO and DSRIP measures, including total cost of care, avoidable acute utilization, and quality performance. While MassHealth recognizes that safety net providers need ongoing support above and beyond what other providers receive, it is critical that the same set of expectations around care delivery and value-based performance apply to these supplemental funding streams.

MassHealth also proposes to update the structure of the SNCP to more fully recognize the Commonwealth's commitment to reimburse providers for otherwise uncompensated care delivered to Medicaid and uninsured residents. Massachusetts proposes to create an Uncompensated Care Pool for the Commonwealth's expenditures for uninsured care. Currently, the level of uncompensated care expenditures authorized within the SNCP is limited by a cap linked to the amount of Massachusetts' statutory Disproportionate Share Hospital (DSH) allotment. A separate Uncompensated Care Pool will allow federal matching funds to recognize the Commonwealth's expenditures for uninsured care beyond the amount of the DSH allotment.

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

In summary, MassHealth proposes five streams of SNCP funding totaling \$1.593 billion per year, or \$7.965 billion in the aggregate over five years:

- 1) Delivery System Reform Incentive Program (DSRIP), supporting ACOs and certified Community Partners that participate in MassHealth's new accountable care models
- 2) Public Hospital Transformation and Incentive Initiative (PHTII), providing enhanced delivery system reform support for the Commonwealth's only non-state, non-federal public hospital, Cambridge Health Alliance (CHA), as well as a Public Hospital Uninsured Global Budget Initiative supporting uninsured care at CHA
- 3) Disproportionate Share Hospital (DSH) allotment pool, supporting:
 - a) Restructured Safety Net Provider funding
 - b) Health Safety Net payments to hospitals and community health centers
 - c) Uncompensated care provided at Department of Public Health (DPH) and Department of Mental Health (DMH) hospitals
 - d) Payments to providers designated as Institutions for Mental Disease (IMDs) for otherwise unreimbursed BH care provided to MassHealth members ages 21-64
- 4) Uncompensated Care Pool (UCC), supporting care for uninsured patients through the Health Safety Net and at DPH and DMH hospitals, to the extent the Commonwealth's expenditures for uninsured care exceed (3) above
- 5) ConnectorCare premium and cost sharing affordability wraps

Section 6 includes a breakdown of anticipated funding for each of the five streams listed above. However, funding levels of individual initiatives are subject to change based on ongoing negotiations between the Commonwealth and CMS.

Expansion of Substance Use Disorder Treatment Services

A key feature of the proposed demonstration extension is to address the growing crisis related to opioid addiction. Massachusetts proposes enhanced MassHealth substance use disorder (SUD) services to promote treatment and recovery. Specifically, the demonstration seeks to: (1) incorporate certain 24-hour community-based SUD treatment services at American Society of Addiction Medicine (ASAM) Levels 3.1 and 3.3 into the MassHealth benefit; (2) expand access to 24-hour community-based services across the continuum of SUD treatment (including members dually diagnosed with SUD and mental health disorders); (3) expand access to Medication Assisted Treatment; (4) expand access to care management and other recovery-focused support; and (5) engage in SUD workforce development across the health care system.

Other Proposed Changes

Finally, Massachusetts proposes certain other changes to the demonstration to improve cost efficiency and member continuity of care. MassHealth proposes to require students to enroll in Student Health Insurance Plans when it is cost effective to do so, with premium and cost sharing assistance from MassHealth to ensure that students' out-of-pocket costs are no higher than they would be if they were enrolled in direct coverage from MassHealth. This also ensures that students' overall costs do not increase and that MassHealth remains the payer of last resort. In addition, we propose to expand CommonHealth to adults who turn age 65 while enrolled in CommonHealth and who continue to meet

CommonHealth eligibility requirements for working adults. This expansion will help preserve needed services for working seniors in Massachusetts.

MassHealth looks forward to working in partnership with CMS to realize the reforms outlined above and described in detail in this proposal.

Introduction

MassHealth (Massachusetts' Medicaid and Children's Health Insurance Programs) provides health coverage to more than 1.8 million Massachusetts residents and is key to maintaining the Commonwealth's overall level of coverage at over 96 percent, the highest in the nation. However, MassHealth spending is growing unsustainably and, at \$15 billion, is now almost 40 percent of Massachusetts' budget. While the Commonwealth has taken necessary actions to slow short-term growth in MassHealth by addressing program integrity and implementing operational improvements, MassHealth must fundamentally alter its course in order to ensure the long-term sustainability of the program. At the same time, MassHealth's basic structure has not changed in 20 years. A predominantly fee-for-service payment model leads to care that is often fragmented and uncoordinated. Massachusetts also faces a burgeoning opioid addiction epidemic, both statewide and among MassHealth members. Over the past year, MassHealth has undertaken an extensive stakeholder engagement and policy development process to devise strategies to address each of these challenges.

MassHealth's 1115 demonstration provides an opportunity for Massachusetts to restructure MassHealth in order to emphasize value in care delivery, better meet members' needs through more integrated and coordinated care, and moderate the cost trend.

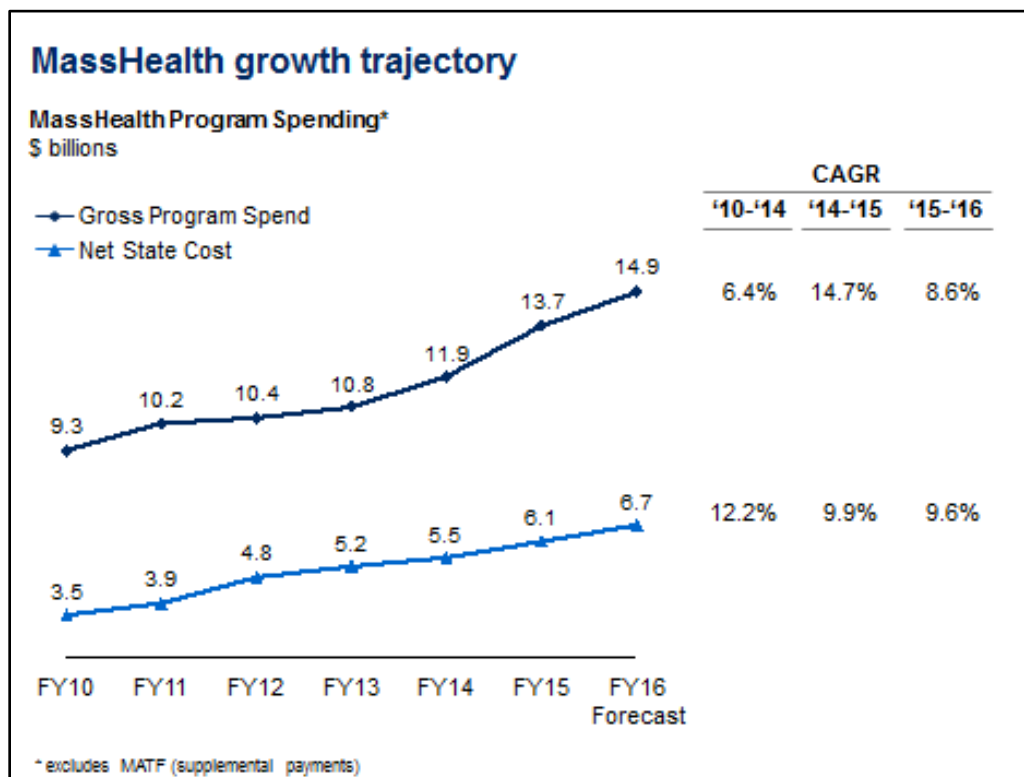
The current demonstration is authorized through June 30, 2019, with a key portion of the demonstration – the Safety Net Care Pool (SNCP), which includes payments to providers through such programs as the Health Safety Net, Delivery System Transformation Initiatives and Infrastructure and Capacity Building grants –authorized only through June 30, 2017. If Massachusetts does not reach an agreement to restructure the Safety Net Care Pool before the end of June 2017, it will lose federal authorization for over a billion dollars in expenditures each year. Massachusetts proposes to amend its current demonstration and to begin a five-year extension of the entire demonstration starting July 1, 2017. This request for an amendment and five-year extension of the current demonstration will support a restructuring of MassHealth's health care delivery and payment system. Given the significant changes described in this demonstration proposal, a new five-year extension will provide an opportunity for successful implementation far beyond what an amendment affecting only the final two years of the current demonstration agreement would allow.

The proposed demonstration extension's goals are to: (1) enact payment and delivery system reforms that promote integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improve integration among physical and behavioral health, long-term services and supports, and health-related social services; (3) maintain near-universal coverage; (4) sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals; and (5) address the opioid addiction crisis by expanding access to a broad spectrum of recovery-focused substance use disorder services.

Section 1. The Evolving Massachusetts Health Care Landscape

Over a quarter of Massachusetts residents rely on MassHealth for comprehensive, affordable health care coverage. However, MassHealth is on a financially unsustainable trajectory. MassHealth spending has significantly outpaced revenue growth for the Commonwealth and consumes approximately 40 percent of the state's budget appropriations.

EXHIBIT 1 – MassHealth Growth Trajectory



To avoid the risk of significant cuts in benefits, eligibility or provider reimbursement, MassHealth is committed to building a more sustainable long-term financial path. While MassHealth has identified and begun to implement a variety of strategies to address near-term cost growth, a long-term solution requires significant restructuring of the way MassHealth pays for and delivers care. The Commonwealth recognizes it must move away from a fee-for-service system that rewards volume, and toward a more common-sense approach that rewards value by paying providers on the basis of the cost and quality of health care.

Massachusetts providers have been moving in that direction, adopting Alternative Payment Methods (APMs). In 2014, 37 percent of lives in Massachusetts had their care paid via APMs. Although these percentages demonstrate meaningful progress away from fee-for-service arrangements, MassHealth recognizes that the Commonwealth has not achieved the scale or pace of transformation originally anticipated, particularly for the MassHealth population.

In addition, many of the existing APM arrangements have not been sufficient to truly transform care delivery on the ground from a member point of view. Despite efforts and some progress toward integration in Massachusetts, behavioral health care remains fragmented and often siloed from physical health care delivery. While some providers in the Commonwealth have developed closer integration between primary care and behavioral health, physical health and behavioral health care providers still operate largely as two distinct delivery systems, treatments and services. Furthermore, individuals with behavioral health needs are often left to navigate a complex system with limited and often inconsistent help. Behavioral health capacity and infrastructure varies significantly across the state. In some cases, individuals are subject to care management and/or care coordination from several different providers, managed care entities and state agencies, with limited communication amongst the various entities. This is exacerbated for individuals with co-occurring behavioral health and substance use disorders and/or for individuals with severe illness.

Massachusetts providers' experience and capacity to address the unique medical needs and diagnostic challenges presented by individuals with physical, developmental, and intellectual disabilities varies widely across the state. Similarly, providers vary widely in their capabilities to serve multi-cultural populations in a culturally and linguistically competent manner. These challenges may result in undiagnosed chronic conditions, untimely access to specialty care, unnecessary acute episodic care in EDs, and avoidable hospitalizations.

Finally, Massachusetts, like many states, is in the midst of an opioid epidemic which affects residents without regard to race, age, income, or insurance status. The Commonwealth is working to prevent addiction while simultaneously improving access to treatment for substance use disorders (SUD). As a recovery-focused system of care, the Massachusetts SUD treatment system offers an array of treatments and services, including resources for prevention, intervention, treatment, and recovery support, which addresses addiction across an individual's lifespan. While Massachusetts may go further than many other states, it still must be significantly improved by enhancing timely access to services and improving coordination throughout the system to best serve all of the individuals in the Commonwealth with an opioid, alcohol or other substance use disorder.

Section 2. Goals of the Demonstration: Progress and Plans

Massachusetts' goals for the proposed demonstration amendment and extension are to:

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

A brief review of Massachusetts' progress and plans toward these goals follows.

2.1 Goal 1: Enact payment and delivery system reforms

MassHealth has set out a vision to restructure its delivery system in which it primarily contracts with coordinated, accountable entities that are responsible for members' overall health and costs, rather than for individual services. This approach will require a transitional investment to provide a financial bridge from the current system to a sustainable one of member-driven, integrated care.

Massachusetts' reforms address several major concerns heard from stakeholders and from CMS over the past year through concrete commitment to delivery system reform, sensible changes to payment that support better care and a strategic investment approach to incentivize and support the transition. Specifically, MassHealth aims to integrate care across service types, to address social determinants of health in members' care, to balance the needs of large health systems with those of small community providers, and to support a shift in the delivery system to appropriate higher value and lower intensity settings.

Recognizing that the Commonwealth has many providers experienced with alternative payment models, MassHealth's proposed set of payment models includes advanced risk-based models that in many cases go beyond first-generation ACOs such as the Medicare Shared Savings Program (MSSP), incorporating more sophisticated population health management tools and greater expectations for integration.

MassHealth plans to support a shift towards managed, accountable, and integrated models of care by making the benefit design of these models more attractive to its members. MassHealth's goal is to move away from our current program design, which has remained largely unchanged for decades and in which it pays for unintegrated care. Instead, MassHealth aims to contract more with entities like ACOs, MCOs (with significant enhancements to our current MCO program), and integrated care models like One Care plans, all of which are responsible for the continuum of care for defined populations.

MassHealth is further supporting this movement towards a programmatic focus on population health through investments in primary care and behavioral health workforce development, training, and retention of providers in safety net settings such as community health centers and community mental health agencies. Investment in BH providers, LTSS, and community services for health-related social needs will directly incentivize functional integration.

2.2 Goal 2: Improve integration of physical health, behavioral health, long-term services and supports and health-related social services

The stakeholder engagement process supporting the overall MassHealth restructuring efforts raised several key themes regarding the challenges in integrating care across physical health, BH, and LTSS, as well as linkages to health related social services, in the current delivery system in Massachusetts. Some specific themes included:

- 1) Establishing explicit expectations for integration of physical health and behavioral health to improve members' health outcomes, particularly for members with significant behavioral health needs
- 2) Establishing explicit expectations for the role and expertise of community mental health and community addiction treatment providers in coordinating care and managing the complex needs of these populations
- 3) Ensuring better access to mental health and SUD treatment for children, youth, and adults
- 4) Ensuring provider systems are evaluated on delivery processes and member outcomes related to integration of behavioral health and physical health for children, youth, and adults
- 5) Establishing explicit expectations for the coordination and delivery of care for frail seniors, or members with disabilities, including building in explicit expectations to ensure members' LTSS care is not "over-medicalized"
- 6) Ensuring provider systems are evaluated on member outcomes related to long-term services and supports

Therefore, a major focus of MassHealth's delivery system restructuring approach, and an explicit goal of this demonstration, is the integration of physical health, behavioral health and long-term services and supports (LTSS), as well as strengthened linkages to social services, to meet members' needs in a more comprehensive way.

As part of this demonstration goal, MassHealth seeks to ensure that members will have access to an interdisciplinary care team that includes appropriate representation from community-based BH, LTSS and social service providers to best meet the members' needs. Additionally, MassHealth acknowledges that in the current system there are typically many care coordinators from different entities who engage with the member in an uncoordinated manner. Therefore, an explicit policy priority for MassHealth is to ensure that care coordination is seamless and easy to navigate from a member point of view.

2.3 Goal 3: Maintain near-universal coverage

The Commonwealth has made a long-standing commitment to striving for universal health care coverage. As a result of state and federal coverage expansions and enrollment efforts, today nearly all Massachusetts residents have health insurance coverage; national surveys rank Massachusetts' insurance coverage rate either first¹ or second² among states. The Massachusetts Health Insurance

¹ United States Census Bureau, Health Insurance Coverage in the United States: 2014 Current Population Reports (September 2015). Accessed at

<http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>

<http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>

² Centers for Disease Control and Prevention. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2014. Accessed at

<http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201506.pdf> Accessed at

<http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201506.pdf>

Survey estimated that 96.4 percent of residents were insured in 2015.³ MassHealth continues to work to close the remaining gap and to ensure that everyone who has access to health insurance is enrolled in a plan.

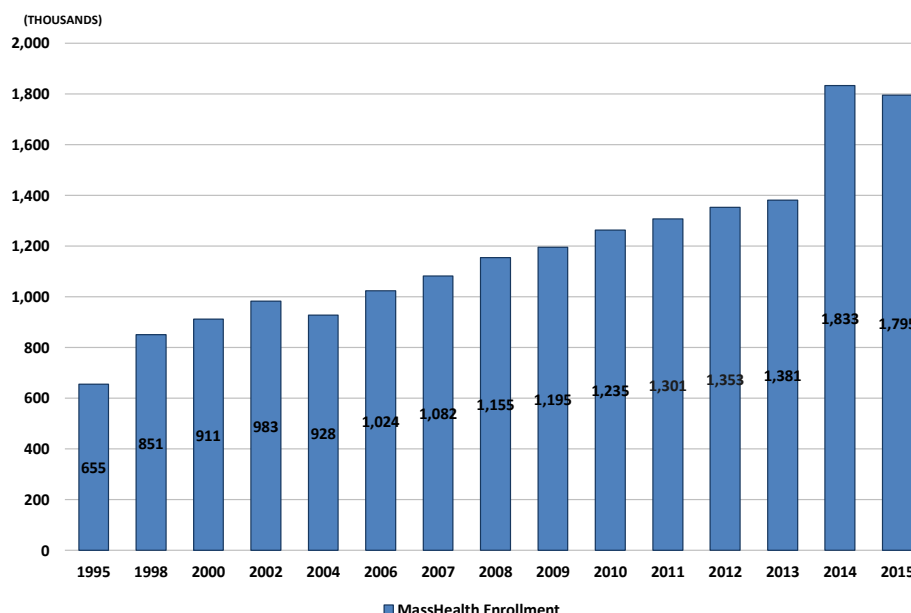
MassHealth has played a key role in the expansion and maintenance of health insurance coverage. Since the inception of the demonstration, MassHealth has expanded coverage to populations such as HIV-positive individuals, women with breast or cervical cancer, higher-income children and adults with disabilities, individuals with serious and persistent mental illness, and long-term unemployed adults. When the Affordable Care Act went into effect in January 2014, MassHealth further expanded coverage for all eligible low-income adults with incomes at or below 133 percent the federal poverty level (FPL), adding more than 200,000 in membership.

As of January 2016, enrollment stands at 1.86 million, about 27 percent of the state's population.⁴ MassHealth provides coverage for approximately 40 percent of all children in the Commonwealth and over 60 percent of all residents with disabilities in the state. MassHealth also covers one in five persons age 65 or older, and about two-thirds of all residents of nursing homes. MassHealth is the sole source of insurance for a majority of our members, but also provides supplemental coverage to about 600,000 individuals who have other insurance, including almost 300,000 who have Medicare and approximately 44,000 working people who receive premium assistance to help pay for their employee share of health coverage through an employer.

³ Massachusetts Center for Health Information and Analysis. Findings from the 2015 Massachusetts Health Insurance Survey (December 2015), accessed at <http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf>

⁴ MassHealth Snapshot reports. The population of Massachusetts is taken from the United States Census Bureau Population Estimates, accessed at <http://www.census.gov/popest/data/state/totals/2015/index.html>
<http://www.census.gov/popest/data/state/totals/2015/index.html>

MassHealth Enrollment



SOURCES: MassHealth figures are from the Office of Medicaid and are monthly averages, except 1998-2002 and 2007-2015, which are as of June 30.

In addition, the demonstration has enabled the Commonwealth to expand affordable coverage for residents beyond the MassHealth program. In 2006, the demonstration authorized the Commonwealth Care program, which provided coverage for lower-income, uninsured adults through the state's health insurance exchange (now known as a state-based marketplace), the Health Connector. When the Affordable Care Act made new subsidies available to residents with incomes up to 400 percent of the FPL purchasing insurance through the Health Connector, the Commonwealth created the ConnectorCare program to provide additional subsidies that would maintain health insurance affordability levels for former Commonwealth Care enrollees. The demonstration currently authorizes state-supported premium subsidies through ConnectorCare, and MassHealth proposes to expand the demonstration authorization to encompass state cost sharing subsidies that support affordability and access at the point of service, to achieve cost sharing levels similar to the levels that this population had access to in the Commonwealth Care program.

2.4 Goal 4: Sustainably support safety net providers

Even in the context of near-universal health insurance coverage in Massachusetts, safety net providers continue to serve a critical role in ensuring access to care for low-income and vulnerable populations, including many MassHealth members, the remaining uninsured population, homeless individuals, and

others who face a variety of social or linguistic barriers. In fact, as coverage has expanded for previously uninsured populations under state and national health care reform, safety net providers have seen a dramatic increase in the number of patients they care for on a regular basis.

MassHealth is committed to supporting these providers through funding that addresses the otherwise uncompensated care they provide to MassHealth members and uninsured patients. We see this support as a critical component of upholding the system of care that allows us to maintain our high rates of coverage and access to high quality health care services for all residents.

In this demonstration extension, MassHealth proposes to redesign the current Safety Net Care Pool to ensure that funding support for safety net providers is sustainable and aligned with its broader delivery system and payment reform goals. As outlined in more detail below, MassHealth proposes to establish an Uncompensated Care Pool that more fully recognizes uncompensated care for uninsured patients. At the same time, MassHealth proposes to reform funding targeted to safety net hospitals by expanding the pool of eligible providers, establishing a more sustainable level of long-term funding support and linking these payments to value-based outcomes measures such as cost, quality and avoidable acute care utilization.

2.5 Goal 5: Expand access to substance use disorder services

Massachusetts, like many states, is in the midst of an opioid epidemic that impacts citizens from every part of the Commonwealth. As a recovery focused system of care, the Massachusetts substance use disorders (SUD) treatment system offers an array of treatments and services, including resources for prevention, intervention, treatment, and recovery support, addressing addiction across an individual's lifespan. While Massachusetts may offer more services and coverage than many other states, the SUD treatment system must be improved through improving timely access to services and better coordination throughout the system, to best serve all of the individuals in the Commonwealth with an opioid, alcohol, or other substance use disorder.

The Commonwealth envisions an SUD treatment system that treats addiction as a chronic medical condition, understands that relapse is a part of the recovery process, and provides enhanced funding for recovery focused supports. Treatment must begin with a solid foundation of education and prevention and provide individuals with access to treatment at many different entry points. Across the system, treatment professionals, along with their counterparts in the physical and behavioral health systems, must be trained to provide access to the right care, in the right setting, at the right time. The Commonwealth recognizes the importance of aligning incentives across the substance use treatment system with those within the traditional health care system, to ensure that all providers and payers are working collaboratively to improve care for the whole person, including addressing substance use disorders.

The Commonwealth is actively working to prevent addiction and improve treatment for SUD and it is within this context that Massachusetts proposes to expand access to SUD services for MassHealth

members. To ensure that all MassHealth members have access to the full continuum of SUD services, MassHealth proposes to add American Society of Addiction Medicine (ASAM) Level 3.1 treatment services to the list of covered services, including Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS). Also described in further detail below, MassHealth plans to increase care coordination and recovery coach services for members with significant SUD needs, as well as develop an assessment instrument for use throughout the Commonwealth's treatment system. By providing improved access to treatment and ongoing recovery-focused support, the Commonwealth believes individuals with SUD will have improved health and increasing rates of long-term recovery.

Section 3. Description of Stakeholder Engagement Process

The approach outlined in this document to support MassHealth's restructuring is the result of nearly a year of intensive design work and stakeholder engagement.

Between April and July 2015, MassHealth held eight public listening sessions and additional individual stakeholder meetings across the state. MassHealth used the input from the listening sessions to shape the next phase of its restructuring work. Between August 2015 and February 2016, MassHealth sought stakeholder input on restructuring design through eight workgroups. This process involved approximately 150 individuals from 120 organizations and sister state agencies. Members of the workgroups were solicited through an open and public nomination process and represented a diverse array of stakeholders from across the state, including members, advocates, payers, providers and academics.

Each of the eight workgroups met approximately eight times, totaling approximately 60 workgroup sessions, held between August 2015 through February 2016. The table below shows the scope of design decisions that were discussed in each of the workgroups:

Workgroup	Scope of Work
Strategic Design	This workgroup discussed the overall approach to delivery system and payment reform for MassHealth members, with specific consideration for accountable and integrated care, and payment models across the care continuum.
Attribution (<i>co-led by the Mass. Health Policy Commission [HPC]</i>)	This workgroup discussed approaches for determining the appropriate accountable provider for each member.
Payment Model Design	This workgroup discussed payment approaches to drive better care and lower cost for ACO members, including the many technical details of how financial accountability for providers might work (e.g., risk adjustment, scope of services, relative vs. absolute performance measurement).
Certification Criteria (<i>co-led by the HPC</i>)	This workgroup discussed the key capabilities that ACOs should demonstrate so that MassHealth could certify them as ready to bear financial and clinical accountability for population health.

Health Homes	This workgroup discussed the Health Home model of care, with a particular focus on primary care and behavioral health. The group made recommendations about care management and coordination staffing models, which would enable practitioners to practice at the top of their license.
Quality Improvement	This workgroup discussed the performance measurement approach for quality of care, as well as multi-payer coordination around metrics, and improved standardization of quality reporting.
LTSS Payment and Care Delivery Models	This workgroup discussed integrated and patient-centered care for members with disabilities or significant LTSS use, and payment models that support such integrated and patient centered care models.
BH Payment and Care Delivery Models	This workgroup discussed integrated and patient-centered care for members with severe and persistent mental illness and/or substance use disorder, and payment models that support such integrated and patient centered care models.

MassHealth used the discussions from each of the workgroups as input to its policy development process. Stakeholders provided robust oral and written feedback which highlighted the transparent, inclusive, and collaborative nature of the endeavor.

MassHealth held open meetings between August 2015 and April 2016, to solicit broad public input and provide updates on progress and issues being raised and debated in the workgroups. MassHealth notified tribal organizations of the upcoming submission of this demonstration proposal. In addition, on April 14, MassHealth posted a summary of MassHealth's restructuring approach on a public website, in a commitment to a transparent process (<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/masshealth-restructuring-updates.html>).

Consistent with federal requirements, the Commonwealth conducted a public notice and comment process from June 15 to July 17, 2016 to enable the public to review and provide input on this demonstration request. The public notice process included tribal consultation, two public hearings, and a process to accept both oral and written comments on the draft proposal. Details on this public process and a summary of the comments received and MassHealth's responses are included as Section 11 of this document. All public comments received during the comment period (Appendix C) will be posted online and available to the public, along with this final demonstration proposal as submitted to CMS.

MassHealth is committed to continued transparency and stakeholder input throughout the further development and implementation of these reforms. Following its submission of this proposal to CMS, MassHealth will continue to seek input from technical advisory groups on key topics through 2016 and 2017, leading up to implementation. These topics may include certification criteria for Community Partners, quality and member experience measurement approach, and ACO model details. In addition, MassHealth will establish an advisory group, which will include member representatives, advocates,

providers, ACOs and other stakeholders, to ensure that there is an appropriate, ongoing forum for stakeholders to provide input to support MassHealth’s design and implementation work.

Once the MassHealth ACO program is launched, MassHealth will release an annual report on ACO performance as a way of providing public transparency throughout the implementation of the program.

Section 4. MassHealth Payment and Care Delivery Reform Strategy

This section describes our strategy to achieve payment and care delivery restructuring across the MassHealth program, and includes:

- A detailed overview of MassHealth’s ACO models (the three full ACO payment models and the ACO pilot)
- Descriptions of MassHealth’s approaches to addressing quality of care and member choice in ACO models
- Description of MassHealth’s strategy for ensuring the integration of physical health, BH, LTSS and health related social needs, including a description of Massachusetts’ Community Partners model, which will facilitate the integration of community-based behavioral health and long-term services and supports providers with ACOs for members with complex BH and LTSS needs
- A description of the role of MCOs as partners in care delivery and payment reform
- An overview of changes to MassHealth’s benefits and copayment structures to encourage member enrollment in coordinated care options such as ACOs and MCOs

4.1 Overview of ACO Models

A central focus of our payment reform effort is the roll-out of three ACO models (see Exhibit 3).

Massachusetts recognizes that providers vary in their levels of preparedness to develop and participate in accountable delivery systems, and therefore MassHealth will provide a range of ACO participation options for providers across these three models.

- **Model A ACO/MCO** is an integrated partnership of a provider-led ACO with a health plan. Members will enroll in Model A ACOs, which will serve as their health plan as well as their provider system. Model A ACOs are responsible both for administrative health plan functions (such as claims payment and network development), and for coordinated care delivery for the full range of MassHealth managed care organization (MCO) covered services. Like MCOs, Model A ACOs will be paid prospective capitation rates and will bear insurance risk for enrolled members’ costs of care.
- **Model B ACO** is an advanced provider-led entity that contracts directly with MassHealth and may offer Members preferred provider networks who deliver well-coordinated care and population health management although MassHealth’s directly contracted provider network (and contracted managed behavioral health “carve-out” vendor) will be available to Model

B ACO members. At the end of the performance period, MassHealth will share savings and losses with the ACO based on the total cost of care the ACO's attributed members incur.

- **Model C ACO** is a provider-led ACO that contracts directly with MassHealth MCOs. Members enroll in MCOs, and the MCO serves as their health plan and is responsible for contracting provider networks and paying providers for MCO covered services for these members. MCO members will be attributed to Model C ACOs, primarily based on primary care relationships. At the end of each performance period, each MCO will share savings and losses with the ACO based on the total cost of care for the MCO's enrolled members who are attributed to the ACO. MassHealth will set parameters to foster alignment across payers at the ACO level, while still allowing flexibility for Model C ACOs and MCOs to negotiate many contract provisions.

MassHealth will launch an ACO pilot with a small set of experienced ACOs in 2016, to test accountable care payment and prepare for the full launch of ACO models in 2017. The ACO pilot will use a retrospective shared savings and risk model for ACOs' attributed PCC Plan members; it will not alter the payment model for any MCO-enrolled members who receive care with participating ACOs.

Members eligible for attribution to or enrollment in ACOs will be MassHealth members who are eligible for managed care. Dual-eligible members, children in the custody of the Department of Children and Families or the Department of Youth Services who do not enroll in an MCO or the PCC Plan, and members with third party coverage or temporary/partial coverage – will not initially be eligible for ACOs. Some MassHealth members enrolled in one of MassHealth's Home and Community-Based Services (HCBS) waiver programs will therefore be eligible to enroll in MassHealth ACOs, as long as they are otherwise eligible for managed care and are not eligible for Medicare. HCBS waiver services, however, will be provided to those members outside of ACO scope and budgets (in contrast, *State Plan* LTSS will eventually be included in ACO scope and budgets, as described below).

We will work to expand ACO eligibility further, in particular by considering our existing integrated care programs for dual-eligible members like One Care, Senior Care Options, and Programs for the All-inclusive Care of the Elderly. Any future enhancements will occur only after stakeholder engagement and sufficient time for planning and implementation.

Total cost of care (TCOC) will be risk adjusted in each of MassHealth's ACO models. ACOs that serve higher acuity populations (e.g., populations with greater need for services, more complex conditions, etc.) will generally receive higher total cost of care budgets (or, in the case of Model A, prospective capitation payments) as a result. MassHealth is launching an improved risk adjustment methodology which will for the first time include certain social determinants of health (e.g., housing status, employment status). Including these social determinants is intended to improve the performance of MassHealth's risk adjustment and, critically, to ensure that ACOs are appropriately incentivized to serve socially complex populations and geographies.

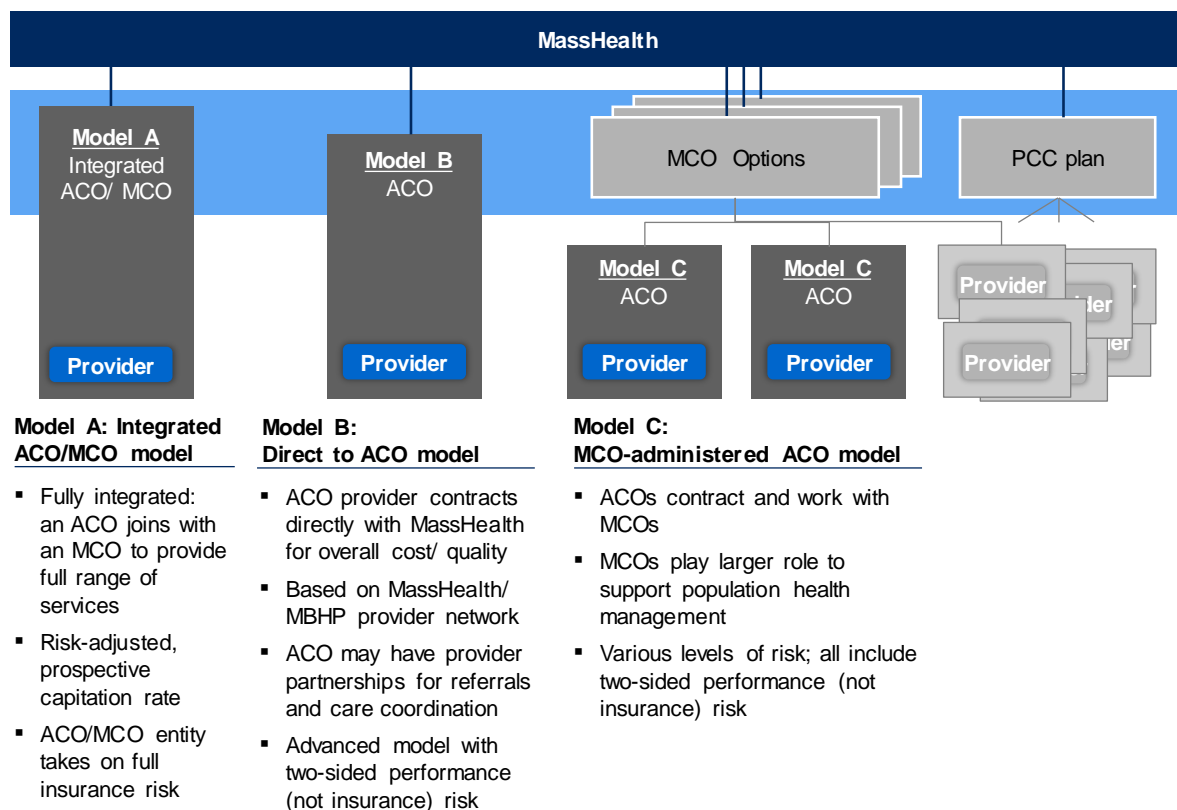
Total cost of care measures for ACOs will generally align with the scope of managed care covered services, and will include physical health, behavioral health, pharmacy (with appropriate adjustments for high cost drugs) starting in Year 1. Accountability for state plan LTSS costs will be phased in for both ACOs and MCOs over the course of the demonstration period, with appropriate measures to ensure that ACOs and MCOs demonstrate the necessary capacity to manage LTSS. Including LTSS in the ACO TCOC will align financial incentives for the ACOs to leverage community-based LTSS and BH services. It will ensure a preventative and wellness based approach for members with disabilities and LTSS needs in order to re-balance spending of LTSS away from more intensive settings of care to the least restrictive setting of a member's choice. Before ACOs begin assuming financial responsibility for LTSS, MassHealth will conduct a rigorous readiness process with each organization, which will incorporate feedback from the LTSS stakeholder community. The elements of readiness review will be targeted to the scope of responsibility in each ACO model, but all ACOs will need to demonstrate philosophical competencies (such as understanding of Independent Living, disability culture, cultural competency, and person-centeredness), as well as meet administrative and accessibility requirements to ensure all members (or their authorized representatives as appropriate) can effectively communicate with their providers and teams, and direct their care decisions. In addition, ACO contractors must be ready to accept enrollments, support person-centered assessment and care planning processes. For Model B and C ACOs, MassHealth or its contracted MCOs, respectively, (after demonstrating readiness and appropriate competencies) will continue to be responsible for contracting the LTSS network, establishing fee schedules and paying claims for LTSS services. Additional readiness processes for Model A ACOs are described more fully in Section 4.3.1.3 below.

All ACOs will also be required to seek out community-based LTSS expertise for assessments, information and referral, and care planning through LTSS Community Partners (CPs), as described more fully below.

As MassHealth transitions to ACO models, MassHealth members will continue to receive dental care benefits as they do today, as described in the MassHealth dental program regulations at 130 CMR 420.000 and 450.105. MassHealth will promote the integration of oral health and quality of oral health care through a range of methods (e.g., inclusion of oral health metrics in the ACO quality measure slate, contractual expectations for ACOs). In addition, for members who will be enrolled in ACOs, dental services will continue to be paid FFS and associated dental costs will not be counted against the ACO total cost of care budget. In future years, MassHealth will explore ways to increase the integration of oral and physical health, including considering the feasibility of introducing financial accountability for oral health costs into ACO models.

MassHealth ACO models: 3 types of ACO models (1 of 2)

Member enrollment

**4.1.1 Overall expectations for ACOs across models**

All MassHealth ACOs (except those in the pilot, due to timing of the pilots) must meet the Massachusetts Health Policy Commission's⁵ certification requirements and will be held accountable for the quality and total cost of care of their members. These certification requirements include:

- Patient-centered, accountable governance structure, evidenced by meaningful participation of ACO participants in the governance structure, patient/consumer representation in governance structure, as well as the presence of a Patient and Family Advisory Committee (PFAC)
- Participation in quality-based risk contracts
- Population health management programs
- Evidence of cross continuum care: coordination with BH, hospital, specialist, long-term care services, and community service providers for adults and children

⁵ The Massachusetts Health Policy Commission (HPC) is an independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care. The HPC is developing a certification program for ACOs in the Commonwealth of Massachusetts. The purpose of the certification program is to complement existing local and national care transformation and payment reform efforts, validate value-based care, and promote investments by payers in efficient, high-quality, and cost-effective care. <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/certification-programs/aco-certification-final-criteria-and-requirements.pdf>

In addition, MassHealth ACOs will have explicit requirements to partner with community-based behavioral health and LTSS providers to serve members with complex BH, LTSS and co-occurring needs.

Furthermore, MassHealth set expectations through the procurement process to ensure that all ACO models will incorporate:

- An approach to support patient centered primary care
- Member engagement and member-driven approaches to care planning and integration
- Performance expectations for quality and member experience metrics, which will influence an ACO's financial performance (see section 4.1.7)
- Cultural competence to serve diverse populations
- Integration of physical, behavioral health, oral health, social determinants of health and long-term services and supports (see section 4.2)
- Mental health and Substance Use Disorder services built on recovery principles for adults and strength-based and resiliency principles for children and youth
- Physical and behavioral accessibility requirements to better serve individuals with disabilities

MassHealth is making a significant investment of state and federal resources in ACOs through DSRIP payments and the administration of the ACO program; the ACO payment model also provides significant financial incentives for ACOs to provide strong performance on cost and quality. To ensure appropriate accountability on the part of ACOs, all ACOs will bear some degree of downside risk; different ACO models and risk tracks will allow ACOs to appropriately match their level of downside risk to their capabilities and financial readiness.

4.1.2 Overview of member choice in MassHealth ACO models

All eligible members will enroll in a managed care option and select a primary care provider, as they do today. All eligible members will have the opportunity to select their health plan and PCP.

Eligible members will often have more choices than today; they will choose among the following managed care options (as available):

- Available MCOs in their region, including the option (*new choice after restructuring*) to receive care from available Model C ACOs contracted with these MCOs, based on the member's choice of PCP
- Available Model A ACOs in their region (*new choice after restructuring*)
- Available Model B ACOs in their region (*new choice after restructuring*)
- The PCC Plan

4.1.3 Model A

4.1.3.1 Overview, contracting structure and payment model

Model A fully integrates the functions of an ACO and MCO and is characterized by a close partnership between a well-coordinated provider network and a closely aligned health plan. Model A ACO/MCOs

must be licensed carriers in accordance comply with state law and are subject to federal managed care regulations.

Model A ACO/MCOs will receive a prospective payment, as MCOs do today, with financial risk arrangements similar to those for MCOs, including accepting insurance risk. This model can provide ACOs with the means to invest more in new models of care and expanded benefits.

Over time, Model A ACOs will have financial accountability for LTSS in their scope of covered services and accountability, subject to further stakeholder engagement and MassHealth evaluation. Critical to the success of this model, Model A ACO/MCOs will be required to demonstrate competencies in the independent living philosophy, Recovery Models, wellness principles, cultural competence, accessibility, and a community-first approach, consistent with the One Care model. Model A ACO/MCOs will also be required to demonstrate compliance with the new Medicaid Managed Care regulations, and to demonstrate meaningful supports and processes for providers to achieve full ADA accessibility compliance. A Model A ACO/MCO must demonstrate competencies and readiness in these areas before it takes on accountability for LTSS.

4.1.3.2 *Member experience and network*

Members will access Model A ACOs through their choice of a Primary Care Provider (PCP) that participates in that ACO/MCO. Each Model A ACO/MCO will have a defined provider network that meets access and adequacy requirements. Members in the ACO/MCO will have access to the providers in that network.

Model A ACO/MCOs are required to ensure that their affiliated PCPs participate as PCPs only in that ACO. Affiliated PCPs may also participate in MassHealth FFS and in all MCOs, ACOs and the PCC Plan for non- primary care services (e.g. specialty services). Other providers (such as hospitals and specialists) affiliated with a Model A ACO/MCO can also participate in all MCOs, ACOs, the PCC Plan and FFS.

4.1.3.3 *Financial requirements*

A Model A ACO/MCO must meet all requirements of MassHealth MCOs, including network adequacy, member protections and appeals, risk-based capital and other features. In addition, the health plan in a Model A ACO/MCO must partner (e.g., through a joint venture, ownership, or a joint governance committee) with an ACO that meets MassHealth's ACO criteria. MassHealth will require Model A ACO/MCOs to demonstrate compliance with federal Managed Care regulations (newly revised in May 2016).

4.1.4 *Model B*

4.1.4.1 *Overview, contracting structure, and payment model*

In a Model B ACO, MassHealth contracts with the ACO to manage the cost and quality of care for members attributed to its primary care network. The ACO is accountable for the total cost of care of those members, for MassHealth's ACO quality measures, and for additional contractual expectations of ACOs, including BH and LTSS integration through CPs. MassHealth serves as the health plan for

attributed members, enrolling members, maintaining the provider network and playing a role in authorizing services.

Model B ACOs will initially be paid fee for service, reconciled against a total cost of care budget. ACOs must demonstrate the ability to bear risk and guarantee payment of their potential responsibility for shared losses to the Commonwealth.

MassHealth is exploring additional tools to offer Model B ACOs in future years that are operationally sustainable and in line with the ACO program's goals of improving the quality and value of member care. These tools may include options to take on more advanced payment models, including forms of prospective payment in which providers may elect to have some of their fee schedule payments reduced or withheld, and instead paid directly to the ACO. These potential future options are similar to options available to the most advanced Medicare ACOs operating in the Commonwealth. MassHealth plans to conduct additional stakeholder engagement and evaluation prior to implementing any such changes.

4.1.4.2 *Member experience and network*

Members will access Model B ACOs through their choice of a PCP that participates in that ACO. Model B ACO-enrolled members will have access to MassHealth's PCC Plan network, including the behavioral health vendor for the PCC Plan for BH services. Each Model B ACO may define a subset of the PCC Plan network to be the ACO's preferred providers and may encourage members to receive coordinated care from these providers, using incentives such as enhanced access through primary care "referral circles." If an ACO designates a referral circle that MassHealth approves, the enrolled member will not need a primary care referral for any services rendered by a provider in that ACO's referral circle, making it easier for members to receive coordinated care. Model B ACOs must ensure that participating PCCs make referrals to any provider, as appropriate, regardless of the provider's affiliation. Model B ACOs cannot impose additional requirements for referrals on providers who are outside the list of preferred providers.

Model B ACOs are required to ensure that their affiliated PCPs participate as PCPs only in that ACO. Affiliated PCPs may also participate in MassHealth FFS and in all MCOs, ACOs and the PCC Plan for non- primary care services (e.g. specialty services). Other providers (such as hospitals and specialists) affiliated with a Model B ACOs can also participate in all MCOs, ACOs, the PCC Plan and FFS.

4.1.4.3 *Financial requirements*

Model B ACOs must demonstrate that they have submitted application to the Massachusetts Division of Insurance (DOI) pertaining to the Risk Certificate for Risk-Bearing Provider Organizations (RBPO) and must maintain appropriate DOI-issued RBPO certification or waivers. Model B ACOs must have a repayment mechanism – a line of credit, restricted capital reserve, or performance bond – to ensure they can bear the financial responsibilities of the ACO risk model. The specific requirement for a given Model B ACO will vary based on the level of performance risk on total cost of care assumed by the Model B ACO.

4.1.5 Model C

4.1.5.1 *Overview, contracting structure, and payment model*

Model C is a provider-led ACO that takes accountability for its members through contracts with MassHealth MCOs, which serve as the health plan for these members. MassHealth will require the MCOs and ACOs to engage in the contracting process in a way that promotes alignment of ACO incentives and administrative responsibilities across contracts while allowing appropriate flexibility. This process will require Model C ACOs and MCO to contract with one another guided by alternative payment model principles outlined by MassHealth and will require Model C ACOs to be accountable for total cost of care.

As they are today, the MCOs are responsible for managing a provider network their members can access. MCOs will contract with Model C ACOs for the total cost of care, with shared savings and risk. Because Model C ACOs are likely to be less advanced than ACOs in other models, this model is likely to have less risk than a Model B ACO.

4.1.5.2 *Member experience and network*

Members can enroll in a traditional managed care plan as they do today, where such plans are available. MCO-enrolled members will also select an available PCP from their network or, if they do not select, will be attributed to one. If the member's PCP is part of a Model C ACO, the member will be considered part of that ACO's attributed population. Members attributed to a Model C ACO will have access to their health plan's provider network.

Model C ACOs are required to ensure that their affiliated PCPs participate as primary care providers only in that ACO. Affiliated PCPs may also participate in MassHealth FFS and in all MCOs, ACOs and the PCC Plan for non- primary care services (e.g. specialty services). Other providers (such as hospitals and specialists) affiliated with a Model C ACOs can also participate in all MCOs, ACOs, the PCC Plan and FFS.

4.1.5.3 *Financial requirements*

Model C ACOs must demonstrate that they have submitted an application to the Commonwealth of Massachusetts Division of Insurance (DOI) pertaining to the Risk Certificate for Risk-Bearing Provider Organizations (RBPO) and must maintain appropriate DOI-issued RBPO certification or waivers. Model C ACOs must have a repayment mechanism – a line of credit, restricted capital reserve, or performance bond – to ensure they can bear the financial responsibilities of the ACO risk model. The specific requirement for a given Model C ACO will vary based on the level of performance risk on total cost of care assumed by the Model C ACO.

4.1.6 Pilot ACO

In May 2016, MassHealth released a Request for Responses for ACOs to participate as Pilot ACOs. Selected bidders will start operating as MassHealth ACOs, with total cost of care accountability, at the end of calendar year 2016. This pilot is intended to address three goals:

- Provide an opportunity for providers who have ACO experience and are eager to begin TCOC accountability on a faster timeline;
- Accelerate the readiness work that ACOs are performing during this period;
- Test and refine key systems, operations, and rate-setting functions with a small ACO cohort, to ensure readiness for the full launch in late 2017.

4.1.6.1 *Overview, contracting structure, and payment model*

Pilot ACOs will contract directly with MassHealth for accountability for the quality and total cost of care for all PCC Plan (non-MCO) enrolled members attributed to the ACO's participating PCCs. The payment model will be for retrospective shared savings and risk, with modest downside risk. Providers in the PCC Plan network will continue to submit claims to MassHealth for services rendered to members in the ACO pilot, and MassHealth will use these claims and other sources (e.g. behavioral health encounter data) to calculate each Pilot ACO's target and performance.

4.1.6.2 *Member experience and network*

If a current PCC Plan member's PCP is part of a pilot ACO, that member will be automatically attributed to and included in that ACO. Members may opt out of the pilot ACO if they wish to change PCP. Pilot ACOs may identify primary care referral circles, similar to those available in Model B. MassHealth members in pilot ACOs will continue to have access to the broader MassHealth-contracted provider network and the behavioral health providers in the MassHealth Behavioral Health Carve Out vendor's network.

Pilot ACOs will need to demonstrate similar capabilities to Models B or C ACOs, but MassHealth may prioritize selection criteria that indicate early readiness for the total cost of care payment model and allow more time for meeting other criteria.

Members directly enroll in Model A and Model B ACOs based on their selection of PCP. If a member chooses one of the available MCOs (rather than a Model A or B ACO or the PCC Plan), the member's choice of MCO and PCP will determine their attribution (if any) to a Model C ACO. Each PCP will be aligned with only one ACO at a time.

Members in the PCC Plan or in Model B ACOs will have access to MassHealth's PCC Plan network (which includes the behavioral health vendor for the PCC plan for BH services), under PCC Plan network policies. The PCC Plan's policies regarding prior authorization and primary care referral requirements will apply.

Members in MCOs (including those in Model C ACOs) will have access to the MCO's provider network (which must satisfy all applicable MCO rules and network adequacy requirements) subject to their MCO's network policies. A member in an MCO who is attributed to a Model C ACO will have access to the same network as a member in that MCO who is not attributed to an ACO. Members in Model A ACOs will have access to the Model A ACO's provider network.

As MassHealth continues its ACO design, it will pay particular attention to the implications of network design for various sub-populations, including children and youth as well as adult members with more complex needs. MassHealth is committed to implementing contractual requirements as well as a robust monitoring program to ensure adequate access for all members, including various sub-populations with complex health care needs.

4.1.7 Quality and Member Experience strategy for MassHealth ACO models

MassHealth ACOs will be accountable for providing high-value care across a range of measures. MassHealth will align its quality measures with existing national and state measure sets. These measures will be used both for payment purposes and for reporting to CMS. Additional measures will be for reporting only, though they may transition to accountability after a baseline period. Custom measures may be added in key reporting domains.

Priority domains for MassHealth's quality measurement strategy are:

- Prevention and Wellness (including sub-populations such as pediatrics, adolescents, oral, maternity)
- Reduction of Avoidable Utilization
- Chronic Disease Management
- Behavioral Health / Substance Abuse
- Long Term Services and Supports
- Member Experience

Each applicable domain will include adult as well as pediatric measures to ensure high quality care for all members.

MassHealth's quality accountability strategy will build on nationally used approaches, including the quality strategies in Medicare's ACO models. Quality scores will be used to determine ACOs' ability to receive shared savings and DSRIP payments. A higher quality score may raise an ACO's shared savings payment, or may reduce the amount the ACO needs to pay back in shared losses.

MassHealth's approach for evaluating member experience will initially focus on experience in the primary care setting, using a nationally validated survey as the base survey instrument in order to be able to tie payment to member experience as soon as possible. Over time, MassHealth will phase in new approaches to evaluate ACO performance on member experience on a key goal of the 1115 demonstration – improved integration of physical health, behavioral health, long-term services and supports, and health related social services. MassHealth will also evaluate member experience in the behavioral health and long-term services and supports settings of care in outer years of the demonstration.

4.1.8 Member Rights and Protections

As MassHealth moves forward with these crucial payment and care delivery reforms, we remain focused on preserving and improving the MassHealth member experience. Among other things, this means a continuing commitment to robust requirements for member rights and protections. Some, but by no means all, of these member rights and protections are highlighted below.

First and foremost, MassHealth will ensure that members have timely access to high quality primary care, specialists, long terms services and supports and behavioral health providers regardless of the delivery model they choose, be it an MCO, an ACO or the PCC Plan. MassHealth expects that these networks will consist of providers who are able to deliver care in a culturally competent manner and who will work collaboratively with the member to deliver treatment options that meet their individual needs and preferences. In addition, MassHealth will work closely with its MCOs, ACOs and PCC Plan providers to ensure providers offer their patients with disabilities the medical and diagnostic equipment and accommodations necessary to receive appropriate medical care. MassHealth will closely monitor MCOs and all ACO models to assure that they respect member dignity and privacy and provide their members with the opportunity to participate in treatment decisions.

Second, MassHealth members will continue to have access to all grievance and appeals processes available today. Fixed enrollment period determinations will be appealable upon implementation. In addition, for MassHealth members who participate in an MCO or ACO, MassHealth will create a new ombudsman role, that will be available to help resolve problems or concerns that enrollees have. MassHealth expects that the ombudsman will play a crucial role in ensuring a successful rollout of our payment and care delivery reforms.

Third, MassHealth recognizes that delivery system and payment reforms cannot be successful unless members understand how to match enrollment options with their needs and have the opportunity to be fully engaged in their own care. To that end, MassHealth will work with internal and community partners to ensure that members get clear information on enrollment options and the support they need to make their decisions. While special attention will be paid to maintaining primary care relationships in assignment and attributions, members will need access to accurate information about the full range of health services offered. MassHealth will require ACOs and MCOs to make information about their plan readily accessible, and MassHealth will enhance its own customer service, website, publications, and community engagements to support members as we transition to new delivery models and options.

Finally, MassHealth will monitor and evaluate its ACOs on a set of member experience and quality metrics, as described further in Section 4.1.7., to assure that new care delivery models provide the high quality member experience that MassHealth expects.

4.2 Integration of physical health, behavioral health, long-term services and supports and health related social needs, and Community Partners strategy

As articulated throughout this document, an explicit goal for this demonstration is to improve the integration of services across the care continuum – most significantly, across the siloed realms of physical health care and behavioral health care, particularly for adults and children with complex medical, BH, and LTSS needs who would benefit from a comprehensive treatment delivery approach.

4.2.1 What Integrated Care Delivery Means

- 1) Members will have access to an interdisciplinary care team that includes a member's PCP, BH clinician, and LTSS representative (where needed) working off one integrated care plan for the member.
- 2) There will be seamless care coordination for adult members with complex BH and LTSS needs (versus current state where adult members might have as many as six to eight care coordinators from different entities). The interdisciplinary care team should designate a primary contact and navigator for the member. Children with Serious Emotional Disturbance (SED) will continue to access Care Coordination from a Community Service Agency, just as they do today. The interdisciplinary care team for members with complex BH needs must include community-based BH providers with expertise across the entire care continuum of BH treatments and services, from emergency and crisis stabilization through intensive outpatient, community-based services, and peer specialists.
- 3) The interdisciplinary care team for members with complex LTSS needs must include existing community-based LTSS entities which collectively demonstrate expertise in all LTSS populations including elders, adults with physical disabilities, children with physical disabilities, members with acquired brain injury, members with intellectual or developmental disabilities, and individuals with co-occurring behavioral health and LTSS needs.
- 4) The interdisciplinary care team should follow a systematic clinical approach, based on national standards and best practices, including the Substance Abuse and Mental Health Services Administration (SAMHSA) Recovery Principles for adults and System of Care Principles for children, that achieves the following:
 - a. Employs methods, in partnership with the member, to identify and assess the member's need for comprehensive physical health, behavioral health, long-term services and supports as well as health related social services
 - b. Empowers and engages members in their care, and helps members define their own goals for the future
 - c. Cares for members using an explicit, unified, and shared treatment plan, based on the member's goals
 - d. Ensures appropriate access to treatment and services based on the member's treatment plan, including linkages to social services for addressing health related social needs
 - e. Ensures systematic follow-up and adjustment of care plans if member's health is not improving as expected

4.2.2 MassHealth's Role in Improving Integrated Care Delivery

For members with the most significant and complex behavioral health and/or LTSS needs, MassHealth will require ACOs to have formal relationships with organizations known as Behavioral Health Community Partners (BH CPs) and LTSS Community Partners (LTSS CPs), which will be certified by MassHealth. ACOs and CPs will need to demonstrate meaningful partnerships in their development of integrated care coordination and comprehensive care management, via their memoranda of understanding. This will also be a pre-requisite for disbursement of DSRIP funding.

For members with fewer BH and/or LTSS needs, MassHealth will reference national best practices for care integration and build these definitions and standards into the ACO procurement and contractual requirements. ACOs and CPs will be encouraged to develop innovative approaches above and beyond MassHealth's requirements for integrated care model in terms of how they compose, convene and operationalize their care teams and care model operations. MassHealth-defined standards will also include provisions to ensure the delivery of Children's Behavioral Health Initiative services to members under 21 and delivery of culturally appropriate interventions designed to increase access to and engagement in behavioral health and recovery-focused services.

MassHealth will set forth clear expectations for ACOs and CPs to address social determinants of health. These expectations will include assessment of member social service needs, inclusion of social services in members' care plans, making referrals to social service organizations and providing navigational assistance for accessing social services.

A portion of DSRIP funding to ACOs will be explicitly designated for "flexible services" to fund members' social service needs. ACOs will have the ability to direct the use of flexible spending dollars, as long as they meet these minimum criteria:

- Must be based on the assessment of member's social service needs
- Are not covered benefits under the MassHealth State Plan
- Must be consistent with and documented in a member's care plan
- Are determined to be cost-effective alternatives to covered benefits and likely to generate savings
- Are to improve health outcomes or prevent or delay health deterioration
- Funding is not available from other publicly-funded programs
- Other criteria established by MassHealth

MassHealth will establish clear benchmarks to review ACOs' and CPs' progress toward a highly-functional integrated care delivery system. Some portion of DSRIP funds will be at risk based on how ACOs and CPs perform on specific quality and/or process metrics (e.g., ED utilization rate for SMI/SUD population, percent of BH CP members who receive care from a BH community-based provider, penetration rates for primary and medical care access for members with SMI and/or SUD).

4.2.3 Community Partners

MassHealth will certify the following two types of Community Partners to partner with ACOs to support integrated care delivery approaches for members with complex BH and LTSS needs:

Behavioral Health Community Partners (BH CPs): The BH CPs will be responsible for performing the following six services: (1) care management, (2) care coordination, (3) health promotion, (4) transitional care, (5) patient and family support, and (6) referral to community and social supports. Members eligible for BH CP services are those with serious mental illness (SMI), serious emotional disturbance (SED), serious and persistent substance use disorder (SUD), or co-occurring SMI/SUD. For these members, MassHealth will require that BH CPs have primary responsibility for performing all six of these services. BH CPs must either be a Community Service Agency (CSA) for the Children's Behavioral Health Initiative (CBHI) or have agreements with local CSAs for serving children. For children and youth under 21, these services will be provided by Community Service Agencies (CSAs). Established and certified in 2009, CSAs deliver Intensive Care Coordination (ICC) and Family Support and Training (FS&T). CSAs will be automatically deemed to be BH CPs for MassHealth members under 21.

LTSS Community Partners (LTSS CPs): The LTSS CPs will be primarily responsible for supporting members with LTSS needs. This may include members with physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD) and others. ACOs and LTSS CPs will collaborate and form an integrated care team, similar to the One Care model of care. The LTSS CP (or its designee) will be an active participant on the care team and participate in comprehensive care management, care planning, functional assessment, care coordination, care transition, and health promotion for members.

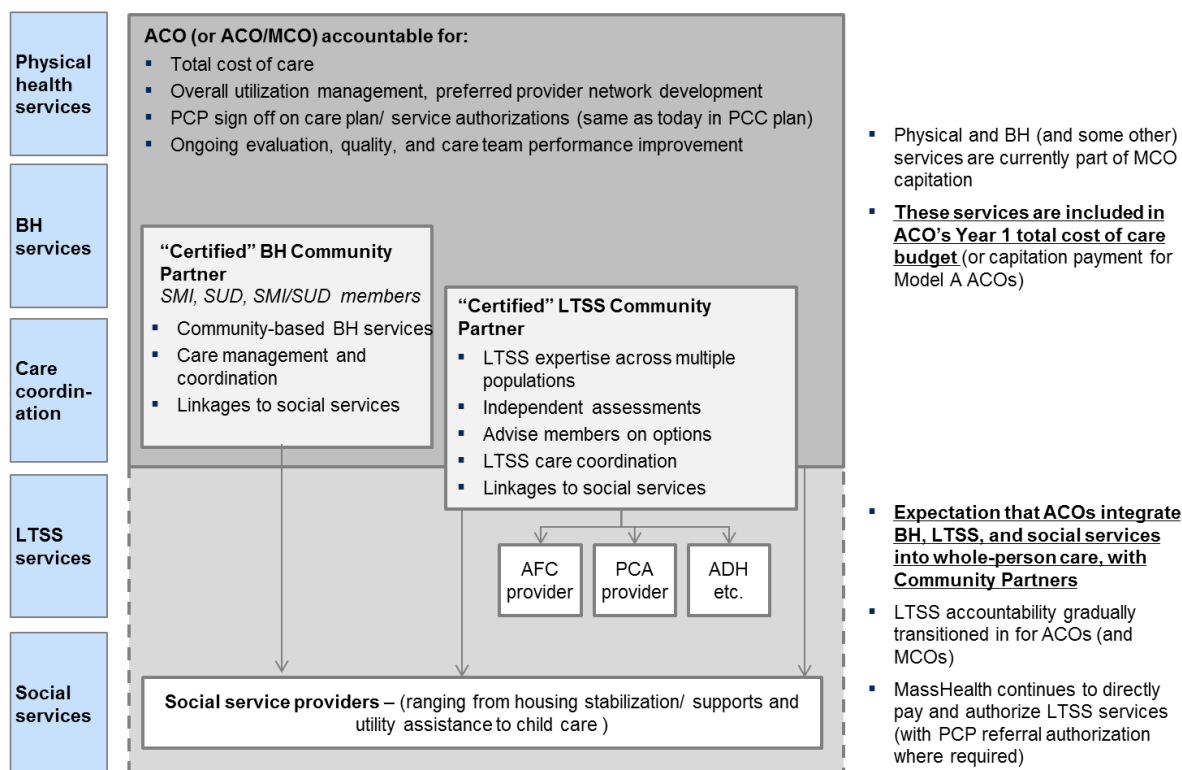
ACOs will be required by MassHealth to delegate certain responsibilities to LTSS CPs, which will include counseling and decision support on service options, LTSS and social needs assessments, patient and family support, and certain referral and navigation services for LTSS or community care. These responsibilities will be conducted in close coordination with the PCP.

Please see Exhibit 4 for a depiction of how ACOs and CPs are expected to work together.

EXHIBIT 4– MassHealth Community Partners Approach

Certified Community Partners: graphical overview

→ Indicate referrals and relationships



To maximize the benefit of DSRIP investments, MassHealth will also be assessing opportunities for CPs to serve members who are not eligible for ACOs; these expectations and opportunities will be included in contractual language and program expectations in advance of the CP program launch.

4.2.3.1 Community Partner (CP) Member Identification

MassHealth will define the criteria by which members will be eligible for Community Partners (CP). MassHealth will provide the information on these members to the CPs as well as the ACOs to facilitate outreach to the member and subsequent screening and assessments for participation in a CP. Members can also self-refer to CP services. MassHealth will also continue to utilize existing mechanisms for screening. For example, in 2008, MassHealth enhanced its EPSDT screening requirements to establish standardized BH screening for children and youth under 21 during pediatric well-child visits. These screenings will continue to be used to identify children and youth who may need BH services, which will be integrated with BH CPs.

4.2.3.2 Overview of ACO and Community Partner Agreements

MassHealth will establish a framework for ACO and CPs to formalize their partnerships, e.g., through a Memorandum of Understanding (MOUs). MassHealth will define the domains that must be agreed upon between the ACO and the CPs, including:

- Roles and responsibilities in care coordination and management

- Shared decision-making and governance
- Performance management & reporting
- Clinical, IT and systems integration
- Approach to address cultural competency and health literacy
- Workforce development and training

DSRIP funding is contingent on ACOs and CPs formalizing arrangements for how they work together on behalf of MassHealth members.

MassHealth will establish minimum expectations for the partnerships between ACOs and their Community Partners based on the domains identified above. However, ACOs and CPs may define terms of above the minimum requirements (e.g., additional services CP may provide for the ACO, increased financial risk and/or performance incentives).

4.2.3.3 *Certification of BH and LTSS CPs*

Community-based providers will need to meet robust set of requirements to qualify as CPs, particularly with regard to their experience and expertise serving members with complex BH and LTSS needs. At a minimum, BH CPs must demonstrate ability to provide the six services described in Section 4.2.3, as well as capacity to deliver outpatient mental health and SUD services, including outreach & home-based services, in a culturally competent manner, according to SAMHSA Recovery Principles. As noted above, Community Service Agencies will be deemed to be BH CPs for children and youth under 21.

At a minimum, LTSS CPs must demonstrate expertise in serving more than one of the following populations with disabilities: (1) elders, (2) adults with physical disabilities, (3) children with physical disabilities, (4) members with acquired or traumatic brain injury, (5) members with intellectual or developmental disabilities, and (6) individuals with co-occurring behavioral health and LTSS needs. LTSS CPs must also demonstrate ability to conduct independent assessments, counseling and decision support on LTSS service options, and navigation to quality LTSS providers.

MassHealth intends to certify community-based LTSS CP organizations that demonstrate the experience and capabilities necessary to provide assessments, information and referral, care coordination, transition care management and planning, and choice counseling to members participating in Model A, B, and C ACOs, or in MCOs.

These entities would need to demonstrate expertise in person-centered planning and independent living principles, cultural competency, and comply with language requirements and accessibility requirements for members with disabilities. MassHealth will establish certification criteria for LTSS CPs which will take into account the principles of independence and person centeredness in assessments and care delivery.

CPs must also demonstrate to MassHealth their internal processes for referring members to available BH and LTSS services in the community. While BH and LTSS CPs will be allowed to self-refer, MassHealth will establish checks and balances to avoid inappropriate self-referrals for services.

The MassHealth certification process will also ensure that BH and LTSS CPs have the staffing, organizational structure and expertise to meet a robust set of requirements to qualify as CPs. Examples of certification domains include:

- Infrastructure and systems (e.g., ability to collect, analyze and share information electronically)
- Care management and coordination
- Staff expertise and training
- Relationships with social service providers and local and public agencies
- Quality measurement and reporting
- Cultural competency

4.3 Managed Care Organizations (MCOs)

4.3.1 Overview of the role of MCOs

As part of its overall restructuring, MassHealth is working to build up and strengthen the existing MCO program. MassHealth plans to re-procure its MCOs for a new contract that will begin in October 2017. The new MCO contracts will include requirements for MCOs to act as partners in administering ACOs and other value-based payment models, new tools to help MCOs manage costs and population health, and an expanded scope of responsibility for MCOs to take on accountability for the coordination and delivery of LTSS. MassHealth sees MCOs as critical partners to support ACO providers in improving care, and these new contracts will be designed to support that role.

4.3.1.1 *Participation in ACO models*

MCOs have a significant role in administering and supporting the ACO program. In most cases when a member enrolls in an ACO, MCOs will remain the insurer. For example, MCOs may integrate with ACOs for Model A. For Model A ACOs and Model C ACOs, MCOs will be explicitly responsible for working with ACO providers to improve care delivery and build provider capacity, including providing analytics for population health management. MCOs may also help provide support to Model A and Model C ACOs as they integrate with BH and LTSS Community Partners.

MCO contracts will require MCOs to assure that their network providers are able to make specific accommodations for MassHealth members with disabilities, including the provision of accessible medical and diagnostic equipment. DSRIP funding may be available to support related enhancements.

4.3.1.2 *Plan Selection and Fixed Enrollment Periods*

To ensure that ACOs and MCOs have sufficient stability in their populations to support member-driven care planning and services, MassHealth will implement 12-month enrollment periods for members. When a member enrolls into an MCO or ACO, they will have a 90-day Plan Selection Period, during

which they may choose a different managed care organization, an ACO, or enroll in the current Primary Care Case Management (PCCM) Plan. After the initial 90 day period, members will be in a Fixed Enrollment Period for the remainder of the year, during which they may disenroll for specified reasons only, in accordance with federal regulations. Members in the PCC Plan may choose to enroll in an MCO or ACO at any time. Fixed Enrollment periods will strengthen the relationship ACOs and MCOs have with enrolled members and the accountability they bear for enrolled members' quality and cost of care, providing an important foundation for investments in population health, preventative care, and community supports.

4.3.1.3 *Phasing LTSS into MCOs' Scope of Services*

Following the implementation of new managed care contracts in October 2017, MassHealth plans to phase LTSS into the scope of services for which managed care entities are responsible. Early quality indicators from Massachusetts' Duals Demonstration program, One Care, show that:

- Members reported better access to care, care coordination, customer service, and communication with their doctors compared to other Medicare plans
- Members reported better access to preventive services than in Medicaid managed care plans
- Members with documented substance use issues were more likely to get treatment than individuals in Medicaid managed care plans

Using the One Care model for Medicaid-only members with disabilities, managed care entities will be required to adopt a person-centered approach to care, invest in community-based LTSS to prevent admissions to and transition members from institutional settings, and support independent living principles. Including LTSS in the managed care entities' capitation payments will align financial incentives for the managed care entities to invest in and leverage community-based LTSS and behavioral health services to reduce avoidable and preventable inpatient and emergency medical services. Focusing on community-based supports as part of a preventative and wellness-based approach to care for members with disabilities and LTSS needs will encourage rebalancing spending away from more acute and facility-based settings and services toward community-based settings and will support independence for MassHealth members.

Critical to the success of this model, managed care entities will be required to demonstrate competencies in the independent living philosophy, Recovery Models, wellness principles, cultural competence, accessibility, and a community-first approach, consistent with the One Care model. Managed care entities will also be required to demonstrate compliance with the recently promulgated managed care regulations, and to demonstrate meaningful supports and processes to ensure members with disabilities can access the services they need from providers in the MCOs' networks. A managed care entity must demonstrate competencies and readiness in these areas before it takes on accountability for LTSS.

MassHealth will incorporate the lessons learned in the development and implementation of the One Care program in order to support the integration of LTSS into its contracted ACOs and MCOs. As

described above, in order to accept responsibility for LTSS, each managed care entity must be ready to accept enrollments, support person-centered assessment and care planning processes, demonstrate cultural competency, language accessibility, and ADA accessibility compliance and proficiency, and fully meet the diverse needs of the LTSS members.

Starting in Year 3, managed care entities must additionally contract for the network of LTSS providers and authorize LTSS service requests for their non-dual, under age 65 members. Those contractors will also need to provide the necessary continuity of care and ensure network adequacy for and access to the spectrum of LTSS providers.

Every managed care entity must pass a comprehensive state readiness review. The readiness review process will include a specific focus on those areas and processes that directly impact the member's care, including assessment processes, care coordination, provider network development and maintenance (as appropriate), IT systems, and the staffing and staff training. Managed care entities will also need to demonstrate capabilities to fully onboard and handle member and provider communications, service authorizations, grievances and appeals, and other administrative processes necessary to effectively and respectfully serve the needs of MassHealth members with disabilities and other community support service needs. Readiness review tools will incorporate each of the requirements of the contract between MassHealth and the managed care entities will incorporate feedback from the LTSS stakeholder community. MassHealth plans to model this readiness review process on One Care's process and is committed to continued consultation and collaboration with the stakeholder community.

Managed care entities will be required to implement a person-centered planning process which focuses on the individual's personal goals and preferences. In order to assure a person-centered planning process when a member requires LTSS, the managed care entities will be required to seek out community-based LTSS expertise by engaging LTSS CPs to assess that members' need for LTSS. MassHealth will establish certification criteria for LTSS CPs which will take into account the principles of independence and person centeredness in assessments and care delivery.

Once LTSS is incorporated in a managed care entity's scope of responsibilities, the managed care entity will be responsible for both community and institutional LTSS benefits and for care management across all service areas, in order to align incentives for MCOs to invest in community-based care and to divert and transition members from long-stay facility settings.

Current State Plan benefits that MassHealth will require managed care entities with LTSS accountability to contract and pay for from their capitation (with no fee-for-service wrap) will include:

- outpatient chronic disease and rehabilitation hospital
- personal care attendant
- transitional living program
- private duty nursing

- adult foster care
- group adult foster care
- adult day health
- day habilitation
- durable medical equipment (DME)

4.4 Changes to benefits and copays to encourage enrollment in coordinated care options

Massachusetts believes that a comprehensive, coordinated and managed model of care will enable members to improve and maintain their health more effectively than an unmanaged model.

Massachusetts therefore will introduce incentives in MassHealth to encourage members to opt for an MCO or ACO rather than the PCC Plan.

To this end, Massachusetts plans to limit certain benefits for members enrolled in the PCC Plan while maintaining them for members in MCOs and ACOs, beginning in October 2017. These services include chiropractic services, eye glasses, hearing aids and orthotics.

As part of its continuing ACA implementation work, MassHealth plans to update the out-of-pocket cost sharing schedule – including copayments and premiums, in 2018. MassHealth members at the lowest income levels will no longer be assessed copayments for medications or services regardless of delivery system. Copayments will be eliminated for members with income under 50 percent of the FPL (representing 50 percent of the total MassHealth population), and the premium schedule will be recalibrated for members with income over 150 percent FPL to tie premiums to a percent of family income. This will smooth out fluctuations in the current schedules that members with income over 150 percent FPL can experience when their income or family circumstances change. For the remaining members who will continue to be responsible for copayments, MassHealth will also be aligning copayment amounts to encourage members to enroll in integrated and coordinated systems of care, with reduced copayment amounts in ACOs and MCOs compared to the PCC Plan and FFS. For example, a PCC Plan member would pay \$3.65 for most medications today. On the new schedule, this amount would increase \$0.35 and the member would pay \$4 for their medications in the PCC Plan, but they could reduce their medication copayments by 50 percent to \$2 by enrolling in an ACO or MCO. MassHealth will also expand the list of services to which copayments may apply. Cost sharing changes are expected to be implemented in 2018, and will be preceded by a public process.

Section 5. Delivery System Reform Incentive Program Investments

Massachusetts' plan is to shift the MassHealth care delivery and payment systems from a predominantly fee-for-service model to one that is value-based and member-focused. Our goal is to achieve meaningful delivery system reform through provider partnerships across the care continuum and broad participation in alternative payment models. Clear targets for cost, quality and member experience will measure progress toward this vision.

To fund the delivery reform, Massachusetts proposes partnering with the federal government in the development and implementation of a DSRIP program. Massachusetts' DSRIP model is unique in that it is also tied to effecting permanent change to the system's underlying payment model. The five year federal investment will catalyze change, after which our reform will be self-sustaining, supported by projected savings. Additionally, unlike other DSRIP programs that focus investment on traditional medical providers, Massachusetts is investing in medical providers (via ACOs) and in certified Community Partners (CPs) with expertise in providing care to members with BH and LTSS needs. DSRIP funding to these providers will be contingent on participation as an ACO or CP, and on the establishment of formalized partnerships between ACOs and CPs. This cross-spectrum coordination requirement is a key tenet of Massachusetts' DSRIP program, and aligns with Massachusetts' goal of creating and strengthening coordination among historically segregated health care delivery systems. Massachusetts accepts accountability for this investment, including making a portion of each year's federal DSRIP funding contingent on the achievement of specific performance metrics. ACOs and CPs will have financial accountability for state-defined cost and quality goals through the ACO payment models and CP performance accountability strategies described above. All efforts and incentives will focus on improving members' experience, improving the population's health and reducing the per member cost of care.

DSRIP funding will play an important role in determining the success of Massachusetts' reform endeavor. A high level of risk and investment is necessary to achieve the aforementioned goals. The Commonwealth and providers are eager to move forward, provided that DSRIP funding can be used to support their efforts and offer sufficient incentive to break away from the traditional FFS business model. Ultimately, the goal is to use this transitional DSRIP funding to move providers towards more accountable, integrated, and effective care, while sharing cost savings with MassHealth.

5.1 Total DSRIP funding, expected annual disbursement and principles of disbursement

Over five years, MassHealth is seeking to allocate a maximum of \$1.8 billion through DSRIP to providers participating in one of the three ACO models, to support the transition to value-based payment and care delivery. DSRIP investments will be disbursed in such a way to achieve the following objectives:

Support Development of MassHealth ACOs

DSRIP funds will help providers transition to the new MassHealth ACO models by enabling implementation of new care delivery models and improvements in infrastructure, coordination of member care across service areas, clinical/community linkages, workforce capacity, and population health management. This funding will give DSRIP-participating providers the transition time needed to generate savings under the new ACO payment arrangements, and will cease after the 5-year DSRIP period.

The funding stream will be available only to providers that participate in accountable care models, and will be calculated on a per member, per month (PMPM) basis. DSRIP ACO funding will be contingent on

ACOs establishing formalized partnerships with Community Partners that clearly delineate responsibilities for both ACOs and CPs regarding integration and coordination of care.

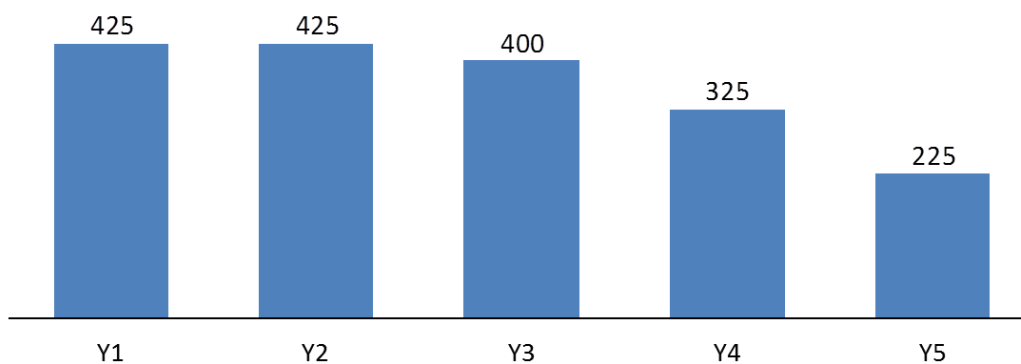
Support Development of Certified Community Partners

DSRIP funds will help CPs build up care coordination capabilities, infrastructure, and workforce capacity to better partner with the MassHealth ACOs and to better serve MassHealth members with BH, LTSS, and social service needs. DSRIP CP funding will be contingent on CPs establishing formalized partnerships with ACOs that clearly delineate responsibilities for both ACOs and CPs regarding integration and coordination of care.

Support Development of Statewide Infrastructure

In addition to provider-specific investments, DSRIP funds will help the state more efficiently scale up statewide infrastructure and workforce capacity. DSRIP funds to ACOs and CPs will taper down over the DSRIP period on both a state and provider level, so as to avoid a funding “cliff” at the end of the DSRIP period. A minimal amount of DSRIP funding will be allocated for state administration in order to ensure robust implementation and proper oversight of the DSRIP program. For the requested DSRIP package of \$1.8B, the projection of funds allocation over five years is as displayed in Exhibit 5.

EXHIBIT 5 – Annual Allocation of \$1.8B DSRIP Funds Over Five Years

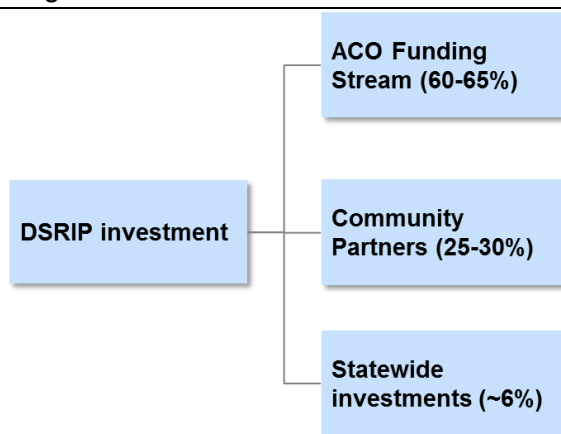


Our proposal directly links DSRIP to payment and delivery system reform, requiring providers to commit to new models of care in order to receive funding. Therefore, if participation in our new payment models is faster or slower than anticipated, annual funding allocations may need to change to keep providers’ per member payments within an appropriate range. We intend to define an appropriate per member per year (PMPY) range for our ACO and CP funding streams, and we request the ability to carry over any remaining spending authority from the annual funding allocation to the following DSRIP year.

5.2 DSRIP funds: general streams of funding

If CMS authorizes a DSRIP investment of \$1.8B over 5 years, Massachusetts will disburse DSRIP funds into four general streams of funding in the following proportions, pending CMS approval:

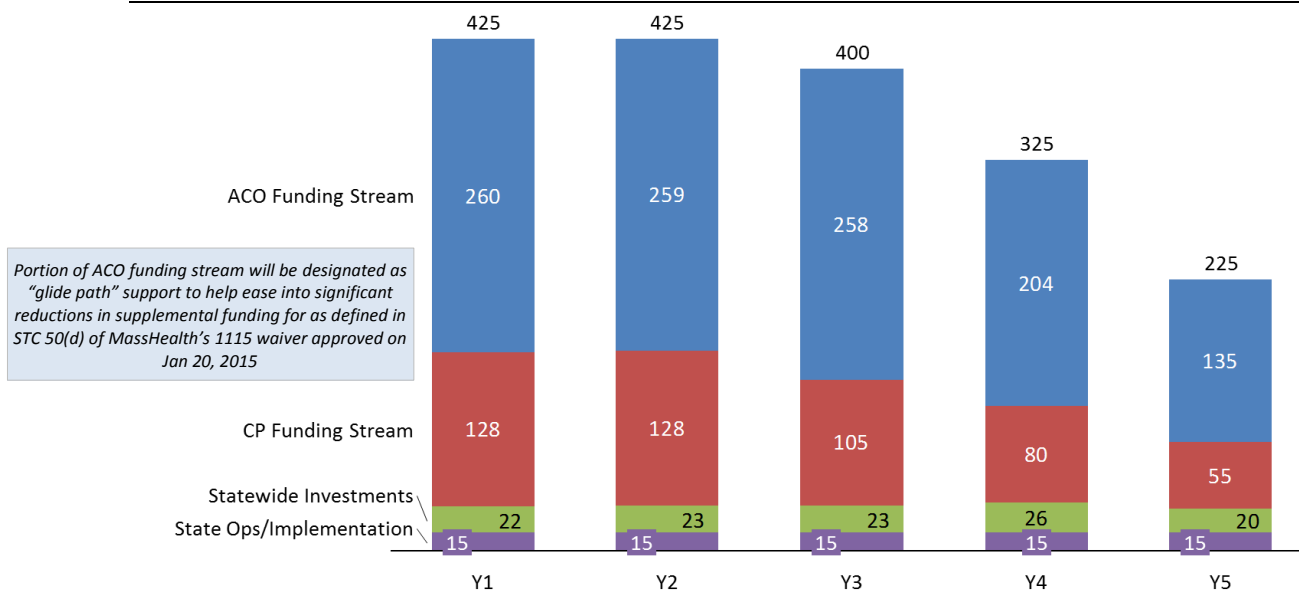
EXHIBIT 6 – DSRIP Funding Streams



*Small amounts of funding (~4%) will be used for state implementation/oversight of DSRIP

Please see Exhibit 7 for a depiction of how the different DSRIP funding streams may vary over the five-year DSRIP period. The amount of funding allocated to the various streams is subject to change based on CMS approval of MassHealth's DSRIP proposal.

EXHIBIT 7 – DSRIP Funding Streams By Year (\$M)



The following sections provide these details for each funding stream:

- Recipients and funding eligibility
- Funding uses and justification
- Method of allocation and distribution
- Decision rights on spending
- Accountability to the State

5.3 DSRIP funds: ACO funding stream

5.3.1 Recipients and funding eligibility

The DSRIP ACO funding stream will be disbursed only to ACOs that enroll all eligible members in one of the new MassHealth ACO models and have met the requisite ACO certification and contractual requirements, as described in the ACO section above. ACOs that leave the DSRIP program prematurely will need to pay back a significant proportion of their already-received DSRIP funds. Finally, ACOs must show memoranda of understanding (MOUs) with certified CPs.

5.3.2 Funding uses and justification

The DSRIP ACO funding stream will serve four general purposes:

- Infrastructure and start-up support (e.g. information technology, contracting/networking development, performance management infrastructure, new care delivery models)
- Ongoing/operational costs to support the ACO model of care (e.g. workforce capacity development, ongoing care coordination/management investment)
- Spending for flexible services to address health-related social needs (specific amount to be designated within the broader ACO funding pool)
- Transitional funding for certain safety net hospitals currently receiving funding through the Delivery System Transformation Initiatives program to establish a “glide path” for reduction in supplemental funding

As further described below, Massachusetts believes that the proposed level of funding is appropriate to support MassHealth ACOs. Massachusetts acknowledges and seeks to build on the existing commercial and Medicare ACO activity in the state. However, MassHealth also believes that the proposed approach imposes new and different requirements on ACOs above and beyond what existing infrastructure can support.

The start-up spending will support the development of new ACOs (particularly among safety net providers) to serve the MassHealth population, and the development of new capabilities and partnerships for existing ACOs. The ongoing costs spending will support expansion of functions like care coordination services to the MassHealth population. Flexible services spending is a new expenditure category for all ACOs in the Commonwealth, part of our broader push towards integration of social and community services.

5.3.2.1 ACO funding purpose 1: infrastructure and startup spending

The Commonwealth expects significant participation from new ACOs and from existing ACOs that will expand to contract with MassHealth. MassHealth’s ACO models go beyond Medicare and commercial ACO models – even established ACOs do not have all the core capabilities needed to serve MassHealth’s members. Many members have more specialized care management needs than members in commercial or Medicare populations, including behavioral health comorbidity, substance use disorders, and long-term or community care needs. Massachusetts has built in significant requirements for member-driven,

culturally competent care for these populations, which will require even experienced ACOs to make investments in new areas, including translation and language services, colocation and integration of BH services, and the use of comprehensive care assessments in care plans for members with disabilities.

In addition, the ACO participation targets to which Massachusetts is committing are only achievable if MassHealth is successful at encouraging the formation of many new ACOs. The ACOs' success, in turn, will depend on sufficient start-up DSRIP funding.

Additionally, MassHealth's ACOs will be member-facing to a greater degree than current ACOs, requiring investments in member communication and customer service that can be particularly challenging for a Medicaid population. Potential strategies include greater use of mobile health, telephony, and practice extenders like community health workers to follow up with members in the community.

5.3.2.2 ACO funding purpose 2: ongoing costs to support the ACO model of care

ACO DSRIP funds will support the cost of expanding the ACO care model to the MassHealth population, e.g., care coordination and population health management. DSRIP funds for this purpose taper over the course of five years; we expect these services to be covered within the total cost of care budget over time. DSRIP funds will be distributed in a way that ensures no overlap in funding for work by ACOs and work by CPs. The Commonwealth will also ensure no duplication of payment to ACOs and MCOs.

5.3.2.3 ACO funding purpose 3: direct spending for traditionally non-reimbursed flexible services to address health-related social needs

A portion of ACO DSRIP funds will be dedicated to spending on flexible services, not currently reimbursed in MassHealth, which address health-related social needs. Categories of flexible services include:

- Housing stabilization and support, search and placement
- Utility assistance
- Non-medical transportation
- Physical activity and nutrition
- Sexual assault and domestic violence supports

ACOs and CPs will be responsible for supporting navigation of health related social services (as described in sections above), whereas the DSRIP flexible services funding to ACOs can be used to pay for services. For example, an ACO or a CP can help a member fill out an application for utilities assistance, and DSRIP flexible services funding can be used to actually pay the electric bill, if deemed necessary by the member's care management team.

For members receiving BH and LTSS CP services, MassHealth's expects that ACOs will work with their partnered CPs to help determine the best uses for flexible service dollars to meet members' needs.

5.3.2.4 *ACO funding purpose 4: transitional funding for certain safety net hospital providers*

As described in further detail in Section 6, during the five-year waiver term, MassHealth will restructure waiver funding for safety net hospital systems to be more sustainable and aligned with value-based care delivery and payment incentives. The seven safety net hospitals currently receiving funding through the Delivery System Transformation Initiatives (DSTI) program will instead receive a combination of transitional DSRIP funding to support ACO adoption and ongoing operational support through Safety Net Provider payments authorized under the Safety Net Care Pool. Ultimately, the overall level of funding these hospitals receive will be reduced to a more sustainable level of ongoing operational support through only the latter stream. Over the next five years, DSRIP funding will serve both to support the transition to ACO models and to smooth the shift to a lower level of ongoing Safety Net Provider funding. As a result, ACOs that include any of these safety net hospitals will be expected to ensure that a portion of their DSRIP funding is available to the hospital(s) to ensure this smooth glide path.

5.3.3 **Method of allocation and distribution**

The amount of funding will be determined in the following manner:

- **ACO Start-Up and Ongoing Support:** The amount of DSRIP funds an ACO receives will be proportional to the size of its attributed member population and a per member per year (PMPY) dollar amount. If the \$1.8B DSRIP proposal is authorized, PMPY funds for each ACO will be highest in Year 1 and taper down over time to avoid a funding “cliff.”
 - **Safety Net PMPY Increase:** The PMPYs used to calculate the ACO start-up and ongoing costs will be modified by a “safety net” increase schedule, where ACOs with a higher percentage of revenue derived from the MassHealth/uninsured population will have a larger increase in their PMPYs. Combined with an additional PMPY increase for DSTI safety net hospitals, the safety net PMPY increase schedule will contribute to higher PMPYs for safety net ACOs.
 - **ACO Model PMPY Increases:** To promote adoption of the more advanced ACO Models, Massachusetts requests the flexibility to apply an additional PMPY increase schedule to the ACO start-up and ongoing costs for ACOs that adopt these models. MassHealth’s current thinking is to apply an ACO Model PMPM increase for Models A and B (same increase factor for Models A and B)
 - **Investments in Primary Care:** MassHealth will designate a certain portion of startup/ongoing funding to fund investment in patient-centered primary care models under an accountability and performance management structure agreed upon by the ACO and its participating PCPs, based on principles that will be defined by MassHealth
- **Glide Path Funding for Certain Safety Net Hospitals:** ACOs with safety net hospitals currently participating in DSTI will receive transitional “glide path” funding for these hospitals, as described above. These ACOs will then need to distribute the glide path DSRIP funding to any DSTI hospitals that are included in the ACOs.
- **Flexible Services:** The amount of funding dedicated to flexible services will be determined as a PMPY amount; this PMPY will remain the same across the 5 year DSRIP period, and will not be affected by the safety net and ACO model PMPY increases.

Massachusetts requests the flexibility to vary the PMPY amount within an agreed-upon range, subject to the overall agreed-upon annual funding amounts for the ACO DSRIP funding stream. The annual ACO funding amounts in this DSRIP proposal are based on MassHealth's current understanding of how many members may be attributed to ACOs in each DSRIP year. Because ACO attribution may be different from modeling assumptions, the requested flexibility will allow MassHealth to respond to actual ACO participation in early years in ways that reduce program risk and increase long-term participation. Additionally, the Commonwealth requests the flexibility to carry over a portion of DSRIP funding authority for up to two years, in accordance with existing rules on Federal Financial Participation (FFP).

A portion of DSRIP funding to the ACOs will be at-risk: the full amount of funding will depend on an ACO DSRIP accountability score. Please see Section 5.3.5 for more details.

5.3.4 Decision rights on spending

ACO startup/ongoing support

MassHealth will designate a certain portion of startup/ongoing funding to fund investment in patient-centered primary care models under an accountability and performance management structure agreed upon by the ACO and its participating PCPs, based on principles that will be defined by MassHealth. All other startup/ongoing funding to an ACO may be allocated at the ACO's discretion, including the allocation of additional funding to the safety net hospitals and PCPs.

ACO flexible services support

ACOs may only use this funding stream for the aforementioned flexible services described in Section 5.3.2.3. If the ACO does not use the flexible services funding, it loses that funding, which will be diverted into the Technical Assistance statewide investments funding pool.

ACO DSTI glide path support

ACOs with DSTI safety net hospitals will need to pass through the glide path funding to the DSTI hospitals that are included in the ACOs (see Section 5.3.3).

5.3.5 ACO accountability to the State

All ACOs will have a contract with MassHealth accepting accountability for the total cost of care for their members beginning in their DSRIP Performance Year 1 (PY1). In addition, an increasing amount of DSRIP funds (0-20 percent) will be at risk over the five-year DSRIP period. A DSRIP accountability score will determine how much of an ACO's at-risk DSRIP funds will be released each year. The accountability score consists of the following components:

- **Avoidable utilization:** This portion of the score is divided between two measures: percent reduction from PY1 in MassHealth potentially preventable admissions, and percent reduction from PY1 in MassHealth all-cause hospital readmissions. Reporting in PY1 will set the baseline for each ACO; reduction targets from the baseline increase in each of the subsequent four performance years.

- Spending: State spending reduction targets will be passed down to ACOs via target spending goals for an ACO's ACO-eligible PMPM spending, beginning in PY3.
- Quality: ACOs' quality performance will be evaluated for DSRIP using a single, composite score developed from the full ACO quality measure slate. Certain measures, such as LTSS measures and those without baselines, will be phased into the quality slate and the DSRIP composite score. ACOs will be expected to maintain or improve their previous year's performance each year.
- Progress towards integration across physical health, behavioral health and long-term services and supports: MassHealth will establish clear process and outcome metrics to review ACOs and CPs' progress toward a highly-functional integrated care delivery system (e.g., ED utilization rate for SMI/SUD population, percent of BH CP members who receive care from a BH community-based provider).

If an ACO performs below a MassHealth-determined performance threshold for two consecutive years, MassHealth reserves the right to increase the proportion of DSRIP funds at risk in the following year. If an ACO decides to exit the DSRIP program prior to the end of the five year 1115 waiver demonstration period, it will be required to pay back a significant portion of all DSRIP funds received up to that point.

5.4 DSRIP funds: Community Partner funding stream

5.4.1 Recipients and funding eligibility

Funds will be disbursed only to entities that have been certified through the Community Partner certification process. CPs will need to demonstrate establishment of MOUs with ACOs detailing how the two entities will coordinate care for their mutual members.

5.4.2 Funding uses and justification

5.4.2.1 Certified LTSS Community Partners

Funding Stream 1: DSRIP funds for care management, coordination, assessments, and counseling
LTSS Community Partners will receive funding to provide independent assessments, person-centered counseling on service options, and referrals to LTSS providers. LTSS CPs will also receive funding for their participation on the member's care team, which will be led by the ACO. This funding will taper down, beginning in Year 3 of the DSRIP period.

Funding Stream 2: DSRIP funds for infrastructure and capacity building

Funding will be available for infrastructure and capacity development, such as expansion of workforce capacity, health information technology (HIT) investments, performance management and data analytics capabilities; they may also be used for start-up funds for certain services or care coordination approaches. The funding will be higher in the earlier years, and taper off over the 5 year period. Prior to each Performance Year, the LTSS Community Partner must submit, and MassHealth must approve, a proposed workplan and budget for how the CP plans to use its allocated DSRIP infrastructure and capacity development funding within MassHealth-approved categories of investments, which may include:

- Workforce capacity
- HIT investments
- Performance management capabilities
- Contracting/networking resources
- Project management capabilities

5.4.2.2 Certified BH Community Partners

Funding Stream 1: DSRIP funds for comprehensive care management, care coordination, health promotion, transitional care, patient and family support, and referral to community and social supports. DSRIP funding will be used to support the six BH CP services described in Section 4.2.3. The funding will taper off in years 3 through 5 of DSRIP with the expectation that the care coordination services will be increasingly supported by the ACO's total cost of care budget.

Funding Stream 2: DSRIP funds for infrastructure and capacity building

Funding will be available for infrastructure and capacity development, such as expansion of workforce capacity, HIT investments, performance management and data analytics capabilities. The funding will be higher in the earlier years, and taper off over the 5 year period.

Prior to each Performance Year, the BH Community Partner must submit, and MassHealth must approve, a proposed workplan and budget for how the CP plans to use its allocated DSRIP infrastructure and capacity development funding within MassHealth-approved categories of investments, such as:

- Workforce capacity
- HIT investments
- Performance management capabilities
- Contracting/networking resources
- Project management capabilities

5.4.3 Method of allocation and distribution

Massachusetts requests the flexibility to vary the PMPY amount within an agreed-upon range, subject to the overall agreed-upon annual funding amounts for certified Community Partners. The annual CP funding amounts in this DSRIP proposal are based on MassHealth's current understanding of how many members will be served by CPs in each DSRIP year. Because member allocation to CPs may be different from modeling assumptions, this requested flexibility will allow MassHealth to respond to actual CP coverage in early years in ways that reduce program risk and increase long-term participation. Additionally, the Commonwealth requests the flexibility to carry over a portion of DSRIP funding authority for up to two years, in accordance with existing rules on FFP.

A portion of DSRIP funding to the BH and LTSS Community Partners will be at-risk – the amount of funding released will depend on a CP DSRIP accountability score (see section 5.4.5).

5.4.4 Decision rights on spending

Community Partners may utilize DSRIP Community Partner funding for the acceptable uses detailed in sections above and in their approved budgets and workplans.

5.4.5 Community Partner accountability to the State

The CP and MassHealth will agree to a set of metrics and milestones within the MassHealth-approved categories of investments (such as infrastructure and system development, progress toward MOUs with ACOs, staff training and other activities).). For example, if funding is approved to improve HIT capacity to share member-level information electronically, MassHealth will hold the CP accountable to demonstrate progress on this activity.

In addition, MassHealth will establish clear benchmarks to review ACOs and CPs' progress toward a highly-functional integrated care delivery system. Some portion of DSRIP funds will be at risk based on how ACOs and CPs perform on specific quality and/or process metrics (e.g., ED utilization rate for SMI/SUD population, percent of BH CP members who receive care from a BH community-based provider).

MassHealth will actively monitor the funds provided to CPs. MassHealth will require each ACO/CP partnership to provide projected DSRIP budget allocation for the next five years. MassHealth may also require the submission of quarterly reports to illustrate actual spend against the ACO's initial budget projection. Deviations in excess of a pre-determined corridor may require a written justification.

The percentage of DSRIP funds at risk for CPs increases (from 0 to 20 percent) over the five-year DSRIP period, and the amount actually lost will be determined by a DSRIP accountability score. The accountability score will be based on a composite of process measures, quality measures, and ACO/MCO evaluation of CP performance, with various measures phasing in over time. MassHealth will also monitor data and delivery of services between CPs and ACOs to ensure that each deliver unique services.

5.5 DSRIP funds: Statewide investments funding stream

The statewide investment funding stream will allow Massachusetts to fund up to ten high priority initiatives in alignment with the overall DSRIP goals. Initiatives may include health care workforce development, targeted technical assistance, and promotion of clinical/community linkages. These investments are part of the Commonwealth's strategy to efficiently scale up statewide infrastructure and workforce capacity, and will play a key role in moving Massachusetts towards achievement of its care delivery and payment reform goals.

5.5.1 Healthcare Workforce Development and Training (e.g., student loan repayment, workforce development)

Restructuring Massachusetts' health care delivery system requires a well-equipped health care workforce that practices at the top of its licenses. The shift to a population-based delivery model will increase the importance of and need for primary care clinicians, behavioral health providers, care

coordinators, recovery coaches and certified peer specialists. The Commonwealth is experiencing a shortage of primary care clinicians, behavioral health providers and care coordinators, which it can address in part through student loan repayment programs and investments in primary care residency training.

Additionally, as ACOs enter into new global payment models and shift care into integrated clinical service models, providers will need professional development training to effectively operate in the new landscape. Training would include fundamental skills such as care management, patient engagement, teamwork, and technological aptitude.

Therefore, Massachusetts is seeking to fund a five-year program that includes

- Student loan repayment,
- Primary care integration models and retention strategy,
- Expansion of the Community Medicine Residency and Advanced Practice Nurse Mentorship programs at community health centers, and
- Workforce professional development to better meet the demands of the new healthcare landscape.

Massachusetts will prioritize investments in community health centers, community mental health centers and BH and LTSS CPs participating in ACO models, consistent with its desire to support providers delivering care to the Commonwealth's neediest residents.

5.5.1.1 *Student Loan Repayment Programs*

Massachusetts proposes a student loan repayment program for full-time physicians, advanced practice nurses, certified nurse midwives and physician assistants employed at community health centers, in exchange for a two year service commitment. Massachusetts will also fund similar loan repayment programs for behavioral health professionals (such as psychiatric nurse specialists, clinical or counseling psychologists, clinical social workers, and mental health counselors), in exchange for two years of full time service or the equivalent in part time service for the medically underserved. MassHealth or its designee will administer these funds through a grant program.

The student loan repayment program accountability will be based on successful disbursement of funds to primary care providers and to behavioral health providers. MassHealth or its designee will assess the programs' effectiveness on physician and behavioral health professional retention in Years 2 and 5 through surveys and interviews with award recipients.

5.5.1.2 *Primary Care Integration Models and Retention*

MassHealth is requesting the authority to use DSRIP funding for MassHealth or its designee to implement a grant program that provides support for providers to engage in one-year projects related to accountable care implementation, including improving care coordination, integrating primary care and behavioral health, and staff training in serving sub-populations including, but not limited to members of cultural and linguistic minorities, children and youth with an Autism Spectrum Disorder (ASD), members with intellectual and developmental disabilities, and other members with disabilities.

These projects must support improvements in cost, quality and member experience through accountable care frameworks and will also serve as an opportunity to increase retention of providers. Applicants will propose clear metrics as part of their application. Accountability will be ensured through disbursement of funds and reporting of projects including descriptions and outcomes. MassHealth or its designee will assess the program's effectiveness on physician retention in Years 2 and 5 through surveys and interviews with award recipients.

5.5.1.3 *Investment in Primary Care Residency Training*

Data and experience show that a significant percentage of providers who train in community health centers continue to practice in them. However, community health center primary care residency programs require a significant financial commitment from the sponsoring health centers. For each resident or nurse practitioner student a health center trains, the center loses patient service revenue due to lost direct patient care time, and it incurs additional costs related to logistics, scheduling, credentialing, and general oversight. Additionally, hospitals have financial disincentives for sending residents to community health centers because of the revenue a hospital loses from students being placed in community health center residency slots rather than hospital-based slots. MassHealth is requesting authorization for DSRIP funding to help offset the costs of community health center residents for both community health centers and hospitals.

MassHealth or its designee will administer funding on a grant basis to community health centers. Accountability will be ensured through MassHealth or its designee's disbursement of funds and assessments in Years 2 and 5 of whether the investment has led to an increase in the number of physicians who select primary care at a community health center as their specialty.

5.5.1.4 *Workforce Development Grant Program*

MassHealth's payment reform initiatives will introduce new demands and shifting responsibilities for the health care workforce. The Commonwealth would like DSRIP authorization to support a wide spectrum of health care employee training to enable those working in the new system to do so most effectively.

Providers participating in payment reform initiatives will be eligible for this grant. Applications will include a workforce engagement plan for which the grant will be used, including the workforce implications of their reform plans, their proposed partnerships with cross-spectrum care partners, their use of DSRIP incentive funds, their approach for new hiring, and training and redeployment plans for existing staff. For example, if a hospital participates in an ACO, this may require a number of their nurse managers to take on additional roles of care coordination, management between providers, and quality assurances. The ACO can apply for grant funding to have a consultant provide on-site training, assist in developing a workplan, monitor execution of the plan, and be available for questions and guidance where needed.

ACOs and CPs will be required to work with MassHealth or its designee to determine grant specific process measures. Recipients will also need to provide a detailed report to MassHealth describing

completed activities, utilization of funds, and successful implementation of engagement plans or, alternatively, revised plans and actions to date.

5.5.2 Technical Assistance

As ACOs and CPs take on additional responsibility of more actively managing and meeting the needs of a Medicaid population, providers may struggle with identifying the interventions that result in the highest return on investment (ROI). MassHealth can help ACOs and CPs structure their Technical Assistance approach such that it is built upon evidence-based and high ROI interventions from a cost and quality point of view. To this end, Massachusetts will procure vendors to administer technical assistance upon the principles mentioned above, ensuring access to high quality vendors for all ACOs and CPs. Providers will be required to contribute 30 percent of the overall TA costs, which will create an incentive to work diligently with the TA vendor and MassHealth to effect change.

Providers may apply for technical assistance in the following categories.

- 1) Education: Initial and ongoing education to ACOs and CPs on delivery system reform topics such as governance requirements, shared savings and shared losses, network development, care coordination, quality and financial management analytics, assistance with health care literacy, and cultural competency.
- 2) Legal: Consultations related to contract arrangements between ACOs and CPs at the start of the DSRIP program, and other arrangements throughout the course of the demonstration; or assistance in establishing protocols and procedures, such as regarding care coordination.
- 3) Actuarial: Actuarial consulting to support participation in payment models
- 4) Financial: Baseline education and readiness assessments that address financial business process changes, patient attribution, budgeting and practice management systems
- 5) Performance Management: Technical assistance to support program improvements, project management and provider performance management to improve ACO/CP's overall performance. This includes performance improvement on patient outcomes and other quality metrics.
- 6) HIT: Consultations to provide insight into what HIT investments and workflow adjustments will be needed to achieve goals regarding data sharing/integration across the delivery system
- 7) Culturally Competent Care: Training and coaching to increase the availability of culturally competent care to members of racial, ethnic and language minorities, as well as for LGBTQ members and members with physical, intellectual, and development disabilities

5.5.3 Alternative Payment Methods (APM) Preparation Fund

Massachusetts seeks authorization to use DSRIP funding for an APM Preparation fund, which will support providers that are not yet ready to participate in an ACO but want to take steps towards APMs, such as responsibility for the total cost of care for a population. Funds can be used to develop, expand, or enhance shared governance structures and organizational integration strategies linking providers across the continuum of care.

Applicants will be required to agree to specific goals and metrics. Preference will be given to those with limited experience and resources. Applicants will need to demonstrate a clear pathway to APM adoption as part of their application. Recipients will be required to report their activities and movement towards APMs as well as the status of their goals and metrics.

5.5.4 Enhanced diversionary behavioral health services to address Emergency Department boarding

Each day, Massachusetts residents are unable to obtain timely access to the mental health and substance use disorder services they need. As a result, an increasing number of patients who are waiting for admission into acute inpatient treatment or diversion to a more appropriate placement end up being boarded in hospital emergency departments (EDs).

The Commonwealth seeks DSRIP funding to support investment in and reimbursement for new or enhanced diversionary levels of BH care that will meet the needs of patients within the least restrictive, clinically most appropriate settings. Models considered for development and funding include:

- Urgent care and intensive outpatient program (IOP)
- Community-based Acute Treatment (CBAT) for adults
- Enhanced ESP/Mobile Crisis Intervention (MCI) Capacity
- Clinical Stabilization Services (CSS)
- Greater use of Certified Peer Specialists in crisis services
- Telemedicine and Telepsychiatry
- Discharge navigation services

Accountability for funds will depend on achieving a pre-determined target to reduce the number of ED BH boarders in the five years of DSRIP. If the proposed approaches are successful, we will explore paths for other vehicles and authorities (e.g., state plan) to ensure that these interventions can be scaled and sustained.

5.5.5 Improved accommodations for people with disabilities

MassHealth has hundreds of thousands of members with disabilities who need reasonable accommodations to receive the medical services they need. Massachusetts providers strive to meet such needs, but some providers lack the resources to further enhance accommodations. Examples include physical site access, medical equipment access, communication access as well as programmatic access to accommodate physical, cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities. Massachusetts plans to encourage members to work with their ACOs and PCPs, and will ensure that all members have equal access. To promote this goal, MassHealth requests authorization to use DSRIP funding to assist providers in purchasing necessary items or making adjustments to accommodate persons with disabilities.

Providers will be required to apply for such funding in the form of a grant. Providers will also be expected to contribute financially to such improvements. They will be required to submit reports

confirming the use of funds as well as the number of members with disabilities they served. MassHealth will collaborate with providers to establish additional process measures to guarantee accountability.

5.6 DSRIP funds: State administration funding stream

DSRIP funding allocated to state operations/implementation will be used to fund Massachusetts staff and vendors to administer the DSRIP program, and to ensure a robust rollout and proper oversight of the DSRIP program. This funding stream will be a small portion of total DSRIP funding (4 percent).

5.7 State DSRIP accountability to CMS

5.7.1 State Accountability to CMS

Massachusetts is committed to full accountability for all DSRIP funding, with an emphasis on reduction in utilization, strong performance on quality metrics, and savings in the total cost of care. The amount of DSRIP funds that Massachusetts will have at risk will increase over the five-year DSRIP period, starting from 0 percent and increasing to 15 percent. The portion of at-risk funds CMS releases to the Commonwealth will be determined by a statewide accountability score comprising the following elements:

- ACO adoption (20 percent): Massachusetts will have an increasing target of the percentage of MassHealth ACO-eligible lives enrolled in ACOs. The target percentage will start at 30 percent in Year 1 and increase to 60 percent by Year 5.
- Avoidable utilization (30 percent): Massachusetts will be accountable for reporting hospital admissions and readmissions in Year 1, and then reducing them in each of the next four years. Massachusetts will work with CMS to calculate state baselines and reduction targets each year.
- Spending (25 percent): Massachusetts will be accountable for reducing PMPM spend for ACO-eligible members beginning in Year 3. The target reduction is 0.3 percent off of the status quo trend in Year 3, and moves to 2.5 percent off of status quo in Year 5.
- Quality (25 percent): Beginning in Year 2, Massachusetts will be accountable to maintain or improve performance each year on a composite measure constructed from the ACO quality measure slate.

5.8 DSRIP funds: operational considerations

5.8.1 Funding disbursement and at-risk funding

CMS will reimburse MassHealth for DSRIP expenditures made. An increasing amount of state DSRIP funding will be at-risk over the five-year period. If the Commonwealth loses any of its at-risk funding, CMS will provide a smaller reimbursement amount for MassHealth's DSRIP expenditures that corresponds to the lost amount of at-risk funding. CMS will retain any funds that it withholds from the Commonwealth. Any reduction in DSRIP reimbursement to MassHealth will be distributed proportionally to all DSRIP funding streams.

5.8.2 Funding rollover considerations

Massachusetts requests authority to roll over DSRIP funding from one year to the next within overall DSRIP expenditure authority limits.

Section 6. Safety Net Care Pool Restructuring

6.1 Overview

The Safety Net Care Pool (SNCP) was established as part of the demonstration on July 1, 2005. Its purposes were (1) reducing the percentage of people in Massachusetts who lacked insurance, while (2) funding providers to deliver residual uncompensated care and care for publicly-insured low-income residents, and (3) supporting infrastructure expenditures and access to state health programs that serve low-income and vulnerable populations.

The Commonwealth has made significant progress in expanding access to health coverage. Since 2005, the SNCP has evolved to support expenditures for delivery system reform and related infrastructure aimed at building capacity among safety net providers to improve the quality, integration and cost effectiveness of care. In the demonstration extension approved in 2014, CMS required the Commonwealth to examine the current structure of the SNCP and propose a redesigned framework that ensures the Commonwealth can sustainably support delivery of care to low-income populations and align with system-wide restructuring around accountable care. CMS approved the current SNCP structure through June 30, 2017 to allow for the development and approval of, and the transition to, a new SNCP structure. The Commonwealth proposes to implement the redesigned SNCP, described below, starting July 1, 2017.⁶

6.2 SNCP redesign

In considering its design for restructuring the SNCP, MassHealth focused on aligning the new SNCP framework with its proposed delivery system reforms to support the shift to accountable care. A majority of the restructured and new payments listed below are linked to a provider's performance in ACO models. For example, tying SNCP payments to the same performance metrics that determine success in an accountable care construct ensure that safety net providers are focused on the same goals and objectives as MassHealth.

Through this redesign, Massachusetts recognizes that first and foremost, DSRIP investment funding is needed to transition MassHealth providers into a new accountable care delivery and payment model. The shift to ACO models that MassHealth envisions, supported by DSRIP funding for a five-year transition period, is key to making the system truly sustainable. By re-orienting care toward integrated models in which providers are accountable for the total cost and quality of care, MassHealth will reduce

⁶ All components would begin on July 1, 2017 except for ConnectorCare cost sharing subsidies which would begin upon approval of the 1115 Demonstration; in addition, while planning for a Public Hospital Global Budget for the Uninsured initiative would begin upon approval of the demonstration request, MassHealth and CMS would work toward implementation of the new initiative in year 2 of the new waiver term.

the cost trend over time and give providers the opportunity to sustain themselves financially by delivering the best care for their patients.

In addition, there remains a significant need to support providers to recognize uncompensated care they provide to Medicaid, uninsured and underinsured patients. While the Commonwealth has taken significant steps to achieve near-universal health care coverage for its residents, uncompensated care persists due to the remaining uninsured population (three to four percent of Massachusetts residents) and due to the fact that payer reimbursements do not always cover providers' full costs of delivering care, especially for particularly complex or vulnerable populations. Safety net providers in particular, including the seven hospitals currently receiving incentive funding through the DSTI program, need ongoing operational support because of their high public payer and low commercial payer mix. Such support will enable safety net providers to continue to serve large numbers of MassHealth and uninsured patients, while robust accountability measures tied to SNCP funding will ensure that MassHealth payment incentives are aligned toward value-based care delivery.

Consistent with these principles, Massachusetts proposes a redesigned SNCP aligned with and supporting the transition to ACO models. The new structure will move providers in the same direction and ensure that future payment streams will be sustainable for providers, the Commonwealth and CMS.

To meet the identified health system needs and align the SNCP with the Commonwealth's ACO reforms, MassHealth proposes five streams of funding totaling \$1.593 billion per year, or \$7,965 billion in aggregate over five years:

- 1) Delivery System Reform Incentive Program (DSRIP)
- 2) Public Hospital Transformation and Incentive Initiative (PHTII)
- 3) Disproportionate Share Hospital allotment pool (DSH)
- 4) Uncompensated Care Pool (UCC)
- 5) ConnectorCare affordability wrap

Details and preliminary sizing of these initiatives are summarized in the following exhibit and described in the section below. Funding levels of individual initiatives are subject to change based on ongoing discussions between the Commonwealth and CMS. In addition, MassHealth and CMS are also working through approaches to transition certain public hospital payment streams over the course of the 5-year waiver to further align payment with performance and value-based care delivery.

Safety Net Care Pool (SNCP) structure: proposed

\$ millions

Component	What's included	5-Yr Avg.	5-Yr Total	
DSRIP	<ul style="list-style-type: none"> ▪ Incentive / infrastructure funding for providers entering ACO models ▪ Ends after 5 years 	360	1,800	Incentive-based pools
PHTII / Public Hospital Payments	<ul style="list-style-type: none"> ▪ Incentive payments to CHA 	171	855	
DSH allotment pool	<ul style="list-style-type: none"> ▪ Health Safety Net payments to Hospitals and CHCs for uncompensated care ▪ Safety Net Provider Payments to 11 qualifying hospitals ▪ Payments to DPH/DMH hospitals and Institutions for Mental Disease for uncompensated care 	675	3,375	
UCC pool	<ul style="list-style-type: none"> ▪ Additional payments to Hospitals, CHCs, DPH/DMH hospitals, and IMDs for uninsured uncompensated care 	215	1,075	
ConnectorCare affordability wrap	<ul style="list-style-type: none"> ▪ Funding to support Connector subsidies for cost sharing and premiums 	172	860	
Total waiver		1,593	7,965	

Note: SNCP funding levels are under active discussion and subject to change

The Commonwealth's share of funding for the redesigned SNCP will be supported by an increase of \$250 million in the expanded hospital assessment as well as by General Fund resources used to support current waiver payments. The assessment increase was passed into law as Chapter 115 of the Acts of 2016.

6.2.1 Delivery System Reform Incentive Pools

The Commonwealth proposes to establish two pools of incentive-based funding that support system reform. These pools are critical to the overall delivery system and payment reform efforts and pave a pathway for successful execution and implementation.

6.2.1.1 DSRIP

As described in greater detail above, in order to change delivery systems, the Commonwealth proposes a \$1.8 billion DSRIP investment program over five years to support providers that participate in the Commonwealth's ACO initiatives in their transition. The DSRIP investments will focus on (1) launching ACOs, (2) supporting behavioral health and LTSS Community Partners, and (3) statewide investments in infrastructure to support accountable care models. (See Section 5 for additional details.) To ensure providers' accountability for progress, DSRIP payments will be tied to performance on total cost of care, reduction of avoidable acute utilization and a slate of ACO quality measures. MassHealth will phase out its existing DSTI program and infrastructure and capacity building grants in favor of DSRIP, which promotes reform across the full system and is directly linked to providers' participation in new care delivery and payment models.

6.2.1.2 *Public Hospital Transformation and Incentive Initiative (PHTII)*

Cambridge Health Alliance (CHA) is the Commonwealth's only non-state, non-federal public acute hospital and has the highest concentration of patients participating in MassHealth demonstration programs of any acute hospital in Massachusetts. It is known for its behavioral health services – a disproportionate need among MassHealth members – as well as its experience in delivering multi-lingual, multi-cultural care to a diverse patient base.

In the redesigned SNCP, a revised PHTII will be an entirely incentive-based program, closely aligned with the goals of DSRIP, while recognizing the unique role of CHA within the Commonwealth's safety net.

PHTII will be structured around two areas:

- **Enhanced DSRIP incentives:** An increasing portion of PHTII funding will be tied to the same ACO performance measures as in the broader DSRIP initiative, including total cost of care, avoidable acute care utilization (e.g., readmissions) and ACO quality scores. Because CHA relies on PHTII as an important component of its overall MassHealth funding structure, enhancing the level of incentive funding tied to these critical measures will ensure full alignment across payment streams and enable CHA to devote attention and resources to improving these outcomes.
- **Continuation of selected current PHTII initiatives:** Some of the transformation initiatives under the current PHTII will continue with increasingly strong outcome and improvement measures to reflect the opportunity to advance outcomes and performance improvement over time. Examples include expanding behavioral health integration with primary care, enhancing services to treat mental health and substance use disorders, and developing community-centered health homes.

6.2.2 *Payments for uncompensated care*

As noted above, despite the Commonwealth's high rate of health insurance coverage, there remains a significant level of uncompensated care in Massachusetts. CMS and the Commonwealth share a commitment to ensuring that funding is available for providers to address the costs of uncompensated care for Medicaid members and uninsured patients. Under the current SNCP, payments for uncompensated care, such as Health Safety Net payments to acute hospitals and expenditures for uninsured DPH and DMH hospitals, are financed by the Commonwealth's DSH allotment. Massachusetts proposes to align its policies with CMS' principle of financing "charity care" for individuals lacking health insurance beyond a state's DSH allotment with a new Uncompensated Care (UCC) Pool. Massachusetts and CMS are working together to determine the overall size of the new UCC Pool, with the input of providers.

6.2.2.1 *(A) DSH and UCC Pool structure*

The DSH Pool will include expenditures for:

- Health Safety Net payments to hospitals and community health centers for care provided to eligible low-income uninsured and underinsured patients
- Safety Net Provider Payments to 11 qualifying hospitals (details described below)

- Public Hospital Payments (details described below)
- DPH and DMH hospital uncompensated care
- Payments to Institutions for Mental Disease (IMDs) for care provided to MassHealth patients

UCC Pool will include expenditures for:

- Additional Health Safety Net payments to hospitals specifically for care provided to eligible low-income, uninsured patients
- DPH and DMH hospital uncompensated care specifically for uninsured patients

Massachusetts will only claim expenditures under the UCC Pool to the extent that allowable expenditures, in aggregate, exceed the amount available through the DSH Pool. The proposed size of the UCC pool may change depending on the outcome of the ongoing analysis of the size of overall uncompensated care in the Commonwealth.

6.2.2.2 (B) Safety net provider payments

In its analysis of the SNCP, the Commonwealth found that payments for the DSTI program, while important for implementing initiatives that focused on delivery system reform, were also necessary to support hospital operations. A recent MACPAC/NASHP report found that many hospitals across the nation that have participated in 1115 demonstration delivery system reform programs view this funding as a means to preserve supplemental payments. In recognition of this reality, Massachusetts proposes a restructured set of payments to an expanded pool of safety net hospitals that separates payments to hospitals for delivery system reform from payments that support ongoing operations. Payments that are made to providers for the purposes of delivery system reform will be made through the DSRIP program, as described above.

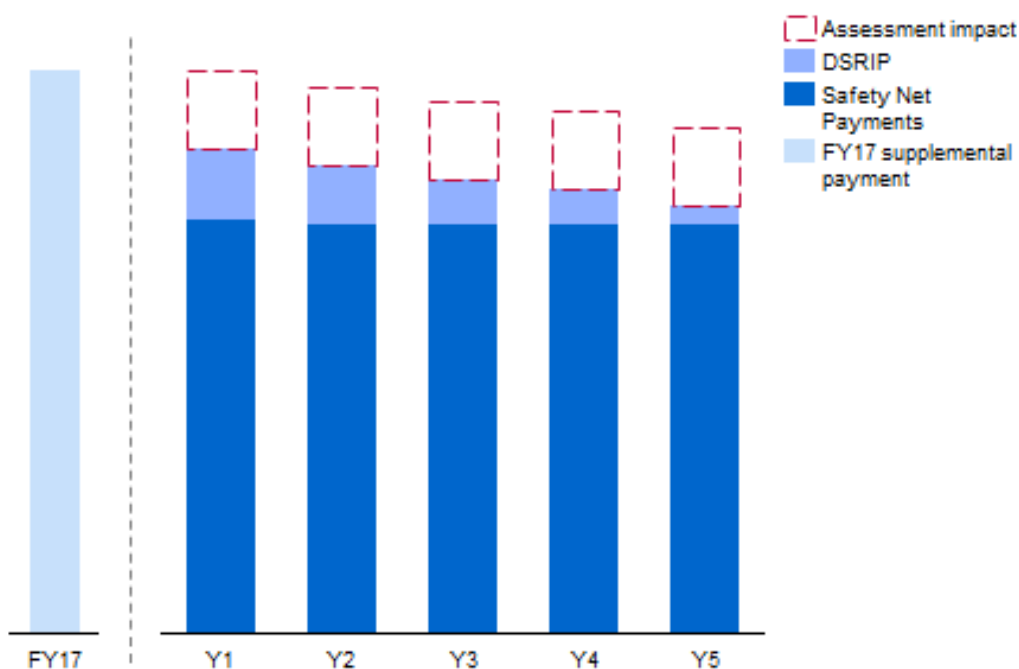
Separate from DSRIP, MassHealth proposes a new set of safety net payments that focus on supporting hospital operations and are aligned with the state's overall goal of transitioning to accountable care models. These support payments should be sustainable and available to a broader set of providers that serve a high proportion of MassHealth and uninsured patients. Unlike the system transformation payments, these payments should not be time-limited since they are meant to support ongoing safety net hospital needs. MassHealth has identified 11 hospitals that qualify for the new proposed safety net provider payments, based on an analysis of all Massachusetts hospitals' payer mix and uncompensated care, performed by MassHealth's contractor, Navigant Consulting. While these payments are not meant solely for delivery system reform, the payments will be held to the same measures of accountability as the DSRIP payments in order to fully align incentives across funding streams for these providers. The safety net provider payments will be included within the DSH and UCC pool structure.

The seven hospitals that currently receive DSTI payments are among the 11 hospitals eligible to receive these new sustainable safety net payments. Over the course of the five-year demonstration term, the hospitals will have the opportunity to transition to the new sustainable payment levels. The combination

of the new safety net payments and DSRIP payments (for hospitals that participate in an ACO model), as well as the positive impact of non-waiver payments supported by the increased hospital assessment (which particularly benefits safety net providers), allows for a gradual, sustainable glide path. The interaction of these payments will allow the hospitals to transition to the reduce safety net payment levels by year five of the demonstration.

The graph below provides a visual representation of MassHealth’s proposal for a gradual downward slope of payments for the seven hospitals that currently receive DSTI payments. This graph demonstrates an example trajectory for safety net hospitals from their current state through the end of the waiver term. The light blue bar at the left represents the current supplemental payments that a safety net provider receives in FY17. In the new waiver term, the payments to safety net providers will be made up of new and restructured streams of funding. The bottom dark blue bar in years 1-5 represent the restructured safety net payments for providers for ongoing operational support. On top of that, the medium blue bar shows potential DSRIP payment to the safety net provider each year, depending on the number of attributed lives within an ACO. Finally, the dotted red line at the top of each bar demonstrates the impact of the payments supported by the increased hospital assessment – Massachusetts expects that safety net providers will have a net positive impact. Hospitals serving a disproportionate share of Medicaid members will benefit most from the higher payments, while hospitals with more commercial business pay a greater share of the assessment. The two streams represent a gradual downward trajectory to the new safety net payment level, which will continue in year 6.

Concept – Gradual trajectory for current safety net providers



6.2.2.3 (C) Public Hospital Global Budget Initiative for the Uninsured

In lieu of HSN payments and separate from the Public Hospital Transformation and Incentive Initiatives (PHTII), MassHealth proposes to work with CMS and Cambridge Health Alliance (CHA) to establish a Global Budget for the Uninsured. Under this proposal, CHA would not participate in the HSN Fund but would receive a fixed budget to care for residually uninsured populations including those with HSN eligibility. This budget amount would be capped within a global budget and would not grow in future years, even if CHA's costs of care for the uninsured increased. CHA would be expected to manage care within this budget, but at the same time would be given both the incentive and the flexibility to deliver care in the most effective ways possible (e.g., moving uninsured care out of the ED and acute settings, focusing on preventative and primary care, tightly managing care for high cost / high need patients). MassHealth is working with CMS and CHA to define this approach and determine how to make this transition over the course of the 5-year waiver period. MassHealth will work with CMS to implement this new program in the second year of the new 5-year demonstration extension period.

6.2.3 ConnectorCare premium and cost sharing subsidies

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

Section 7. Enhanced Services for People with Substance Use Disorder

7.1 Overview and Objectives

7.1.1 Alignment with Overall Delivery System and Payment Reform Activities

MassHealth and the Department of Public Health's (DPH) Bureau of Substance Abuse Services have collaborated on the development of a Substance Use Disorder 1115 demonstration proposal. This proposal has been developed in response to the July 27, 2015 letter from CMS to State Medicaid Directors titled *New Service Delivery Opportunities for Individuals with a Substance Use Disorder*. The proposal is being submitted as part of the Commonwealth's 1115 Demonstration Waiver and is aligned with the Commonwealth's SIM Model Test effort, and the Commonwealth's Certified Community Behavioral Health Center (CCBHC) pilot program. EOHHS, which includes MassHealth and its sister agencies that also work to address addiction, recognizes the importance of aligning incentives across the substance use treatment system with those within the traditional health care system, to ensure that all providers and payers are working collaboratively to improve care for the whole person, including addressing the individual's substance use disorder.

The Commonwealth's goal is to improve health outcomes and reduce costs through payment reform and this proposed SUD 1115 demonstration. By providing improved access to treatment and ongoing recovery-focused support, EOHHS believes there will be improved health outcomes and increasing rates of long-term recovery for individuals with SUD, which will contribute to reduced use of the emergency department and unnecessary hospitalizations. By investing more in expanding access to treatment across the continuum, EOHHS will use the SUD 1115 demonstration to test whether these interventions will stabilize, and potentially reduce, costs over the term of the SUD 1115 demonstration. EOHHS will also use the SUD 1115 demonstration to test whether improved treatment for SUD will also lead to improvements in National Outcomes Measures (NOMs) such as reduced court-involvement for youth and adults, increased attendance and graduation rates at high school and increased employment.

7.1.2 Massachusetts Context

Massachusetts, like many states, is in the midst of an opioid epidemic that impacts citizens from every part of the Commonwealth, regardless of race and ethnicity, income and insurance status. The Commonwealth is actively working to prevent addiction and improve treatment for substance use disorders (SUD) as demonstrated through the passage of Chapter 258 of the Acts of 2014, An Act to Increase Opportunities for Long-Term Substance Abuse Recovery, the work of Governor Charlie Baker's 2015 Opioid Task Force, which made 65 recommendations focused on prevention and education initiatives, and expanded access to treatment and increased monitoring of prescribing practices. In March, Massachusetts passed additional substance abuse prevention and treatment legislation⁷, making the state the first in the nation to establish a seven day limit on first-time opioid prescriptions. It is within this broader context that the Commonwealth proposes to implement the SUD 1115 demonstration.

Massachusetts has a strong history of providing comprehensive benefits through MassHealth, providing significant state funding to serve individuals without insurance and for services not traditionally covered through Medicaid. As a recovery-focused system of care, Massachusetts offers a range of treatments and services for residents that address addiction across the individual's lifespan, including prevention, intervention, treatment, and recovery support.⁸ While Massachusetts may offer more services and coverage than many other states, SUD services must be improved by increasing access and better coordinating care for members throughout the continuum, to best serve all of the individuals in the Commonwealth with an opioid, alcohol or other substance use disorder.

To ensure that all MassHealth members have access to the full continuum of SUD services, MassHealth proposes to add American Society of Addiction Medicine (ASAM) Level 3.1 treatment services to the list of covered services. These services are currently paid for by DPH through its state appropriation. In year one of the SUD 1115 demonstration, the additional FFP generated by the inclusion of these services in

⁷ Massachusetts General Laws, Chapter 52 of the Acts of 2016.

⁸ While the SUD Treatment System provides services to individuals covered by commercial and public coverage, this application focuses on publicly funded coverage.

the MassHealth benefit will be used to fund the addition of an estimated 480 new ASAM Level 3.1 placements. This represents an increase of 18 percent above current statewide capacity and will allow the Commonwealth to provide care to members who have completed detoxification. Funds will also be used to purchase care coordination and recovery coach services for members with significant SUD needs, as well as an ASAM based assessment instrument for use throughout the Commonwealth's treatment system.

Most people who meet the criteria for SUD do not receive treatment. Nationally, only 11 percent of individuals with a SUD receive treatment. Of those who do not receive treatment,⁹ 2 percent reported that they were unable to access services, while the vast majority (95 percent) report not feeling a need for treatment.¹⁰ In addition, there is evidence of disparities in treatment. Members of minority groups who need treatment are less likely to access services when controlling for socioeconomic status and criminal justice history.¹¹

The potential effects of untreated SUDs can be serious. In 2015, Massachusetts had 1,531 confirmed unintentional opioid overdose deaths, an 18 percent increase over 2014 (1,294). Data from the first two quarters of 2016 suggest that we will see an increase in deaths again in 2016. An analysis by the Commonwealth's Center for Health Information and Analysis (CHIA) of the individuals who were determined to have died from an overdose in Massachusetts in 2014 found that approximately 75 percent were enrolled in MassHealth, indicating that MassHealth has a significant responsibility to ensure that treatment services are available to address the opioid epidemic. This dramatic increase in unintentional opioid overdose deaths is occurring despite the widespread availability and use of nasal naloxone (commonly referred to as Narcan) across the Commonwealth.¹²

Despite these grim statistics, SUDs are both preventable and treatable. While addiction cannot always be cured, it can be managed successfully, similarly to other chronic diseases. Behavioral therapy combined with medication assisted treatment (MAT) has proven to be successful in helping people to recover from the effect of substances on their brain and behavior, and to regain control of their lives. However, the chronic nature of addiction means that relapse is likely,¹³ with relapse rates similar to those for chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both

⁹ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012-2013 combined.

¹⁰ Ibid.

¹¹ Cook BL, Alegria M. Racial-ethnic disparities in substance abuse treatment: the role of criminal history and socioeconomic status. *Psychiatric services*. Nov 2011;62(11):1273-1281.

¹² Since Massachusetts began its Overdose Education and Naloxone Distribution (OEND) Program in 2007, there have been nearly 6,000 overdose reversals reported by bystanders, and almost 2,000 overdoses reported by first responders. Since November 2014, there have been 1208 overdose reversals reported by first responder grant communities. MA Overdose Education and Naloxone Distribution Program (OEND) Information Sheet, Massachusetts Department of Public Health, Bureau of Substance Abuse Services, October 1, 2015.

¹³ National Institute on Drug Abuse (NIDA). (2014). *Drugs, Brains, and Behavior: The Science of Addiction*; accessible at <http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/addiction-health>

physiological and behavioral components.¹⁴ As with other chronic conditions, substance use relapse may indicate a need for renewed intervention or modification of treatment and continuous support to better meet the individual's needs.

7.1.3 The Commonwealth's Vision for this SUD 1115 Demonstration

With the support of an SUD 1115 demonstration, EOHHS envisions an SUD treatment system that treats addiction as a chronic medical condition, understands that relapse is a common part of the recovery process for many, and provides enhanced funding for recovery supports. The treatment system must begin with a solid foundation of education and prevention and provide individuals with access to treatment at many different entry points. Across the system, treatment professionals, along with their counterparts in the medical and mental health systems, must be trained in motivational interviewing and understand the stages of readiness to change. With this training, professionals across health care will be more likely to successfully provide access to the right care, in the right setting, at the right time.

While this may appear to be a simple vision, it can be difficult for individuals to access treatment today, regardless of insurance coverage. This SUD 1115 demonstration provides the Commonwealth with the opportunity to create a SUD treatment system, ensuring that the system of care is built on ASAM principles, allowing for individualized treatment within a recovery-focused community of care. To develop this SUD 1115 demonstration application, MassHealth and DPH, which is the single state authority on SUD treatment, have worked jointly to envision and develop a SUD treatment system that begins with strong prevention services funded through DPH and supported by SAMHSA block grant funding, continuing across a continuum of services funded through MassHealth which provides for intervention and initial treatment, ongoing treatment, and recovery-focused supports. Through it all, EOHHS envisions a strong combination of care management, recovery navigation, and recovery coaching to provide individualized and consistent support to MassHealth members regardless of where they are in the treatment continuum, or the recovery process.

The Massachusetts continuum for addressing substance use disorders begins with prevention. DPH, through its state appropriation, will continue to fund primary prevention efforts, including public awareness and education campaigns and community prevention coalitions. These efforts focus on providing education to adolescents, young adults, parents, and others regarding the risk of addiction. Primary care and other medical providers will be encouraged to be more active in providing secondary prevention services at the individual level across the lifespan. MassHealth's health plans are implementing initiatives to curtail opioid prescriptions, where appropriate. The medical and dental schools in the Commonwealth have recently agreed to modify their curriculums to increase training on substance use issues, and there will continue to be significant ongoing training of providers in terms of potential addictiveness of certain medications. In addition, the Commonwealth is strengthening the Prescription Monitoring Program (PMP) which requires all prescribers to utilize the PMP prior to issuing

¹⁴ McClellan, AT, Lewis, DC, O'Brien, CP, and Kleber, HT, (2000). Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation, *JAMA*, 284(13): 1689-1695.

an opioid prescription. The new PMP program, which will launch at the end of August 2016, will have the capability to be integrated into EHR, will provide access to neighboring states' PMP data, and will easily integrate into prescriber workflows.

Under the SUD 1115 demonstration, intervention and initial treatment will be available in different settings and allow for a bio-psycho-social clinical assessment, based on the ASAM principles, to gain an understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability, and other issues. These assessments will also help to document an individual's strengths and weaknesses. Following assessment, individuals will begin to receive treatment based on that assessment and an individual, patient-centered care plan will be developed. All care plans will consider the potential for relapse and appropriate harm reduction strategies based on an individual's particular circumstances.

As envisioned, the Commonwealth will pilot the utilization of a common assessment tool for adults that allows for improved ability to collect data and report on outcomes while also increasing the ability of providers to share information, with individual consent, across the care continuum. The Commonwealth has begun to pilot the utilization of a common assessment tool for youth and young adults to ensure age-appropriate questions are included. Through these pilot assessment activities, the Commonwealth will be able to assess how it would most appropriately use the assessment tools, what the cost of statewide implementation would be, and how the tool may assist the Commonwealth, its health plans and its providers in improving the outcomes for our members, including by helping to identify capacity needs and what treatment is working based on real time data. In addition, piloting a common assessment tool will allow the Commonwealth to compare patient placements made with and without the tool, to learn how effective the tool is in matching patients with recommended ASAM levels of care.

In addition to providing direct support to individuals, EOHHS envisions that the SUD treatment system will provide for the transition across the continuum to/from different levels of care to ensure that an individual continues in treatment, and for providers to assist individuals in transitioning across care settings. In addition, treatment will include population-based programs that are gender, age and culturally-based.¹⁵ When admitting individuals in treatment programs, consideration will be given to geography and the family supports an individual has and how to appropriately engage families in assisting in recovery. Treatment will also enhance effective evidence-based treatment options for both youth and adults with a dual diagnosis of substance use and mental health conditions.

While Massachusetts provides a substantial array of SUD treatment services today, it seeks to improve its system's capacity to fully stabilize individuals in acute treatment services and ensure an appropriate

¹⁵ A culturally based program focuses on serving individuals of a particular ethnicity and becomes adept in the particular cultural barriers to treatment and successful approaches to address them. One example is Casa Esperanza located in Boston, which is a bi-lingual substance use treatment center. For more information see: <http://www.casaesperanza.org/http://www.casaesperanza.org/>.

transition to the most appropriate level of care through greater availability of step-down services, including Residential Rehabilitation Services (RRS). DPH data shows that individuals who receive RRS are less likely to have inpatient and emergency department (ED) usage after treatment than if they did not complete this level of treatment.¹⁶ It is important to note that the system is not linear. It is designed to support individuals across the continuum based on their treatment needs and ensure appropriate services across the continuum.

The table below shows current and planned expansion for Acute Treatment Services (ATS or detoxification services) Clinical Stabilization Services (CSS), Enhanced Transitional Support Services (ETSS) for individuals whose co-occurring conditions are too complex to be appropriately served in a TSS setting, Transitional Support Services (TSS) and RRS. Over the course of the SUD 1115 demonstration, MassHealth and DPH will closely monitor the SUD treatment needs of Massachusetts residents and seek to ensure that network capacity is expanded to meet demand across the ASAM continuum of care.

EXHIBIT 9 – Current and Planned Capacity for Facility Based Substance Use Disorder Treatment

Service Type	ASAM Level	Current Capacity FY 2016	Planned Capacity Enhancement FY 2017	Estimated Capacity Enhancement FY 2018 (Year 1 of SUD 1115 Demonstration)
ATS	3.7/4.0	816		
CSS	3.5	377	~200	
ETSS	3.3		60 ¹⁷	
TSS	3.1	312	32	
RRS	3.1	2667	100	<ul style="list-style-type: none"> • 420 for Adults • 30 for Families • 30 for Transitional Age Youth and Young Adults

Increased availability of Medication Assisted Treatment (MAT) is planned, including the use of Opioid Treatment Centers to increase access to MAT at current methadone treatment programs by expanding their scope to include provision of buprenorphine and naltrexone. The Commonwealth expects this to be operational in FY 2017.

¹⁶ Bureau of Substance Abuse Services data; other states have seen similar reduction in ED usage based on SUD treatment, including Washington. See July 27, 2015 State Medicaid Director Letter.

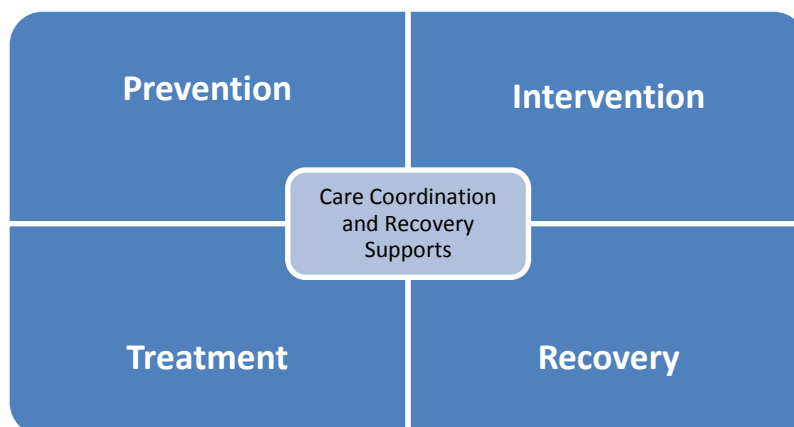
¹⁷ This enhancement may not occur until FY18.

Individuals with SUD will require significant ongoing support as part of their recovery. As such, through this SUD 1115 demonstration, the Commonwealth seeks to enhance care management, recovery navigation, and recovery coaching. As envisioned, these services will be provided through Community Partners. Behavioral Health Community Partners (BH CP) will serve as centers for care coordination for high risk individuals, whose primary diagnoses involve mental health or SUDs, providing the backbone for a coordinated system of care and fostering increased communication between an individual's primary care provider and the treatment community. Recovery support navigators and recovery coaches, accessed through the BH CP, will be the primary means to deliver ongoing support and care coordination and management.

The SUD 1115 demonstration provides an important opportunity for Massachusetts to continue its efforts to improve access to the SUD treatment system and implement some of these changes with federal support. However, while changing the current system to meet the Commonwealth's vision, it is essential to maintain stability so that individuals can obtain care in the transition period. An important piece of implementing this new system will be to provide for appropriate training of the SUD workforce, including counselors, case managers, recovery support navigators, and recovery coaches, on basic evidence-based concepts and how to work with individuals with dual-diagnosis.

7.2 Program Description

SUD services are supported by multiple payers in Massachusetts, including commercial insurers, MassHealth, and DPH. Together, with enhanced support through this SUD 1115 demonstration, the Commonwealth will provide MassHealth members with a comprehensive approach to address SUD, which can be grouped into four major categories: prevention, intervention, treatment, and recovery-focused support, all held together through a combination of care coordination and recovery supports across the continuum. Each aspect of the continuum plays an important role in the prevention and treatment of SUDs for all Massachusetts residents. This section provides an overview of the SUD treatment system as a whole, including services funded by both DPH and MassHealth, and describes the current and expanded services to be provided by MassHealth through the SUD 1115 demonstration. These services, which include a comprehensive set of inpatient and outpatient services, will be available to MassHealth members without any cost sharing.



The SUD treatment continuum is not linear – that is, given the likelihood of relapse, individuals often move across and within the different SUD treatment services. Many individuals will complete detoxification on several occasions over the course of treatment and will also use other services on the continuum at different points in their recovery process. Providing ongoing recovery-focused supports, such as 24-hour community-based SUD treatment and long-term recovery coaching, promotes successful long-term recovery.

7.2.1 Prevention

Many individuals with SUD do not seek treatment. Prevention strategies are the first part of the continuum of care and are primarily funded by DPH. Initiatives focused on prevention are aimed at educating the general public, particularly adolescents and young adults, to delay the age of onset for alcohol use, prevent prescription drug abuse and in turn, to reduce the risk of developing a SUD.¹⁸ These prevention strategies are focused on helping individuals to develop the knowledge, skills and attitudes to make healthy choices, identify and understand risky use of substances, and avoid or stop harmful behaviors before the behavior becomes problematic. Utilizing SAMHSA's Strategic Prevention Framework, prevention strategies supported by DPH funding take root in local communities and are tailored to their unique characteristics. Environmental prevention strategies aim to restrict youth access to alcohol and other drugs. This focus on youth, beginning with simple messages as early as elementary school and becoming more sophisticated as children move to middle school and high school, is vitally important. Studies have shown repeatedly that the earlier an individual begins experimenting with drugs and alcohol, the greater the harm done to the physiological development of the brain, and the greater the likelihood that a person will develop a SUD later in life.¹⁹

While DPH will continue to fund primary prevention strategies as described above, EOHHS believes that the alignment of this SUD 1115 demonstration with the Commonwealth's ACO strategy provides an important opportunity to provide targeted prevention for at-risk individuals through implementation of evidence-based practices in a variety of settings including primary care and pharmacies. In an ACO environment where providers are responsible for the total cost of care, there will be an incentive to provide individualized prevention services. Examples of individual prevention strategies that EOHHS will encourage include:

- Non-pharmaceutical approaches to chronic pain management
- Identifying potential abuse through the Prescription Monitoring Program and providing education, intervention, and referral

¹⁸ See description of prevention on the SAMHSA website, accessible at <http://www.samhsa.gov/prevention>

¹⁹ For example, see Adolescent Substance Use: America's #1 Public Health Problem, CASA Columbia, June 2011, accessible at: <http://www.casacolumbia.org/addiction-research/reports/adolescent-substance-use><http://www.casacolumbia.org/addiction-research/reports/adolescent-substance-use>, which shows that 25 percent of individuals that use substances before the age of 18 will develop a substance use issue as an adult; similarly, 90 percent of all adults with substance use problems started to use substances prior to the age of 18.

- Provision of screening for members as part of primary care visits to understand how they may be affected by SUDs as they age and their bodies change
- In primary care, identifying adults and children with adverse childhood experiences (ACES) and providing education, intervention and referral, to help prevent SUDs
- Conducting Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care settings to identify risky alcohol use and potential SUD. SBIRT has been shown to be particularly effective in identifying unhealthy alcohol use and is endorsed by the U.S. Preventive Services Task Force.²⁰ The Commonwealth will explore covering SBIRT within primary care settings during the initial year of the SUD 1115 demonstration

7.2.2 Intervention

Intervention strategies are the second part of the continuum of care and, as with prevention, are primarily funded by DPH. These initiatives focus on early identification of a SUD and beginning of treatment, as well as strategies that help reduce fatal overdoses. Since 2007, Massachusetts has administered the Overdose Education and Naloxone Distribution (OEND) program, which provides training and nasal naloxone rescue kits to potential bystanders (any person likely to witness an overdose) and first responders across several communities in the Commonwealth. In addition to the Commonwealth's support of the OEND program, MassHealth also covers naloxone rescue kits provided to its members. Another tool aimed at intervention is the Massachusetts Prescription Monitoring Program (PMP), a secure website that provides a patient history of all prescriptions for controlled substances over the most recent 12 months.²¹ Prescribers are required to utilize the PMP prior to prescribing opiates for an individual.

7.2.3 SUD Treatment Services

Many individuals access SUD treatment during a crisis – such as acute intoxication or overdose, an accident or an acute exacerbation of another health condition that is caused by substance abuse. In many crisis situations, individuals enter treatment following an emergency department visit.²² In others, individuals begin treatment following an arrest for criminal behavior related to intoxication or substance use. The Massachusetts Office of the Trial Court, in conjunction with DPH and the Department of Mental Health, has developed a network of “drug courts” where individuals with SUDs can participate in

²⁰ U.S. Preventive Services Task Force, Final Recommendation Statement: Alcohol Screening and Behavioral Counseling Interventions in Primary Care; accessible at: <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>

²¹ For more information on the PMP see Massachusetts Online Prescription Monitoring Program Frequently Asked Questions; accessible at <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/pmp-faq-public.pdf>

²² The Drug Abuse Warning Network (DAWN) estimated 5 million ED visits in 2011 due to alcohol or drug use. 40% of individuals who came to the ED for detoxification were referred for ongoing or follow-up care. K. Somal and T. George, *Referral Strategies for Patients with Co-Occurring Substance Use and Psychiatric Disorders*, Psychiatric Times, December 23, 2013; accessible at: <http://www.psychiatrictimes.com/addiction/referral-strategies-patients-co-occurring-substance-use-and-psychiatric-disorders/page/0/1>

treatment to avoid jail time for nonviolent offenses.²³ Many individuals facing probation have requirements within their probation orders to maintain SUD treatment. Likewise, for those leaving incarceration and placed on probation or parole, there are often similar requirements. In addition, involuntary civil commitment petitions provide a method for families and concerned others²⁴ to seek court-ordered detoxification and stabilization services for a family member whose SUD makes the individual an imminent threat to himself/herself or others.²⁵

In less emergent cases, people may seek referrals to SUD treatment from their primary care provider, or be identified through routine screening for unhealthy substance use as part of an annual visit. When initial screening indicates signs of a SUD, physicians are increasingly conducting a brief intervention and then referring patients to treatment.²⁶ Many individuals self-refer to acute treatment services (detoxification) and outpatient services, including MAT services.²⁷ While some individuals seek detoxification or a longer term treatment in a 24-hour community-based setting, the most frequently utilized SUD services are outpatient services.²⁸

In order to determine the appropriate level of care, individuals seeking care need to receive a comprehensive assessment. The most widely recognized patient placement criteria for treatment of SUDs are the six dimensions developed by ASAM.²⁹ As part of this SUD 1115 demonstration, the Commonwealth proposes adoption of a standardized ASAM assessment across all providers by the start of the third year of the demonstration. This will increase member access to appropriate and effective services and streamline utilization management processes.

7.2.4 Levels 3.1 and 3.3 Treatment Services

Treatment needs vary depending on the particular substance an individual is using. For adults using opioids, alcohol, and benzodiazepines, treatment often starts with withdrawal management (detoxification) (ASAM Levels 3.7 and 4.0) followed by Clinical Stabilization Services (CSS) (ASAM Level 3.5), both currently covered by MassHealth. Further stepdown treatment is provided through Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS) (ASAM Level 3.1), which

²³ There are 18 adult drug courts and one juvenile drug court in Massachusetts. For more details, including where the courts are located, see <http://www.mass.gov/courts/programs/specialty-courts/>. Individuals facing first or second degree driving under the influence (DUI) charges may be eligible to participate in SUD interventions in lieu of sentencing if they do not have other charges.

²⁴ The statute allows for the spouse, blood relative or guardian to request commitment under Section 35. (Chapter 123, Section 35 of the Massachusetts General Laws.)

²⁵ M.G.L., Part 1, Title XVII, Chapter 123, Section 35, Commitment of alcoholics or substance abusers

²⁶ Some health insurance carriers will cover substance use screenings and/or brief interventions (SBIRT). When covered, these services are not subject to prior authorization. Members may be required to pay a co-payment towards the service however, and these co-payments can vary dramatically between plans. While MassHealth covers screenings and brief interventions for youth, it does not provide any additional payments for providers that utilize screening or brief interventions for adults.

²⁷ CHIA Massachusetts Provider Survey for Substance Abuse Treatment Access, December 2014

²⁸ See Types of Treatment Programs for Substance Use Disorders; accessible at <http://www.massresources.org/substance-use-disorders-treatment.html>

²⁹ Mee-Lee, D., *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, American Society of Addiction Medicine, Inc.

the Commonwealth proposes adding to the MassHealth benefit. Adults with more intensive diagnoses, such as dual diagnoses resulting in cognitive impairment, need specialized treatment services to meet their complex needs (ASAM Level 3.3). MassHealth proposes developing this service through this SUD 1115 demonstration.

Adolescents require different models of service than adults. For adolescents, detoxification and clinical stabilization services are combined to provide comprehensive detoxification and behavioral health stabilization in the same setting ³⁰(combined ASAM Levels 3.7 and 3.5.) That is followed by developmentally appropriate 24-hour community-based SUD treatment services for young adults and transitional aged youth (ASAM Level 2.5.) Both services are currently covered by MassHealth. DPH provides family SUD treatment services in 24-hour community-based settings, serving both the parent with a SUD and their children. The Commonwealth proposes adding this service to the MassHealth benefit.

To summarize, under this SUD 1115 demonstration, the Commonwealth proposes to expand SUD treatment by adding Medicaid coverage for 24-hour community-based rehabilitation through High-Intensity Residential Services (ASAM 3.3), Transitional Support Services (TSS)(ASAM 3.1) and Residential Rehabilitation Services (RRS)(ASAM 3.1)(for youth, adults and families). See service descriptions below:

Service Type	ASAM Level	Service Description
Clinically Managed Population-Specific High-Intensity Residential Services	3.3	Services provided to an individual with a substance use disorder in a 24-hour setting. For members in whom the effects of the substance use, other addictive disorder, or other co-occurring disorder results in cognitive impairment so significant, that other levels of 24-hour or outpatient care are not feasible or effective. This service does not exist today in Massachusetts and will need to be developed as part of the SUD 1115 demonstration.
Clinically Managed Low-Intensity Residential Services	3.1	Services provided to an individual with a substance use disorder in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to ensure safety for the individual, while providing active treatment and reassessment. MassHealth will provide up to 90 days of Level 3.1 services to adults, families and adolescents. This service can be provided through a TSS provider and/or a RRS provider.

³⁰ This is also true for individuals who are committed to treatment through Section 35.

In order for a member to receive TSS or RRS services, the Commonwealth requires the provider to conduct a pre-admission assessment, which is reviewed and approved by a Masters-level clinician, to determine whether an individual meets the ASAM level of care for admission to that service. The assessment must include the following elements:

- Determination of the appropriateness of the service to the member's treatment needs;
- History of alcohol, tobacco, and other drug use, including age of onset, duration, patterns and consequences of use; use of alcohol, tobacco, and other drugs by family members; types of and responses to previous treatment and risk for overdose
- Assessment of the member's psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; disability status and accommodations needed, if any; trauma history; and history of compulsive behaviors, such as gambling
- Assessment of member's HIV and TB risk status
- Identification of key relationships supportive of the member's treatment and recovery;
- The name and contact information of the member's current primary care physician and any current medications, based on pharmacy labels showing the date of filling, the name and contact information of the prescribing practitioner, the name of the prescribed medication and the condition for which the medication is prescribed
- When indicated, providers must conduct or make arrangements for necessary testing, physical examination and/or consultation by qualified professionals

This initial assessment must include a statement as to the status and nature of the member's substance use disorder. This assessment must be completed before a comprehensive service plan is developed.

Consistent with the required elements of ASAM 3.1 programming, under DPH regulations³¹, all licensed TSS and RRS programs provide clients with an array of individual and group services, including:

- Individual and group cognitive and motivational therapies
- Daily clinical programming (not including house meetings), at a minimum 5 hours a week of clinical groups combined with skill building and health promotion
- Individual counseling as an addition to group counseling, provided according to the member's treatment plan
- Clients with high acuity such as co-occurring conditions may receive additional services in the community

The Commonwealth's contracts with TSS and RRS providers include additional requirements, including:³²

- **Daily Programming:** Providers must establish a program of daily activities for individuals and groups which are designed to facilitate resident participation in community interaction, and

³¹ See 105 CMR 164.074.

³² These requirements are excerpted from the Commonwealth's current RFP for TSS and RRS services.

to promote resident recovery. Providers must develop daily and weekly schedules that ensure opportunities for residents to participate in groups which include accommodating residents' with disabilities while also scheduling groups to accommodate residents who work. Providers must ensure that staff is able to prepare for groups, including preparation of curricula and follow up as needed after groups. Providers must ensure that staff are available and will regularly communicate with residents outside of scheduled sessions to monitor status and progress.

- **Individual and group services offered in TSS and RRS:** Providers must provide the following individual and group services using methods shown to be effective with the population served, and which are adapted, as needed, to accommodate individual residents:
 - Relapse and overdose prevention and recovery maintenance counseling and education
 - Individual and group counseling in Recovery Homes and Therapeutic Communities
 - Group and Peer Counseling in Social Model Recovery Homes
 - A minimum of one health group per week to cover topics such as stress reduction, nutrition, physical exercise, medication, tobacco cessation, HIV/AIDS, STDs, viral hepatitis, and other wellness topics
 - A minimum of one recovery support group per week
 - Medical, psychological, and psychiatric services through affiliations with community-based agencies
 - HIV/AIDS, viral hepatitis, STDs and blood borne pathogens education within substance abuse education components as well as within individual treatment or service plans
 - Cooperation with court, probation, parole, and other representatives of the criminal justice system to facilitate compliance and the resolution of legal issues for individuals in recovery
 - Opportunities for resident participation in a range of self-help groups on-site or appropriately coordinated in the community

As shown in the table below, the Commonwealth's average length of stay (ALOS) in SUD treatment for persons admitted into all DPH-licensed ASAM Level 3.7, 3.5 and 3.1 programs during state fiscal year 2015 was 15.3 days.³³

ASAM Level	Level of Care	ALOS
3.7	Acute Treatment Services (ATS)	4.1
3.5	Clinical Stabilization Services (CSS)	10.3
3.1	Transitional Stabilization Services (TSS)	21.9
3.1	Residential Rehabilitation Services (RRS)	91.2
	Average Length of Stay (ALOS)	15.3

³³ Average Length of Stay for All Substance Use Disorder 24 Hour Treatment Services, FY 2015 data.

Under this SUD 1115 demonstration, the Commonwealth specifically requests authority to claim FFP for all medically necessary 24-hour community-based SUD treatment services within ASAM Levels 3.1 and 3.3, including when these services are delivered in IMDs. If approved, MassHealth managed care entities (MCEs) will be required to cover all medically necessary Levels 3.1 and 3.3 services, regardless of length of stay. However, MassHealth will use the weighted average length of stay in developing its actuarially sound rate for members enrolled in managed care, ensuring that it is not paying a capitated rate for an average length of stay in 24-hour community-based SUD treatment exceeding 30 days.

For members who receive services on a fee-for-service basis, the Commonwealth requests authority to claim FFP for all ASAM Level 3.1 treatment delivered in a TSS program and full coverage for the first 90 days of ASAM 3.1 treatment delivered in a RRS program, again including when these services are delivered in IMDs, with the understanding that the average length of stay for 24-hour community-based SUD treatment services is expected to remain well below 30 days.

Through this SUD 1115 demonstration, the Commonwealth will expand availability of all types of inpatient and 24-hour community-based SUD services, and is committed to reinvesting an amount equal to 100 percent of the federal match that the Commonwealth will receive into additional SUD services.

7.2.5 Outpatient Treatment

Effective outpatient treatment for SUDs includes behavioral therapy and medication assisted treatment. Behavioral therapies are used to engage people in SUD treatment, to encourage them to modify harmful behaviors, and reduce their use of substances or achieve abstinence. Behavioral therapies help members develop life skills to effectively cope with stress and respond to environmental cues that trigger intense craving for substances.

Once a member's physical health and living situation has stabilized, outpatient treatment by licensed professionals provide interventions and approaches to help them maintain recovery, manage situations that trigger a desire to use substances, address any underlying psychosocial issues, and coordinate care. In some cases, members may be able to start treatment with outpatient counseling; others may start with outpatient treatment even though inpatient services are indicated because outpatient treatment is what they are ready to engage.

There are a number of evidenced-based outpatient treatment models that are currently being implemented in the Commonwealth,³⁴ including cognitive behavioral therapy (CBT), motivational interventions and the Adolescent Community Reinforcement Approach - Assertive Continuing Care (A-CRA/ACC) that combine home and community-based counseling with case management. This model has

³⁴ For a better sense of the breadth and depth of the various outpatient treatment services for those with SUD explore SAMHSA's database of evidence-based programs, accessible at <http://www.nrepp.samhsa.gov/ViewAll.aspx>. A list of evidence-based practices currently utilized and funded by MassHealth and/or DPH is included as Appendix Four.

been shown effective for youth who are white, black, and Hispanic.³⁵ As part of services provided through this SUD 1115 demonstration and the Commonwealth's overall ACO strategy, the Commonwealth will encourage its providers to utilize these and other evidence-based treatments included on SAMHSA's National Registry of Evidence Based Practices and Programs.

For those with opioid addiction, studies show that it is most effective to combine behavioral therapy with medication-assisted treatment (MAT) using one of three medications approved by the Federal Drug Administration (FDA): methadone, buprenorphine, and naltrexone.³⁶ Methadone and buprenorphine are used to treat opioid use disorders in preventing, reducing, and/or eliminating opioid withdrawal symptoms and/or cravings. Naltrexone prevents members from relapsing after being completely detoxed from opioids. Throughout the Commonwealth there is a broad base of opioid treatment providers that can provide MAT in various settings, including methadone treatment programs as well as office based providers in outpatient and primary care settings. Recently, the Commonwealth created payment mechanisms to allow opioid treatment programs to administer all opioid MAT treatments.

7.2.6 Care Management and Formal Recovery Support Services

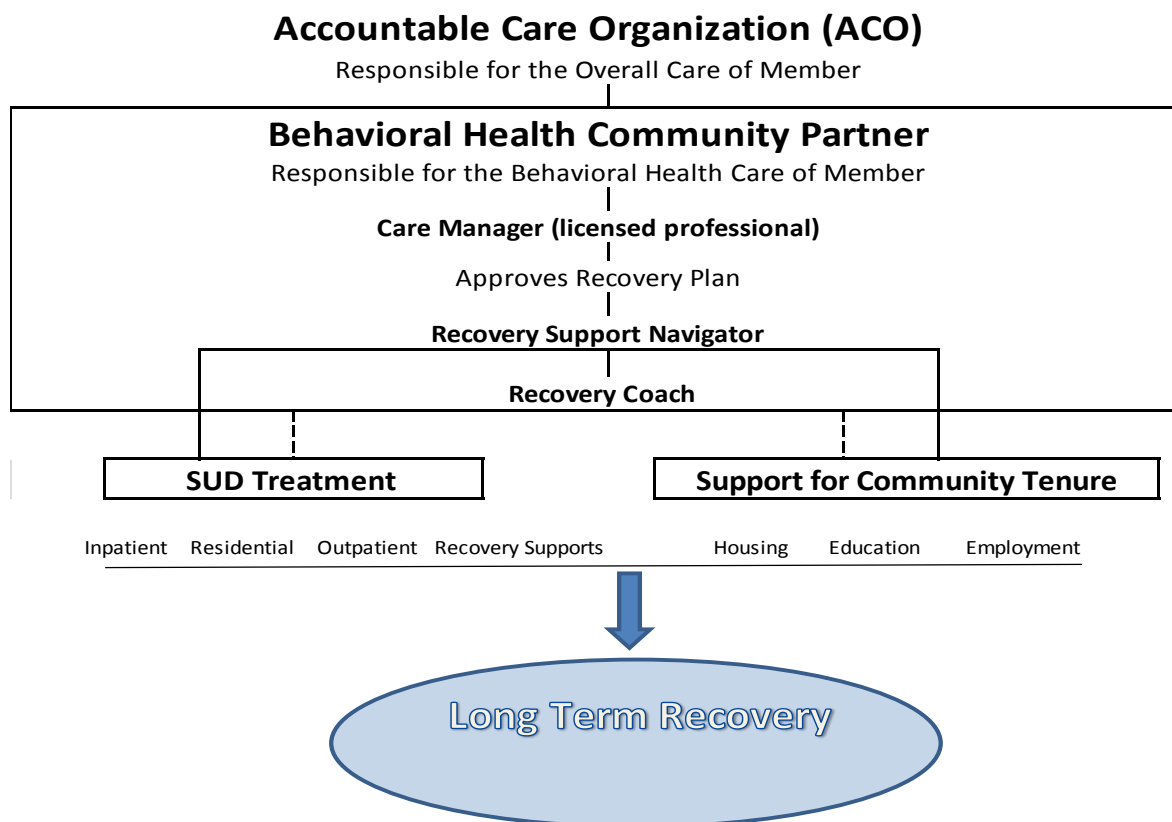
Under this SUD 1115 demonstration, MassHealth proposes to provide members with care management and recovery-focused support services, depending on a member's treatment needs and goals. Recovery-focused support services motivate and engage members in treatment and sustained recovery. They do this by helping people develop meaningful daily activities building on their strengths and connecting people in recovery to their communities and community supports. Recovery-focused support services are intended to assist individuals wherever they live and wherever they are in their recovery.

Given the chronicity of SUD, EOHHS believes that providing care management, care coordination and certain recovery-focused support services through a combination of Care Managers, Recovery Support Navigators and Recovery Coaches, will improve the health of our members with SUD and, in doing so, maintain a stable or reduced cost in caring for them. These services, as shown in Exhibit 10, are the glue that helps support members through the treatment journey.

³⁵ Godley, S.H., Hedges, K., & Hunter, B. (2011). Gender and racial differences in treatment process and outcome among participants in the Adolescent Community Reinforcement Approach. *Psychology of Addictive Behaviors* 25, 143-154. doi:10.1037/a0022179.

³⁶ *Ibid.*

Exhibit 10 – Role of Community Partners, Recovery Support Navigators and Recovery Coaches in Provision of Care Coordination and Support to MassHealth Members with Substance Use Disorder



Through Community Partners, individuals with significant SUD will receive assessment, participate in developing individual/family service plans that include relapse management/risk reduction plans, receive ongoing recovery-focused support, service coordination, referrals to necessary health and social services, and coaching on self-advocacy and advocacy for family needs. These services are overseen by the Community Partner's Care Manager, who will be responsible for establishing relationships among clinical, community, and public health organizations who provide care to the member, and who will approve the member's recovery plan.

The Recovery Support Navigator will develop and monitor a recovery plan in conjunction with the member, coordinate all clinical and non-clinical services, participate in discharge planning from acute treatment programs, work with the member to ensure adherence to the discharge plan, and assist the member in pursuing his or her health management goals.

For members in need of additional support, a Recovery Coach, a person with SUD lived experience, will be offered to the member to serve as a recovery guide and role model. Recovery Coaches provide nonjudgmental problem solving and advocacy to help members meet their recovery goals.

Most formal recovery-focused support services have been paid for by DPH, including Recovery Support Centers, Recovery High Schools and Recovery Coaches. Recovery Support Centers offer a supportive, welcoming and substance -free environment anchored in the community, providing people in recovery with information, referral, self-help groups, access to treatment services, opportunities for peer support, education, support to prevent relapse and promote sustained recovery from substance use disorders. The Commonwealth's five Recovery High Schools help students engage in and maintain their recovery as they complete their High School education. Under the SUD 1115 demonstration Recovery Coaches will become MassHealth covered services. MassHealth seeks authority to claim FFP for these expenditures.

7.2.7 Additional Recovery-Focused Support Services

Massachusetts offers a broad array of formal and informal community-based recovery-focused support services, provided through a variety of support networks, including treatment providers, community-based programs, self-help groups, schools, peers, family members, friends, and faith communities.

Organizations like the Massachusetts Organization for Addiction Recovery (MOAR), Learn2Cope and Allies in Recovery help individuals and their families throughout the recovery process and work to reduce stigma associated with SUDs. Stigma reduction is crucial in furthering both education and prevention around SUDs. Stigma takes many different forms in the various cultural and socio-economic communities across the Commonwealth and we must improve our cultural competency in order to achieve success in stigma reduction.

Many individuals with SUDs also have an underlying mental health diagnosis, and in order to successfully promote recovery and reduce relapse it is important to address both conditions. The Massachusetts Clubhouse Coalition supports Dual Recovery Anonymous meetings, a twelve-step program for those with both an addiction and a mental illness. These meetings provide a supportive atmosphere, leadership development, and community ties for participants.

7.2.8 Workforce Development and Payment Incentives

To ensure member access to needed SUD treatments and supports, the Commonwealth will need to invest in the SUD services workforce, particularly in the development of recovery coaches, recovery support navigators, care managers and training of mental health clinicians in evidence-based practices for treating people with co-occurring disorders.³⁷ Training and support is also needed to ensure the competence of providers to serve people from a variety of cultural and ethnic communities. In addition, to promote better collaboration and integration across disciplines, health care and mental health care providers need to be educated about the availability and expertise of SUD treatment providers. ACOs and certified Community Partners will be able to fund these trainings with their allotted DSRIP funds, as described in Sections 5.3 and 5.4, and additional support received through DSRIP statewide investments (i.e. technical assistance and workforce development grant programs, see Section 5.5). In addition to

³⁷ According to SAMHSA's website, nearly 9 million individuals nationally have co-occurring disorders.
<http://media.samhsa.gov/co-occurring/>

developing the workforce, it will be essential to align financial incentives across the workforce to provide care that treats the whole person.

7.3 Demonstration Eligibility

The Commonwealth plans to offer expanded coverage of SUD treatment services to all MassHealth members, except those whose coverage is limited to emergency Medicaid coverage (known as MassHealth Limited). Members will be able to receive all SUD diversionary services regardless of whether they receive care through a MCE.

To ensure that individuals in treatment receive coverage, MassHealth currently expedites eligibility decisions for individuals who apply to MassHealth while in acute treatment programs, and will continue to do so. In addition, MassHealth has made improvements in expediting MassHealth eligibility for people recently released from custody in state and county correctional facilities. The Commonwealth intends to enhance these efforts by providing information and referral to mental health and substance abuse services.

7.4 Delivery System

As part of the SUD 1115 demonstration, the Commonwealth will work to increase the availability of treatment programs for populations with specific needs such as high-utilizers of the health care system, pregnant women, women generally, parents with SUD and their children, adolescents with SUD and their families, homeless, persons involved with the criminal justice system, individuals with co-occurring conditions, veterans, seniors, and Native Americans. MassHealth members will receive services through a combination of managed care and fee-for-service delivery systems through this SUD 1115 demonstration. As noted above, through this SUD 1115 demonstration we propose that MassHealth covered benefits include 24-hour community-based SUD treatment services provided in ASAM Level 3.1 treatment programs, TSS and RRS.

In addition, given that this proposal includes significant provision of care coordination, recovery coaches and supportive case management services, the Commonwealth will consider these services as it determines the level of care coordination support provided through DSRIP to Community Partners.

7.5 Proposed 1115 demonstrations and Demonstration Authority

Under the current 1115 demonstration, certain SUD diversionary services are delivered within an Institution for Mental Disease (IMD) setting for MassHealth members. Currently the two SUD treatment services which may be delivered in an IMD setting are Acute Treatment Services (detoxification) and Clinical Stabilization Services, both of which are critical treatment services in addressing the crisis in opioid addiction and the prevention of overdoses. Without this 1115 demonstration authority to provide essential SUD services within an IMD setting, more detoxification services would either be provided in acute or psychiatric hospitals greatly increasing the cost of detoxification or would limit services to facilities with fewer than 16 beds, greatly reducing availability and access to this critical service, and increasing cost. Through this SUD 1115 demonstration, the Commonwealth seeks to continue and

expand SUD treatment services to include authority to deliver ASAM Levels 3.1 and 3.3. CMS indicated its willingness to grant this authority as part of its State Medicaid Director Letter dated July 27, 2015. In addition, MassHealth specifically requests authority to claim FFP for all ASAM level 3.1 and 3.3 services provided to MassHealth members enrolled in its managed care plans. MassHealth will use the weighted average length of stay to calculate its actuarially sound capitated payments to its MCEs for these services, ensuring that the average length of stay does not exceed 30 days in 24-hour community-based SUD treatment. For members who receive services on a fee-for-service basis, MassHealth requests authority to receive FFP for all ASAM Level 3.1 treatment delivered in a TSS program and full coverage for the first 90 days of ASAM 3.1 treatment delivered in a RRS program.

MassHealth believes it has current authority to provide for care management, supportive case management, recovery support navigators and recovery coaches that will be added or expanded as part of this SUD 1115 demonstration.

7.6 Quality Measurement and Evaluation Design

Through this SUD 1115 demonstration, Massachusetts seeks to determine whether expanding SUD services improves the health and health outcomes of Medicaid members. MassHealth agrees to report on the relevant quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD, including the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF#0004). It will also report the SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF# 1644) measures.

Specific questions to be included in the Evaluation will be determined in conjunction with CMS during the 1115 demonstration period. However, MassHealth agrees to include many of the suggested evaluation measures that are contained in the SMD Letter, including the Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) as well as assessing the impacting of providing additional SUD services on readmission rates to the same or higher level of care, emergency department utilization and inpatient hospital utilization. In addition, it will evaluate successful care transitions to outpatient care and linkages to primary care, through the role of its Community Partners.

While EOHHS understands the importance of reducing prescription opioid drug abuse as part of this SUD 1115 demonstration, it is not convinced that the Pharmacy Quality Alliance opioid performance measures are appropriate for MassHealth. There are some significant barriers to implementing these measures that it would like to have addressed prior to committing to report on them.

MassHealth is interested in including the following overall global measures of success:

- Improved access and retention in SUD treatment programs

- Improvement in NOMS (including abstinence/reduced use, increased housing, increased employment/education, increased social connectedness, decreased criminal justice involvement)
- Increased use of MAT
- Reduced opioid deaths
- Reduced overall medical costs
- Reduced incarceration

Section 8. Requested Changes to the Demonstration

Massachusetts proposes to use this demonstration to implement ACOs, create a DSRIP program to support and accelerate ACO adoption, expand substance use disorder services, and implement other reforms that promote access to health care coverage and improve the sustainability of the Commonwealth's Medicaid program. This section describes its proposals for new waiver or expenditure authorities to support these policy initiatives.

Massachusetts requests to continue all other authorities approved and waivers granted under the provisions, terms and conditions of the current demonstration, except that Massachusetts no longer needs authority to continue Intensive Early Intervention Services for Children with Autism Spectrum Disorder, as outlined in STC 40, because these services are now provided through the Medicaid State Plan.

8.1 Request for Demonstration Amendments and Early Five-Year Extension Period

Massachusetts is seeking to amend the current demonstration and to begin a new five-year extension of the Demonstration, commencing July 1, 2017.³⁸ It proposes that the authorities described below become effective upon approval of the demonstration amendment and carry over into the new extension period, with the exception of the restructured Safety Net Care Pool expenditure authorities, which generally would become effective with the new extension period July 1, 2017, except as noted below.

8.2 Advancing Accountable Care

Massachusetts requests authority to implement a program to contract with and pay ACOs under the models described in Section 4, including for an ACO pilot starting this year. As described in more detail in Section 4, MassHealth proposes three ACO payment models: Model A, Model B and Model C. Because Model A ACOs integrate with MCOs and because Model C ACOs contract with MCOs, Massachusetts anticipates that the managed care authorities in the current demonstration, with the proposed modifications described elsewhere in this demonstration proposal, should provide sufficient

³⁸ A five-year extension is allowed by Section 1915(h)(2) of the Social Security Act because dually eligible individuals are covered under the demonstration waiver through Medicare Cost Sharing Assistance.

support for these two ACO payment models. However, Massachusetts seeks any new expenditure authority under section 1115(a)(2) of the Social Security Act necessary to authorize Pilot ACOs and Model B ACOs as described in Section 4. Among other described aspects of these two payment models, this expenditure authority must authorize MassHealth to selectively contract with ACOs for performance accountability for cost and quality of care for attributed populations and for associated responsibilities and payments; these ACOs may be health systems or may be other entities that are provider-led, but are not providers of covered benefits for the purposes of these ACO contracts. The requested expenditure authority must also authorize MassHealth to enter into contracts with these ACOs that include risk-based payments to these ACOs, and that may allow or require ACOs to distribute some portion of shared savings to or collect shared losses from select direct service providers.

In addition, MassHealth seeks authority for two more advanced payment models for Model B ACOs that involve pre-paying ACOs in lieu of paying certain direct service providers at the joint request of the ACOs and the direct service providers impacted. These payment models will be in line with payment models Medicare is implementing with some of its ACOs.

8.3 Covered Benefits

As described in Sections 4 and 7, MassHealth proposes authorization to make changes to covered benefits delivered to individuals under the demonstration. These changes fall into three categories: (1) changes designed to encourage eligible members to enroll in an MCO or ACO, where care delivery is best coordinated, (2) enhancements to improve and expand treatment options available to all MassHealth members with substance use disorder regardless of age or managed care enrollment, except members who are only eligible for emergency services, and (3) transitioning accountability for LTSS into MassHealth's ACO and MCO programs over time.

8.3.1 Benefit Differences Across Delivery Systems

In order to encourage eligible MassHealth members to enroll in an MCO or ACO rather than the PCC Plan, MassHealth proposes to provide selected fewer covered benefits to members who choose the PCC Plan, such as chiropractic services, eye glasses and hearing aids. Members who select the PCC Plan as their managed care option can choose to disenroll from the PCC Plan and enroll in an MCO or ACO at any time. MassHealth seeks to expand its existing waiver of comparability provisions established under Section 1902(a)(10)(B) of the Act to support this proposal.

8.3.2 Enhanced Benefits to Treat Substance Use Disorder

MassHealth seeks to expand the expenditure authority currently provided in the demonstration to include ASAM 3.1 and ASAM 3.3 services to members regardless of age or managed care eligibility. In Massachusetts, these services are commonly called Transitional Support Services and Residential Rehabilitation services for youth, adults and families. MassHealth specifically requests authority to claim FFP for these services when delivered in an IMD setting. MassHealth also requests to expand the expenditure authority currently provided in the demonstration for other SUD treatment services described more particularly in Section 7, to the extent necessary to support FFP claims for MassHealth's expenditures for these services.

8.3.3 Long-term Services and Supports (LTSS)

To promote care integration for members with LTSS needs, Massachusetts requests an expansion of services included under the demonstration. The expansion will include most state plan LTSS for the demonstration population, as well as certain additional “in lieu of” services, as described below.

For all MassHealth eligibility types, MassHealth requests authority to include the State Plan LTSS described in Section 4.3.1.3 within managed care provided by the MCOs and Model A ACOs.

MassHealth also requests authority to include additional flexible “in lieu of” services, as described in Section 4.2.2 in the Demonstration and offer these benefits under managed care, including through MCOs and Model A ACOs.

Finally, Massachusetts requests authority to include members under age 65 who are residing in a nursing home or certain other long-term care facilities in the demonstration and in accompanying budget neutrality calculations. This will facilitate the movement of State Plan LTSS into demonstration programs as described above. Currently, individuals who are eligible for MassHealth based on institutional status are generally excluded from the demonstration in accordance with STC 26.

8.3.4 Cost Sharing Differences Across Delivery Systems

As described in Section 4.4, MassHealth proposes to implement differential copayments depending on whether a member is in the PCC Plan or FFS, or enrolled in an MCO or ACO. The primary goal of these changes is to encourage members to choose more comprehensive, coordinated and managed model of care by enrolling in an MCO or ACO instead of the PCC Plan, while updating cost sharing rules in accordance with the ACA. While income based cost-sharing limits will be the same for the member regardless of their delivery system, members at income levels below 50 percent of the FPL (50 percent of MassHealth members) will no longer be charged copayments in any delivery system. To encourage enrollment in MCOs and ACOs, PCC Plan enrollees will pay higher copayments on select services than MCO or ACO enrollees. As discussed in Section 4.3.1.2, members who do choose the PCC Plan will be able to disenroll from the PCC Plan and enroll in an MCO or ACO at any time. While PCC Plan copayments will be higher than ACO and MCO copayments, they will remain nominal (\$4.00) to ensure affordability and continued access to care for all MassHealth members. All members who are currently categorically excluded from paying copayments will maintain their exclusions. In accordance with current MassHealth regulations, a member’s inability to pay a copayment shall not result in denial of service in any delivery system.

MassHealth seeks waiver authority to implement these premium and costs sharing requirements to the extent that they exceed limits established under section 1902(a)(14) of the Act and implementing regulations.

8.4 Extending CommonHealth for Working Adults Age 65 and Older

MassHealth proposes to extend CommonHealth eligibility under the demonstration to adults age 65 and older who are working, notwithstanding disabilities that would meet the federal definition of “permanent and total disability” if these adults were under the age of 65. CommonHealth members with income over 133 percent of the federal poverty level and working 40 or more hours per month at the time they reach age 65 currently receive state-funded CommonHealth coverage. This population will be able to maintain enrollment in MCOs, ACOs, the PCC Plan, the One Care duals demonstration project, SCO, or PACE if the member meets eligibility criteria described in the State Plan. Massachusetts seeks expanded expenditure authority to include this population in the definition of CommonHealth Adults. Massachusetts also seeks a waiver of applicable provisions of Section 1902(a) of the Act, in order to disregard asset and income limits that otherwise apply to individuals age 65 and over.

8.5 Student Health Insurance Program (SHIP): ensuring MassHealth is “payer of last resort”

Massachusetts requests authority to provide premium assistance in the form of direct payments to an institution of higher education (or its designee) for students with access to student individual health plans, to the extent that Massachusetts determines that this is cost-effective. For MassHealth Standard, CommonHealth, CarePlus and Family Assistance members with access to a student individual health plan, Massachusetts requests authority to require enrollment in such a plan as a condition of receiving MassHealth benefits, under the principle that applies generally to all applicants – to maximize other potential benefits or third party sources of medical insurance or coverage.³⁹ Students enrolled in a student health plan with premium assistance will receive cost sharing assistance and a benefit wrap so that they will not be subject to higher cost sharing or reduced benefits than they would be if they were enrolled in MassHealth direct coverage. Once the individual enrolls in the student individual health plan, premium assistance will be provided for the entire plan year or semester. For those individuals enrolled in student individual health plan with premium assistance, Massachusetts requests authority to provide continuous eligibility to coincide with the SHIP plan year or semester for which premium assistance is provided. Massachusetts does not plan to require these individuals to report any changes that may impact MassHealth eligibility (with the exception of death, state residency or fraud) during the period of continuous eligibility.

MassHealth requests the following authority:

- 1) Authority to purchase student individual health plans for individuals who have access to those plans
- 2) Authority to require the individual’s cooperation to obtain or maintain such available plan and treat it as a condition of MassHealth eligibility
- 3) Authority to provide continuous MassHealth eligibility to coincide with SHIP plan year or semester

³⁹ 42 U.S.C. 1396a(a)(25).

- 4) Authority to not require individuals to report any changes that may impact MassHealth eligibility (with the exception of death, state residency or fraud) during the period of continuous eligibility
- 5) Any other waiver or expenditure authority necessary

8.6 Requested changes to the Safety Net Care Pool

Massachusetts requests expenditure authority to modify the Safety Net Care Pool (SNCP). Requested changes to the SNCP from the date of the approved amendment through June 30, 2017 are the following:

- 1) Changes to Infrastructure and Capacity Building (ICB) grant authority: MassHealth requests authority to pay ICB grants to selected pilot ACOs (in addition to hospitals and community health centers) to support ACO infrastructure and care coordination expenses during the ACO pilot, as DSRIP funds will not be available
- 2) Authorization for ConnectorCare subsidies for cost sharing

In addition, Massachusetts requests expenditure authority to redesign the Safety Net Care Pool, beginning on July 1, 2017 through the 5-year extension term:

- 1) Creation of two System Transformation Incentive pools, including:
 - a. A DSRIP pool
 - b. The Public Hospital Transformation and Incentive Initiatives (PHTII)
- 2) Align uncompensated care pool principles with CMS through:
 - a. Continued utilization of an amount that would equal the Commonwealth's DSH allotment to finance approved expenditures for uncompensated care, including:
 - i. Health Safety Net Payments to hospitals and community health centers
 - ii. Uncompensated care provided by state DPH and DMH hospitals
 - iii. Ongoing and sustainable safety net provider payments
 - iv. Payments to IMDs for care provided to MassHealth members
 - b. Supporting expenditures for uncompensated charity care beyond the state's DSH allotment through the creation of a separate Uncompensated Care Pool
- 3) Authorization for ConnectorCare subsidies for cost sharing, in addition to continued authorization for ConnectorCare premium subsidies
- 4) Commitment from CMS to work with the Commonwealth to develop a Public Hospital Global Budget for the Uninsured Initiative that will commence in year 2 of the new 5-year demonstration extension term

The following programs will be discontinued as of July 1, 2017:

- 1) Delivery System Transformation Initiatives (DSTI)
- 2) Infrastructure and Capacity Building (ICB) grants

8.7 Primary Care Payment Reform Initiative (PCPRI)/ Patient-Centered Medical Home Initiative (PCMHI) Shared Savings Payments

Patient-Centered Medical Home Initiative (PCMHI) has ended, and Primary Care Payment Reform Initiative (PCPRI) ends in December 2016. MassHealth requests approval for the shared savings provisions in the PCMHI and PCPRI contracts. It proposes to start paying these retrospective performance payments starting in the first quarter of calendar year 2017.

Section 9. Budget Neutrality

The federal government requires states to demonstrate that federal Medicaid spending for the 1115 demonstration does not exceed what the federal government would have spent in the absence of the demonstration. Since the inception of the demonstration, Massachusetts has met this budget neutrality test and has used program savings (budget neutrality "room") to invest in significant advances, such as premium subsidies in the Commonwealth Care and ConnectorCare programs to promote coverage expansion, and DSTI to support safety net hospitals. The changes proposed in this demonstration request continue to meet budget neutrality requirements during the proposed period. The details of the budget neutrality calculation projections are presented in the Budget Neutrality Appendix.

9.1 Budget Neutrality Methodology

Massachusetts' budget neutrality calculation is detailed in Section XI and Attachment D of the current demonstration's STC. The calculation demonstrates that gross spending under the demonstration ("with waiver") is less than what gross spending would have been in the absence of a waiver (the "without waiver" limit).

As directed by CMS's *Budget Neutrality Savings Principles, December 2015*, Massachusetts limited the roll-over of accumulated budget neutrality savings to savings realized beginning in SFY 2012. No deficit or savings is carried over from years prior to SFY 2012. Accordingly, the budget neutrality demonstration includes "with waiver" expenditures and "without waiver" expenditure limit calculations beginning in SFY 2012. In addition, savings are phased down rather than carried forward in full. For the first five years that an eligibility group is enrolled in managed care and for the first five years that a set of services (e.g. LTSS) is subject to managed care, savings are carried forward in full. Beginning in the 6th year of each managed care initiative, the share of savings recognized is phased down 10 percent per year to a minimum of 25 percent. The percent of savings recognized overall for each waiver year is calculated by averaging the phase down percentage by eligibility group weighted by the actual expenditures for the eligibility group in the waiver year.

The budget neutrality calculation for this demonstration request builds upon what was established in previous extensions and adds new services and populations. Projected actual expenditures build on prior experience and changes detailed in this request. As detailed in Sections 4, 7, and 8, Massachusetts requests adding to the base expenditures the following new services and populations.

- 1) *Long-term services and supports provided to waiver populations:* These LTSS were provided to individuals in each of the waiver eligibility groups. These expenditures are added as a new row in the Appendix. “Without waiver” expenditure projections for these new LTSS services are based on five years of actual historical PMPM expenditures, trended forward based on that LTSS historical trend for each eligibility group, and multiplied by projected caseload. Note that these expenditures include LTSS provided to individuals who are eligible based on institutional status (except those individuals in an ICF or SNF operated by the Department of Developmental Services). This population is no longer excluded from the waiver and from the budget neutrality analysis. LTSS expenditures and member months for this group are included in the expenditure and member months for each applicable eligibility group.
- 2) *Enhanced substance use disorder (SUD) services.* The projected cost of these expanded services, net of expected savings due to reduced utilization in other areas, is included in the projected actual expenditures as a separate row.
- 3) *Waiver services provided to CommonHealth enrollees who work 40 or more hours per month and are over age 65:* The waiver requests expanding the CommonHealth eligibility group to include these individuals. Expenditures and member months for the CommonHealth eligibility group include these individuals.

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

The demonstration continues to incorporate the ACA “new adult” population, as described in STC 31 and STC 31A, as a so-called “hypothetical population.” As a hypothetical population, this population has a net zero impact on budget neutrality. Massachusetts will not accrue budget neutrality savings under the demonstration based on expenditures for this group, nor will expenditures for this group be counted against the budget neutrality limit under the demonstration so long as PMPM spending does not exceed the trended baseline amount, which can be adjusted annually to reflect actual experience.

9.2 Budget Neutrality Impact

As noted above, the changes proposed in this renewal request continue to meet budget neutrality requirements during the extension period. The attached budget neutrality calculation shows that projected expenditures over the life of the waiver from SFY2012 through SFY2022, the end of the demonstration extension request, will be approximately \$69 billion less than projected expenditures in the absence of the demonstration. After phasing down the share of savings recognized, Massachusetts’ budget neutrality cushion is projected to be \$44 billion for the period SFY 2012 – SFY 2022.

This projection incorporates actual expenditures and member months through SFY 2015 as reported through the quarter ending December 31, 2015, the MassHealth budget forecast for SFY 2015-2016,

Commonwealth Care and Health Safety Net (HSN) information from the SFY 2016 budget, and the SFY 2017 Governor's proposed budget.

Massachusetts is proud of the extent to which this budget neutrality room represents ongoing and anticipated efforts to control health care costs in Massachusetts. Massachusetts also recognizes that the extension period may include a time when Massachusetts' economic environment will support investment in the demonstration programs beyond current projections, and is pleased that the budget neutrality calculation provides the potential to make such changes.

Section 10. Demonstration Monitoring and Evaluation

10.1 Monitoring Quality and Access

Massachusetts monitors the quality and access to care provided under the demonstration in multiple ways. At a basic level, all contracts with providers require the monitoring and reporting to the state of key aspects of quality, member experience and access. These contract provisions are the foundation of all quality management activities. In addition, MassHealth assesses its managed care contractors using a number of platforms, including an assessment of members' experiences in the plans. And MassHealth files required reports on preventive and screening services provided to children.

10.1.1 HEDIS

MassHealth's 2014 HEDIS evaluation focused on the six MCOs' performance in four domains: preventive care, chronic disease management, behavioral health care and perinatal health. The MassHealth MCOs performed best in the preventive care domain. The weighted average scores of the six plans exceeded the national Medicaid 90th percentile for seven of the ten measures in this domain, with only two – immunizations for adolescents and HPV vaccine for adolescents – not meeting that high standard. (The tenth measure was not evaluated against national benchmarks because the measure specification had undergone significant changes.) In the behavioral health domain, MassHealth MCOs met or exceeded the 90th percentile benchmark for two measures, but scored below the national Medicaid mean for one, antidepressant medication management. In the other two domains, MassHealth MCOs' performance was statistically equivalent to or exceeding the national 75th percentile but below the 90th.

10.1.2 External quality review

MassHealth's external quality review organization (EQRO) undertook two assessments for calendar year 2014: (1) the CMS-mandated review of MassHealth's MCOs; and (2) a voluntary review of the Primary Care Clinician (PCC) plan, as part of MassHealth's managed care strategy.

10.1.2.1 MCO Comparative Report

The EQRO review of the six MassHealth MCOs included a compliance review with federal and state standards in three areas (enrollee rights and protections, quality assessment and performance improvement, grievance system); validation of three HEDIS measures (cervical cancer screening, initiation and engagement of alcohol and other drug dependence treatment, prenatal and postpartum care); and the validation of two performance improvement projects for each MCO – one selected by

MassHealth (using aftercare to reduce readmission rates for members who receive inpatient substance abuse services) and another selected by the plan. On compliance, the EQRO identified improvement opportunities for two plans – ensuring that individual primary care providers (PCPs) do not have a panel of more than 1,500 enrollees, adequate access to non-English speaking PCPs and access to urgent behavioral health services within 48 hours. There were no other significant issues in the compliance review. MCOs generally performed well on the three HEDIS measures, usually (though not always) matching or exceeding the national 75th percentile, and all plans have improvement strategies in place. The MCOs had mixed results in demonstrating improvement in the MassHealth-selected and their own chosen performance improvement projects. The EQRO identified strengths of each plan's efforts and offered recommendations for improvement.

10.1.2.2 PCC Plan

The EQRO's review of the PCC Plan included the validation of three HEDIS measures – breast cancer screening, cervical cancer screening and postpartum care. The breast cancer screening rate improved from 65 percent in 2013 to 71 percent in 2014, exceeding the national 75th percentile. The cervical cancer screening measure specifications changed significantly in 2014 so the measure was considered new and comparisons with past years not meaningful; the PCC Plan's screening rate in 2014 was 64 percent. The PCC Plan's postpartum visit rate increased from 66 percent to 68 percent, and was eight percentage points higher than in 2011. The 2014 rate exceeded the national median. The report identifies the interventions that were designed to sustain and improve these measures – including producing monthly, member-level gap-in-care reports, educational mailings and (for postpartum visits) participation in the "text4baby" program. The EQRO offers some recommendations to the PCC Plan for increasing its measures, "in the spirit of continuous quality improvement."

10.1.3 EPSDT

Massachusetts files the required CMS Form 416 to report on its Early and Periodic Screening, Detection and Treatment (EPSDT) services for children enrolled in MassHealth. In federal fiscal year (FFY) 2014, a total of 664,085 children under age 21 were eligible for EPSDT, with 615,378 eligible for at least 90 continuous days. On average, children remained eligible for EPSDT for 89 percent of the year. The screening ratio – initial or periodic screenings received, as a percentage of the expected number of screenings based on eligible members – was greater than one. However, just 70 percent of the eligible members who should have received at least one screening actually received one; this was higher than the national rate of 59 percent. About 326,000 members were referred for corrective treatment following a screening. Some 335,000 received dental services, including preventive services, diagnostic services and treatment. About 85,000 received blood lead screening tests.

10.1.4 Consumers' Experiences with MCOs

The National Committee for Quality Assurance (NCQA) requires for accreditation that health plans conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to capture consumer-reported experiences with health care. The MassHealth MCOs conduct the survey annually for their MassHealth members. The report that each plan submits to MassHealth contains extensive

analysis. The table below shows a summary comparison for five MCOs for FFY 2014.⁴⁰ The numbers in the tables are the approximate percentile threshold each plan achieved when compared with national benchmarks.

	BMC HealthNet	Fallon Community Health Plan	Health New England	Neighborho od Health Plan	Networ k Health
Getting Needed Care	50	90	25	25	75
Getting Care Quickly	75	50	<25	25	90
How Well Doctors Communicate	90	75	50	90	90
Customer Service	25	75	50	25	90
Rating of Health Care	75	90	50	90	90
Rating of Personal Doctor	50	90	25	50	90
Rating of Specialist	<25	90	50	75	90
Rating of Health Plan	90	90	75	90	90

10.2 Evaluation results for the prior Demonstration extension

The University of Massachusetts Medical School (UMass) conducted an evaluation of the MassHealth 1115 demonstration extension ending in SFY 2014. The evaluation found that Massachusetts made progress in achieving the goals of coverage, redirection of funds, delivery reform, and payment reform goals of the waiver term.

UMass used a variety of population-level metrics to monitor the prevalence of employer-sponsored insurance, Commonwealth Care, MassHealth, and insurance as a whole. Near-universal coverage was maintained, throughout major shifts in the market due to the ACA. Express Lane Eligibility, an initiative that streamlines the MassHealth renewal process for children and their caregivers who are also on Supplemental Nutritional Assistance Program (SNAP), was successful in improving retention of MassHealth eligibility. Households eligible for the initiative were much less likely to lose MassHealth eligibility in the 90 days after the annual review date (4.4 percent for Express Lane Eligibility households, versus 36.3 percent in other households).

The UMass evaluation also found that Health Safety Net payments and safety net care supplemental payments to all acute hospitals remained relatively stable. As mentioned above, the number of individuals accessing the Health Safety Net has declined since the implementation of certain coverage aspects of the ACA in January 2014.

Finally, the UMass evaluation noted progress in the areas of delivery and payment reform. It examined MassHealth's efforts in DSTI, the Intensive Early Intervention initiative, the Patient-Centered Medical

⁴⁰ A sixth plan, Celticare, became a MassHealth MCO in FFY 2015.

Home Initiative and the Massachusetts Children’s High-Risk Asthma Bundled Payment Demonstration Program.⁴¹

10.3 Evaluation for current waiver

MassHealth has engaged the University of Massachusetts Medical School’s Center for Health Policy and Research (UMass) to evaluate the current demonstration extension (through June 30, 2017). The evaluation will examine five MassHealth initiatives through the lens of how each one affects one or more of the demonstration’s goals, as this chart indicates:

	Demonstration Goal			
Initiative	Near Universal Coverage	Redirection of Spending	Delivery System Reforms	Payment Reforms
Continued monitoring of population measures	X	X	X	
Express Lane eligibility	X			
Delivery System Transformation Initiatives			X	X
Infrastructure and capacity building grants			X	X

UMass is undertaking the evaluation of each of the initiatives as follows:

- Continued monitoring of population measures: A descriptive analysis of existing measures to examine changes in the measures
- Express Lane Eligibility (ELE): A retrospective, quasi-experimental design to examine changes in MassHealth enrollment among households that received the streamlined ELE renewal compared with those who underwent traditional MassHealth (non-ELE) renewal
- Delivery System Transformation Initiatives (DSTI): A two-phased mixed method approach. Phase 1 will use quantitative methods to assess performance variation within and across the DSTI hospitals and in comparison to statewide trends. Phase 2 will use qualitative methods to understand the organizational conditions associated with relatively greater improvement in key measures.

10.3.1 Infrastructure and capacity building (ICB) grants

Case study and qualitative analysis to characterize ICB projects, assess grant awardees’ performance and determine the factors associated with effective initiatives.

⁴¹ University of Massachusetts Medical School, MassHealth Section 1115(a) Demonstration Waiver 2011-2014 Evaluation Final Report (October 24, 2014).

10.3.2 Evaluation of the Proposed Demonstration Extension

For the requested 5-year extension of the demonstration starting July 1, 2017, the Commonwealth will develop and implement an evaluation plan to study the success of the following goals as laid out in Section 2 above:

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

10.3.2.1 Evaluation of Goals 1 and 2: Enact payment and delivery system reform and Improve integration of physical health, behavioral health, long-term services and supports, and health related social services

Goals 1 and 2 seek to (a) enact payment and delivery system reforms that promote integrated, coordinated care and hold providers accountable for the quality and total cost of care; and (b) improve integration of physical health, behavioral health, long-term services and supports, and health related social services respectively. As the two goals are closely linked and interdependent, the Commonwealth will evaluate them together through quantitative and qualitative research methodologies.

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains and performance measures that MassHealth has described in greater detail above for the ACO and DSRIP programs, including:

- ACO Quality Performance
- MassHealth ACO Adoption Rate
- Reduction in Avoidable Utilization
- Reduction in State Spending Growth
- ACO Total Cost of Care Performance
- ACO Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services.

Through the ACO and DSRIP programs, MassHealth will set specific and measurable goals in the above domains that will factor into ACOs' financial accountability to the state and the Commonwealth's financial accountability to CMS. State and ACO performance against these measures will form the foundation of the quantitative evaluation of these two goals under the demonstration.

As a complement to the quantitative evaluation, the Commonwealth will use qualitative evaluation methods to give context to and illuminate the quantitative data and to investigate specific patterns or other findings in this data.

An independent evaluator will measure the successes through a midpoint and final assessment of the aforementioned goals. Massachusetts will also implement additional evaluation techniques, such as rapid cycle evaluation.

10.3.2.2 Evaluation of Goal 3: Maintain near-universal coverage

The independent evaluator will continue to monitor the prevalence of employer-sponsored insurance, MassHealth, Health Connector coverage (including ConnectorCare), and health insurance coverage rates for residents of the Commonwealth as a whole. To accomplish this task and consistent with the current evaluation design, the independent evaluator will: (1) describe existing population-level measures and investigate any changes to coverage that have occurred; and (2) conduct a retrospective, quasi-experimental design to examine changes in enrollment for MassHealth for those enrolled using Express Lane Eligibility.

10.3.2.3 Evaluation of Goal 4: Sustainably support safety net providers to ensure continued access to care

As noted in Section 6, the restructuring of the Safety Net Care Pool aligns the restructured and new payments to providers with the overall goals of delivery system reform and accountable care. The new, restructured Safety Net Provider payments will focus on supporting hospital operations while linking this funding to providers' participation and performance in accountable care models. MassHealth has identified 11 hospitals that qualify for the new proposed safety net provider payments, based on an analysis of all Massachusetts hospitals' payer mix and uncompensated care, performed by MassHealth's contractor, Navigant Consulting.

The independent evaluator will monitor the providers that receive Safety Net Provider payments. These payments will be held at increasing levels of risk each year (up to 20 percent by year 5) of the 1115 demonstration. The at-risk portion of the payments will be tied to the DSRIP measures covering four domains, including total cost of care, avoidable utilization, quality performance and integration of BH and LTSS. While with respect to Demonstration Goals 1 and 2 the evaluation is focused on system-wide performance, the evaluation of Goal 4 will monitor provider-specific performance for those providers receiving Safety Net Provider funding. MassHealth will also work with the independent evaluator to develop measures that assess the financial sustainability of the safety net hospitals and how supplemental payments support these providers.

With respect to other SNCP funding components for uncompensated care, the evaluation will monitor overall uncompensated care in the Commonwealth and the extent to which SNCP funding addresses this uncompensated care, particularly for safety net providers.

10.3.2.4 *Evaluation of Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-focused substance use disorder services*

The independent evaluator will evaluate: (1) whether eligible individuals received needed SUD services, (2) whether those services improve the health and health outcomes of those members receiving SUD services, and (3) whether these services lower medical costs and reduce incarceration.

Receipt of needed SUD services will be evaluated by assessing access and retention in SUD treatment programs. Improved health and health outcomes will be evaluated by assessing increased use of MAT; reduced opioid deaths; and improvement in NOMs (including abstinence/reduced use, increased housing, increased employment/education, increased social connectedness, decreased criminal justice involvement). System effects will be evaluated by assessing the reduced overall medical costs and reduced incarceration.

The independent evaluator will use many of the suggested evaluation measures that are contained in the SMD Letter, including the Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) as well as assessing the impacting of providing additional SUD services on readmission rates to the same or higher level of care, emergency department utilization and inpatient hospital utilization. In addition, it will evaluate successful care transitions to outpatient care and linkages to primary care, through the role of its Community Partners.

Section 11. Public Notice and Comment Process

The public process used prior to submitting this request conforms with the transparency and public notice requirements outlined in 42 CFR § 431.400 et seq., and the requirements of STC 7-9 and 15, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements as outlined in the State's approved State plan. The Commonwealth is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

11.1 Public Notice

The public comment period started on June 15, 2016 and ended July 17, 2016. The Commonwealth released the request for the public comment period by posting the request, Budget Neutrality worksheets, and notice of the request (including notice of public hearings and the instructions for submitting comments) on the MassHealth 1115 Demonstration website at <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html> and at MassHealth's Innovations website at www.mass.gov/hhs/masshealth-innovations, where MassHealth has posted information about its restructuring efforts and stakeholder engagement processes over the last year. The long-form public notice was also published through a link on MassHealth's home page at <http://www.mass.gov/eohhs/gov/departments/masshealth/>. The announcement and links to documents were included in email updates distributed broadly to stakeholders, using both the Massachusetts Affordable Care Act electronic mailing list and the

MassHealth Innovations electronic mailing list. Notice of the Request, hearings, and the public comment period were also provided through announcements in all newspapers of widest circulation in cities of populations of 100,000 or more (namely, the *Boston Globe*, the *Worcester Telegram and Gazette*, and the *Springfield Republican*). Newspaper notices were published at least thirty days before the public comment period ended. The newspaper notices included a link to the state's website containing the Request.

In addition to making the Request and supporting documents available online, MassHealth informed the public that paper copies were available to pick up in person at EOHHS' main office, located in downtown Boston.

11.2 Tribal Consultation

The Tribal consultation requirements were met through providing a summary of the Request during quarterly tribal consultation calls on January 14, 2016 and April 27, 2016. The Commonwealth provided a summary of the call via email. When the Request was posted online, the Commonwealth followed up with tribal representatives with a reminder of the posting, including links to the documents and instructions for providing comment. No comments or questions from tribal representatives were submitted.

11.3 Public Hearings

The Commonwealth hosted two public hearings, also referred to as listening sessions, on June 24, 2016 in Boston (in conjunction with a meeting of Massachusetts' Medical Care Advisory Committee and Payment Policy Advisory Board), and on June 27, 2016 in Fitchburg, to seek input regarding the request. The hearings included a presentation on the Demonstration renewal requests (available on the MassHealth Innovations website at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/160624-1115-waiver-proposal-slides.pdf>) and opportunities for the public to provide both oral and written comments. Both meetings included a telephone conference line available to call in and listen to the session, as well as Communication Access Realtime Translation services for individuals attending in person. These sessions were well attended, with 127 members of the public attending the sessions in person and additional attendees by phone.

11.4 Public Comments

Questions and comments were solicited from members of the audiences at both of the public hearings. A total of 23 individuals and organizations offered oral testimony. The Commonwealth also received 75 comment letters representing more than 200 organizations (Appendix C) during the 30-day comment period. Commenters represented health care organizations, hospitals, including safety net hospitals, consumer advocates, providers, trade associations, labor unions, and individuals.

Many commenters were enthusiastic about the proposal overall. In particular, multiple commenters applauded the goals of payment and delivery reform and key parts of the proposal, including:

- The shift to payment and care delivery models focused on the quality, coordination and total costs of care
- Integration of physical health with behavioral health and LTSS
- Acknowledgment of the importance of community-based services and social supports
- The expansion of services for members with substance use disorders

Commenters also praised MassHealth for its open, substantive, and extensive approach to stakeholder engagement in the development of this proposal and expressed the hope that such engagement would continue in various ways through the implementation of the demonstration.

Commenters also offered a range of suggestions and viewpoints. A synopsis of the major themes from the public comments, and MassHealth's responses, follows here. The complete written comments will be made available, along with this final Request, on MassHealth's 1115 Demonstration website at <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html> and at MassHealth's Innovations website at www.mass.gov/hhs/masshealth-innovations.

11.4.1 LTSS

LTSS providers and advocates for members with LTSS needs expressed overwhelming support for system reforms that encourage integration and care for the whole person. Commenters praised MassHealth's commitment to building a better health care delivery system that incorporates LTSS. Commenters also expressed appreciation for MassHealth's recognition of the need to improve the accessibility of the health care system for individuals with disabilities through better physical accommodations, better training for providers to serve individuals with disabilities and better coordination of care.

On the details, many comments addressed how LTSS would be phased into MCO/ACO programs over time. Commenters asked for a careful process to ensure that ACOs were prepared to take on accountability for LTSS. Several commenters also urged MassHealth to foster ACOs' and MCOs' relationships with existing networks of community-based providers in order to build capacity and competence for delivering LTSS services, rather than relying on ACOs and MCOs building the capacity themselves. Some commenters were also concerned about "over-medicalization" of LTSS. As described in this final request, MassHealth is committed to ensuring the readiness and capacity of ACOs and MCOs to provide LTSS and will apply the model and principles it has developed in implementing the One Care program to honor this commitment. MassHealth will also continue its transparent stakeholder process to garner input to the demonstration, including how MCO/ACO and LTSS Community Partners can best combine efforts to deliver LTSS that meet members' diverse needs.

There were multiple recommendations from commenters to include access to an independent, conflict-free case manager or service coordinator, modeled on the LTSS coordinator role in the SCO and One Care programs. As noted above, MassHealth plans to model its approach to LTSS integration on many of the principles and strategies established as part of the One Care program, and MassHealth will specifically work to meet the goals that underlie these comments.

A number of commenters emphasized the need for LTSS Community Partners with expertise in specific subpopulations, such as people with autism and other developmental disabilities, children and youth, and cultural and linguistic minorities. Some commenters asked for additional information about the certification criteria for Community Partners. In this Request, MassHealth has reiterated its commitment to ensuring that the needs of these subpopulations are met. For example, the Request states above:

“At a minimum, LTSS CPs must demonstrate expertise in serving more than one of the following populations with disabilities: (1) elders, (2) adults with physical disabilities, (3) children with physical disabilities, (4) members with acquired or traumatic brain injury, (5) members with intellectual or developmental disabilities and (6) individuals with co-occurring behavioral health and LTSS needs. LTSS CPs must also demonstrate ability to conduct independent assessments, counseling and decision support on LTSS service options, and navigation to quality LTSS providers.”

MassHealth will remain cognizant of these concerns as it develops more detailed requirements for Community Partners as part of the certification process.

Commenters also urged MassHealth to ensure continued access to providers with whom members with disabilities and LTSS needs have established relationships, and some raised concerns that ACO-established networks and agreements with Community Partners might restrict that access. Members’ ability to access a broad network of skilled providers and to maintain continuity of care with particular LTSS *and* behavioral health services providers was expressed as an important principle. MassHealth agrees that network access and adequacy as well as continuity of care are important for members with special needs, including those with disabilities and significant behavioral health needs. MassHealth will use various mechanisms – including ACO requirements, DSRIP investment dollars that support community LTSS and behavioral health capacity, statewide investments in technical assistance, and network configurations to ensure that members have sufficient access. MassHealth is also committed to monitoring this closely and working with a stakeholder advisory group that includes member representatives and advocates to evaluate areas of progress and areas to refine.

11.4.2 Behavioral Health

Many commenters expressed strong support for the goal of reducing barriers and better integrating behavioral health (BH) and physical health services. A major BH provider trade association noted its deep appreciation for MassHealth’s recognition of the expertise of community-based providers in the design of the Community Partners program. In addition, across commenter type (providers, advocates and law enforcement, for example), the expansion of SUD services was roundly praised.

There were a number of questions and recommendations for including specific subpopulations as target groups for BH services from ACOs and Community Partners. The most frequently mentioned subpopulation was children and adolescents, including very young children (under age four). People with co-occurring medical and BH conditions and cultural and linguistic minorities were also a concern. MassHealth will focus on ensuring access to BH services for a variety of subpopulations in its model,

including cultural and linguistic minorities, homeless people, people released from incarceration, children with significant BH needs, and people with co-occurring mental health and SUD. For children and youth under 21, this demonstration will build on the home and community based behavioral health services implemented through the Children's Behavioral Health Initiative (CBHI). Three levels of care coordination are available through CBHI services and will remain available as MassHealth transitions to ACO models. Community Support Agencies (CSAs) that now deliver Intensive Care Coordination and Family Support and Training (Family Partners) will be deemed BH Community Partners and be eligible for DSRIP funding. ACOs will be required to collaborate with CBHI services to deliver integrated care for their members receiving CBHI services.

A number of commenters recommended that resources such as Certified Peer Specialists and Recovery Learning Centers be included among the behavioral health services offered by ACOs. MassHealth concurs; peers were highlighted within the Substance Use Disorder portion of the waiver request, and the proposal has been updated to emphasize the importance of certified peer specialists as part of the overall BH integration effort, including the delivery of these services through BH Community Partners. A number of commenters also recommended that MassHealth clarify the role of MassHealth's statewide Behavioral Health vendor (MBHP) in the ACO program and its interaction with BH Community Partners, in order to promote financial alignment and care integration across the full continuum of care.

MassHealth is actively working through these programmatic design elements, and the final ACO design will reflect these considerations.

11.4.3 ACO Design and DSRIP

Commenters were universally supportive of the Commonwealth's efforts to secure DSRIP funding to effect the changes needed to deliver improved, integrated care to MassHealth members. They also echoed MassHealth's recognition of the importance of non-medical factors in influencing health outcomes and were very supportive of the proposal to use some DSRIP funds for flexible services to address these factors. Many commenters were also optimistic about the potential for ACOs to provide quality, integrated care and generate savings through incentives and greater efficiency. Many commenters particularly supported the concept of Community Partners as a unique and integral component of both the ACO design and the DSRIP program.

The design of the ACO models, how members will be assigned to them, and the financial details surround them were all frequent comment topics. Some of the areas commenters raised were: *Elements of the Total Cost of Care (TCOC) Model:* Commenters recommended that oral health be incorporated into the TCOC model for ACOs, arguing that coordination of oral health with other health care services is lacking in similar ways to behavioral health and LTSS, both of which will be incorporated into TCOC. MassHealth recognizes the oral health as an important aspect of overall health and plans to require ACOs to incorporate oral health into their care coordination and integration strategies. MassHealth will also consider the feasibility of incorporating financial accountability for oral health into the TCOC model in the future.

Enrollment: Many commenters expressed concern about the 12-month enrollment period for ACOs and MCOs. The primary objection was that it is restrictive and limits members' choice of providers, particularly when ACOs are new and provider networks may not be completely understood. Other commenters raised the prospect of situations such as siblings and parents being assigned to different ACOs and primary care physicians. MassHealth maintains that the 12-month enrollment period is necessary to ensure that ACOs and MCOs have sufficient stability in their populations to support member-driven, person-centered care planning and services. Fixed enrollment periods will strengthen the relationship ACOs and MCOs have with enrolled members, and the accountability they bear for enrolled members' quality and cost of care. MassHealth also points out that members will have 90 days to change their enrollment at the start of each year and that there will be a variety of appropriate exceptions that will enable members to change their enrollment after the 90-day period under specified circumstances, aligned with federal regulations. Members enrolled in the PCC Plan may choose to enroll in an MCO or ACO at any time, for any reason.

Disparities and risk adjustment: Commenters expressed concerns about health disparities and raised questions of how the ACO models would address them. Recommendations included requiring ACOs to have a detailed plan to address disparities in care, explicit policies for matching members to appropriate community-based providers, stratifying quality measures to identify disparities, and addressing the social determinants of health to reduce disparities. Commenters also urged that the risk adjustment of ACOs payments include an adjustment for social determinants. MassHealth agrees that reducing disparities is an important priority. MassHealth is preparing to launch an improved risk adjustment methodology which will for the first time include social determinants of health. Procurements for ACOs and Community Partners will require respondents to document their experience addressing health disparities, and contracts will require ACOs and Community Partners to have strategies in place to ensure members' access to culturally and linguistically accessible care. In addition, MassHealth is looking at ways to better capture data and track health disparities over time, such as through a consumer experience survey that it will implement for quality and program evaluation. MassHealth is also exploring opportunities to partner with ACOs to collect better Race, Ethnicity and Language (REL) data that would enable a better understanding of patterns of health disparities and improvement over time.

Financing and incentives: Several commenters raised the issue of downside risk in the ACO and Community Partner payment models and suggested that an upside risk only option be available. First, MassHealth clarifies that there is no downside risk as part of the CP program; rather, performance accountability for CPs is used to determine the amount of DSRIP funding earned. With respect to the ACO program, MassHealth maintains that all ACOs should bear some degree of downside risk, based on their capabilities and financial readiness, in order to ensure appropriate accountability on the part of ACOs. In part, this accountability recognizes the significant investment of state and federal resources in ACOs through DSRIP payments and the administration of the ACO program. ACO payment models also provide significant opportunities for ACOs to receive new revenue through strong performance on cost and quality. These models are intended to go beyond previous payment reform initiatives in the Commonwealth, including the Patient Centered Medical Home Initiative, which had no downside risk, and the Primary Care Payment Reform Initiative, which included an upside risk only track for providers

with less ability to take on downside risk. As described in this proposal, MassHealth plans to structure varying levels of upside and downside risk options across ACO Models A, B and C to recognize the range of provider capabilities.

Stakeholder input: Many commenters recommended that oversight of ACO program implementation include a body modeled on the One Care Implementation Council, a majority-consumer, multi-stakeholder group. MassHealth is committed to ongoing stakeholder engagement as the program is further developed and implemented. This will include establishing a stakeholder advisory council with meaningful input, including into the more detailed design of ACOs, Community Partners, and related reforms. The advisory council will include a range of stakeholders, including member representatives, advocates, providers, ACOs and others.

Flexible Service Dollars: Some commenters recommended that CPs should be allowed to access flexible services funding to enhance their ability to provide wrap-around services. MassHealth believes that ACOs should have ultimate discretion of flexible services dollars in order to fully align incentives with total cost of care. However, for members receiving BH and LTSS CP services, MassHealth's expects that ACOs will work their partnered CPs to help determine the best uses for flexible service dollars to meet members' needs.

Additionally, some commenters recommended the redesigned MassHealth healthcare delivery system needs a central "social services hub" to be able to offer ACOs and CPs a single point of coordinated access to a wide range of social services which have documented impact on health outcomes. MassHealth is committed to setting expectations for ACOs to screen for and create linkages to social service organizations to support their members for their health-related social needs. MassHealth also expects to partner with the community to identify scalable, systematic approaches to incorporating social services into care delivery models.

Other programmatic details: Commenters raised issues on many aspects of the proposed program design, seeking further information or offering recommendations on details. A representative, though by no means exhaustive, list of these topics includes:

- Consumer protections, such as ACO and MassHealth appeal and grievance processes and the scope of the proposed Ombudsman
- Required representation on the governance bodies of ACOs
- Suggestions for specific information to be included in a public dashboard report for program monitoring, and the frequency of such reports
- Further detail on the flexible services DSRIP funds can purchase, such as what the spending specifically may include and what requirements and restrictions will be placed on the spending
- Member education and outreach, and navigation support for enrollment
- Level and adequacy of rates for ACOs, Community Partners, and certain providers

These and other programmatic issues raised in the comments are beyond the scope of the demonstration proposal, but MassHealth will take them into consideration in the development of ACO procurements, Community Partners certification process and DSRIP program details, which will be released over the next several months.

11.4.4 PCC Plan Changes

There were a number of comments raising concerns about the approach to benefits, premiums and cost sharing, specifically in the proposed differential in the PCC plan, intended as an incentive to enrollment in ACOs and MCOs. Commenters noted that studies have shown that copayments discourage members with lower incomes from seeking care. They advocated that MassHealth not create the differential in benefits and cost sharing requirements between the PCC Plan and fee-for-service members on the one hand and ACO/MCO members on the other; some commenters also recommended that MassHealth keep copayments at current levels and not expand the number of services requiring copayments. . While MassHealth understands and recognizes these concerns, it maintains that patient care and experience will be improved through integrated, managed care options; modest differences in benefits and cost sharing will encourage members to select more coordinated care options without compromising their access to medically necessary care that is affordable. MassHealth clarifies that these changes will occur in the context of a broader set of changes to cost sharing policies. Members at the lowest income levels (under 50 percent of the FPL) will no longer be assessed copayments for medications or services regardless of delivery system. This represents 50 percent of the total MassHealth population. For the remaining members who will continue to have copayments, MassHealth will implement reduced copayment amounts in ACOs and MCOs compared to the PCC Plan. While PCC Plan copayments will be higher than ACO and MCO copayments, they will remain nominal. In addition, in accordance with current MassHealth regulations, a member's inability to pay a copayment shall not result in denial of service in any delivery system.

11.4.5 Children

Several commenters emphasized the importance of focusing specifically on pediatrics and how children will be served in the ACO models. MassHealth agrees that children, youth and young adults have needs that differ in important ways from adults: they are dependent upon families or other caregivers and they are developing, so their strengths and needs change over time. MassHealth has updated its proposal to highlight how children and youth will be better served in ACO models, including receiving more integrated care; improved access to mental health and SUD treatment; and better coordination with specialized services such as CBHI providers, autism services providers, special education and early intervention services. In addition, MassHealth has updated its proposal to reflect its design of the ACO model to best serve the unique needs of the pediatric member population. MassHealth will pay particular attention to implications of network design for various sub-populations, including children and youth as well as adult members with complex needs. MassHealth is also committed to implementing contractual requirements and a robust monitoring program to ensure adequate access for all members, including various sub-populations with unique needs. Finally, MassHealth ACOs will be accountable for pediatric quality metrics, as applicable, to ensure high quality care for pediatric populations enrolled in ACOs.

11.4.6 Housing Supports

Several commenters expressed appreciation for the inclusion of “housing stabilization and support, search and placement” as a category of flexible services funded by DSRIP. Commenters also urged language specifically focused on health care for members who are homeless, and for the expansion of the Community Support Program for People Experiencing Chronic Homelessness (CSPECH) program to all MCOs as well as to Medicare – Medicaid dually eligible members. MassHealth agrees that providing supportive housing services to chronically homeless individuals is key to improving the health and well-being of these members, and is in the process of expanding CSPECH through all of its contracted health plans, including its MCO and One Care programs.

11.4.7 Safety Net Care Pool (SNCP) Restructuring

Commenters supported the overall restructuring of the Safety Net Care Pool to include the DSRIP program and to ensure ongoing support for uncompensated care and safety net providers. A few commenters asked for further details on the financing of the restructured SNCP. While this proposal outlines each of the proposed components of the restructured SNCP and preliminary funding levels for each, further details on SNCP financing are the subject of ongoing discussions with CMS and will be released when they have been further developed.

11.4.8 SHIP, CommonHealth, ConnectorCare

Commenters expressed support for the expansion of Premium Assistance to SHIP plans, though one commenter thought that Premium Assistance should not be mandatory for this population. Several commenters applauded the proposal to extend CommonHealth eligibility under the demonstration to members who work and are age 65 or older. Finally, a number of commenters supported the request for federal reimbursement for cost sharing, in addition to premiums, in the ConnectorCare program. MassHealth appreciates all of the comments received as part of the public comment process and looks forward to continuing to engage stakeholders actively in the ongoing design and implementation of the restructuring efforts and program described in this demonstration proposal.

Acronyms

ACA – Affordable Care Act
ACC - Assertive Continuing Care
ACEs – Adverse Childhood Experiences
ACO – Accountable Care Organization
A-CRA - Adolescent Community Reinforcement Approach
AHRQ – Agency for Healthcare Research and Quality
ALOS – Average Length of Stay
APM – Alternative Payment Methods
ATS – Acute Treatment Services
BH – Behavioral Health
BHCP - Behavioral Health Community Partners
BSAS – Bureau of Substance Abuse Services
CBAT – Community-based Acute Treatment
CBT – Cognitive Behavioral Therapy
CCBHC – Certified Community Behavioral Health Center
CHA – Cambridge Health Alliance
CHART Investment Program - Community Hospital Acceleration, Revitalization and Transformation Investment Program
CHIA - Center for Health Information and Analysis
CMS – Centers for Medicare and Medicaid Services
CP – Community Partner
CSS – Clinical Stabilization Services
DD – Developmental Disability
DME – Durable Medical Equipment
DMH – Department of Mental Health
DPH – Department of Public Health
DSH – Disproportionate Share Hospital
DSRIP – Delivery System Reform Incentive Program
DSTI - Delivery System Transformation Initiatives
ED – Emergency Department
EHR – Electronic Health Record
ELE – Express Lane Eligibility
EOHHS – Executive Office of Health and Human Services
EPSDT - Early and Periodic Screening, Diagnostic, and Treatment
EQRO - External Quality Review Organization
ESP – Emergency Services Program
ETSS – Enhanced Transitional Support Services
FDA – Food and Drug Administration
FFP – Federal Financial Participation
FFS – Fee-For-Service

FFY – Federal Fiscal Year
FPL – Federal Poverty Level
FY – Fiscal Year
HCBS – Home and Community-based Services
H-CUP – Healthcare Cost and Utilization Project
HEDIS - Healthcare Effectiveness Data and Information Set
HIT – Health Information Technology
HMO - Health Maintenance Organization
HPV – Human Papillomavirus
HSN - Health Safety Net
ICB - Infrastructure and Capacity Building
ICF –Intermediate Care Facility
ID – Intellectual Disability
IMD – Institution for Mental Disease
IT – Information Technology
LTSS – Long-Term Services and Supports
MAT – Medication Assisted Treatment
MBHP – Massachusetts Behavioral Health Partnership
MCE – Managed Care Entity
MCI – Mobile Crisis Intervention
MCO – Managed Care Organization
MCPAP - Massachusetts Child Psychiatry Access Project
MOAR – Massachusetts Organization for Addiction and Recovery
MSSP – Medicare Shared Savings Program
NCQA – National Committee for Quality Assurance
NIDA – National Institute of Drug Abuse
NOMs – National Outcome Measures
NSDUH – National Survey on Drug Use and Health
OEND – Overdose Education and Naloxone Distribution
PACE – Programs of All-Inclusive Care for the Elderly
PBF – Premium Billing Family Group
PBP – Population-Based Payments
PCC Plan - Primary Care Clinician Plan
PCMH – Patient-Centered Medical Home
PCMH – Patient-Centered Medical Home Initiative
PCPRI - Primary Care Payment Reform Initiative
PCP – Primary Care Provider
PHTII – Public Hospital Transformation and Incentive Initiative
PMP – Prescription Monitoring Program
PMPM – Per Member Per Month
PMPY – Per Member Per Year
PPAL – Parent/Professional Advocacy League

RRS – Residential Rehabilitation Services
SAMHSA – Substance Abuse and Mental Health Services Administration
SBIRT – Screening, Brief Intervention and Referral to Treatment
SCO – Senior Care Options
SHIP – Student Health Insurance Program
SIM – State Innovation Model
SFY – State Fiscal Year
SED – Serious Emotional Disturbance
SMI – Serious Mental Illness
SNAP – Supplemental Nutrition Assistance Program
SNCP – Safety Net Care Pool
SNF – Skilled Nursing Facility
STC – Special Terms and Conditions
SUD – Substance Use Disorder
TCOC – Total Cost of Care
TSS – Transitional Support Services
UCC Pool – Uncompensated Care Pool

Appendix A: Public Notice

See attachment.

Appendix B: Tribal Consultation

See attachment.

Appendix C: Public Comments

Below is a list of written and oral comments received during the public comment period. See attachment for full comments.

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