MassHealth

Section 1115 Waiver

Demonstration Year: 19 (7/1/2015 – 6/30/2016)

Annual Report

Introduction

The Commonwealth of Massachusetts' current section 1115 Demonstration agreement (Project Number ll-W-00030/l) was approved on October 30, 2014. The new extension period is in effect until June 30, 2017. The goals of the Commonwealth under this demonstration period are:

- Maintain near-universal health care coverage for all citizens of the Commonwealth and reduce barriers to coverage;
- Continue the redirection of spending from uncompensated care to insurance coverage;
- Implement Delivery System reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measureable outcome improvements; and
- Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

In accordance with the Special Terms and Conditions (STCs) of the Demonstration and specifically STC 60, the Massachusetts Executive Office of Health and Human Services (EOHHS) hereby submits its annual report for Demonstration Year 19 for the year ending June 30, 2016.

Enrollment Information

Eligibility Group	Enrollees as of June 30, 2016
MassHealth Demonstration	
Base Families	827,241
Base Disabled	226,956
1902 (r) (2) Children	33,801
1902 (r) (2) Disabled	19,462
Base Childless Adults (19-20)	26,355
Base Childless Adults (ABP1)	24,350

Eligibility Group	Enrollees as of June 30, 2016
Base Childless Adults (CarePlus)	312,637
BCCTP	1,134
CommonHealth	21,693
e - Family Assistance	7,837
e - HIV/FA	656
SBE/IRP	84
Safety Net Care Pool	1
Base Fam XXI RO*	
1902 (r) (2) XXI RO*	
CommonHealth XXI*	
Fam Assist XXI*	
Asthma	
Autism	
TANF/EAEDC	69,473
End of the Month Coverage	
Total Demonstration	1,571,680

Delivery System for MassHealth-Administered Demonstration Populations

MassHealth Enrollment (Members)	SFY2016 Q3 Average	SFY2016 Q4 Average	Difference
MCO	884,788	875,606	-9,182
PCC	377,066	388,363	11,298
FFS / PA	575,466	586,199	10,733
Total	1,837,319	1,850,168	12,849
MBHP (Includes PCC and TPL)	448,138	453,137	4,999
PA Only (included in FFS above)	*15,734*	*18,680*	2,946

Enrollment in Premium Assistance and Small Business Employee Premium Assistance

For SFY 2016, MassHealth provided premium assistance to **12,920** health insurance policies (policyholders), resulting in premium assistance to 27,786 MassHealth eligible members and, by extension, providing the means for coverage for approximately 37,533 Massachusetts residents.

The Small Business Premium Assistance Program is still operating however the numbers continue to drop since the last reporting period. **As of June 2016 we have 90 active enrollments in the SBEPA program.** That is down 14 enrollments from last reporting period (we reported 104 active SBEPA enrollments as of April 2016). The drop in enrollments has been

mainly due to either loss of MassHealth eligibility or private insurance, or the member was determined eligible for a richer benefit and has been transferred to a Premium Assistance benefit under another category of aid.

Premium Assistance Program	Policies	Total Covered by Policy	MassHealth Eligible	Non-MassHealth Eligible
Standard and CommonHealth	8,295	24,527	19,520	5,007
Family Assistance	4,085	12,110	7,415	4,695
CarePlus	413	755	724	31
HIV	37	38	37	1
Small Business Employee Premium Assistance (SBEPA)	90	*103*	90	*13*
Total	**12,920**	**37,533**	**27,786**	**9,747**

ConnectorCare Information

As of June 2016, 171,275 individuals were enrolled in ConnectorCare. The total spending for SFY 2016 was $99.1 million. The projected cost for this program, as authorized in the 1115, was $75.2 million, which was lower than the actual cost of $99.1 million.

Outreach/Innovative Activities

Certified Application Counselor Training and Communication
MassHealth continued its extensive training and communication efforts to continually educate and inform the over 1,600 Certified Application Counselors (CACs) across 270 CAC hospitals, community health centers, and community service organizations. Collaboration with the Massachusetts Health Connector on these activities provides timely, uniform knowledge and messaging across all enrollment Assisters (CACs and the Health Connector Navigators, Broker Enrollment Assisters, Independent Enrollment Assisters).

CAC training and certification starts with successful completion of ten online comprehensive certification training courses (over 850 pages) to prepare CACs to assist consumers in obtaining MassHealth/health insurance per ACA regulations, covering all aspects of MassHealth, subsidized and unsubsidized health coverage, as well as instruction on utilizing the paper and online applications in the most effective and efficient way. Learning for CACs continues throughout the year in the form of Assister emails, conference calls, webinars, meetings, and other outreach activities.

Frequent email communications are distributed to all enrollment Assisters on a wide variety of MassHealth eligibility and related topics, as well as refreshers, in order to help Assisters assist MassHealth applicants/members/consumers effectively. Thorough communications and trainings are provided for all application changes and Health Insurance Exchange (HIX) system releases. Regular one-hour conference call trainings are also provided for the Assisters, providing a more in-depth explanation and include detailed question and answer sessions with subject matter experts.

Over the course of FY16, CAC outreach and educational activities focused on a number of activities. Early in the year, CAC educational activities supported the launch of a dedicated MassHealth Assister telephone line, including a more streamlined Identity Proofing process, which helped MassHealth and other health insurance applicants complete their application with CACs more quickly and accurately. Early in the year, education was also provided on the Health Connector's launch of their redetermination and renewal process, the release of a revised SACA-2 paper application, and the opening of the CAC 2015/16 recertification period.

In Q2 and Q3, CAC outreach and educational activities intensified in support of annual recertification training for over 1,500 Certified Application Counselors (CACs), completion of the rollout of the MassHealth dedicated Assister line, MassHealth Renewals, and Health Connector 2015/16 Open Enrollment activities. Several CAC organizations were also invited to participate in a brief survey about the user experience with the online system at MAhealthconnector.org.

Results were shared internally and used in planning system improvements for future releases. In addition, webinars and email newsletters provided CACs with important details around key updates released into to the online system, improvements to the Request for Information notices, the addition of a provider directory to the MassHealth website, and other changes and improvements that Assisters rely on as they help consumers access and retain their health insurance coverage.

At the end of the year, CAC outreach and educational activities focused on ensuring CACs continued to be well informed about ongoing activities across both MassHealth and the Health Connector. Intensive communication and mandatory training efforts were conducted in April and May to ensure all Certified Application Counselors and Health Connector Navigators were fully knowledgeable about the MassHealth renewal process and how these renewals will be managed through the online system. Mandatory training offered four in-person training sessions, two conference calls, and a new online course in the Learning Management System.

Assister-specific email updates and conference calls also provided CACs with important details around key updates to the online system—including a comprehensive job aid detailing Request for Information (RFI) generation and expiration rules, the launch of the online MassHealth provider directory (a searchable large database of MassHealth-participating providers and health care facilities) on the MassHealth website, details and training for the new temporary HSN presumptive determination process, and other MassHealth and Health Connector changes

and improvements that support Assisters as they help consumers access and retain their health insurance coverage.

In total, MassHealth provided 18 in-person educational Massachusetts Health Care Training Forum sessions and four MassHealth Assister training sessions for CACs over the course of the year. MassHealth also sent approximately outreach 150 emails and held 50 educational conference calls and webinars.

Member Education

The MassHealth Member Education representative continues to provide educational presentations, outreach, and training to community advocate agencies, medical providers, internal and external state agency staff, program members, and any other interested parties per request.

In addition, the MassHealth Member Education representative attends scheduled meetings, collaborations, forums, and round tables to provide updated MassHealth program information, and to solicit member education presentations.

The Member Education representative also plays an integral role on the Massachusetts Health Care Training Forum (MTF) "Convener" team. Members meet monthly to determine the MTF meeting format, agenda, and material presentation content. Member Education regularly presents MassHealth program information quarterly at each of the 4 regional MTF meetings.

Over the course of FY16, the Member Education unit presented at 18 Massachusetts Health Care Training Forums, attended over 50 community meetings to provide program information to participants, and presented at 30 stakeholder events across the Commonwealth. The Member Education also participated as a subject matter expert in the review and edit of over 500 pages of eligibility policy training content in preparation for the 2015/16 Certified Application Counselor (CAC) recertification.

In addition, the Member Education unit also spent extensive time with the Certified Application Counselor Training and Communications team to create an immigration refresher presentation for application enrollment assisters. Input from advocates, hospitals and health centers was taken into account to help create a refresher which will be useful to enrollment assisters when they are helping applicants or members complete applications and renewals. Close collaboration with the Massachusetts Health Connector and the Health Safety Net was necessary to create the immigration refresher which was successfully presented to enrollment assisters.

Payment Reform Initiatives Related to Safety Net Care Pool, including DSTI, ICB grants and Payment Reform Efforts

Safety Net Care Pool (SNCP)

At the beginning of the fiscal year, MassHealth solicited vendors to complete the SNCP Financing Report. MassHealth received two bids and selected Navigant Consulting to perform the analysis and prepare the report. After completing contract negotiations, Navigant began its analysis of the SNCP.

MassHealth worked with Navigant and the providers in the Commonwealth throughout the first half of the year to complete a draft of the Safety Net Care Pool Financing Report. Providers were required to submit cost reports for the analysis, and Navigant met with select providers to gain further understanding of providers' reports. As required by STC 54, the SNCP Financing report was finalized and sent to CMS on February 1, 2016.

The SNCP Financing Report provided critical information for the SNCP Sustainability Report. The Sustainability and Delivery System Transformation report "…will inform the Commonwealth and CMS' collaborative discussions regarding payment reform and a sustainable health care system…". Since the Commonwealth was preparing an 1115 waiver proposal which addressed this solution, the report was combined with the 1115 waiver proposal and submitted to CMS on June 30, 2016.

Delivery System Transformation Initiatives (DSTI)

STC 50(d) of the Demonstration authorizes the Commonwealth to extend the Delivery System Transformation Initiatives (DSTI) funded through the Safety Net Care Pool (SNCP). These initiatives are designed to provide incentive payments to support investments in eligible safety net health care delivery systems for projects that will advance the triple aims of improving the quality of care, improving the health of populations and enhancing access to health care, and reducing the per-capita costs of health care. In addition, DSTI payments support initiatives that promote payment reform and the movement away from fee-for-service payments toward alternative payment arrangements that reward high-quality, efficient, and integrated systems of care.

During the beginning of this year, MassHealth and CMS reviewed the June 2015 DSTI submission. MassHealth continued its collaboration with the DSTI hospitals to strengthen the DSTI program by adding robust quality and outcome measures, and work through the details of the funding allocation mechanism, particularly for the at-risk measures. MassHealth provided its final submission of the DSTI Master Plan and Hospital Specific plans to CMS on September 17, 2015. The Master DSTI Plan and Hospital-specific plans were approved by CMS on October 30, 2015.

Hospitals submitted both their mid-year and final year reports to MassHealth for review and approval. UMass's Commonwealth Medicine reviewed the reports and found that the hospitals completed 100% of the metrics reported. The below payments were made to hospitals in November and December 2015.

DSTI Hospital	FY16 Payments
Boston Medical Center	$103,553,333.33
Cambridge Health Alliance	$44,853,333.33
Holyoke Medical Center	$8,153,333.33
Lawrence General Hospital	$14,433,333.33
Mercy Medical Center	$15,213,333.33
Signature Healthcare Brockton	$16,713,333.33
Steward Carney Hospital	$6,413,333.33

Payment Reform

Throughout the year, MassHealth conducted significant internal work to advance its thinking about accountable care, and worked extensively with stakeholders on this work as well.

MassHealth created a Stakeholder Work Group initiative, which was an intense and thorough effort to build alignment around the goals and strategic vision of our accountable care strategy. By October 2015, MassHealth had held 30 stakeholder workgroup meetings with representation from 145 organizations across the Commonwealth. The eight work groups focused on six functional areas, including Strategic Design, Payment Model Design, Quality Improvement, Certification, Attribution, Health Homes, as well as two population-specific domains to address the needs of individuals with significant LTSS and BH needs.

Workgroup members were actively engaged in the process, bringing unique perspectives to the discussions and sharing ideas about opportunities and challenges in the process of payment restructuring. MassHealth shared takeaways from these workgroups in three Open Public Meetings on November 6, December 15, and January 13 in order to keep the public engaged in the process.

At the end of CY15, MassHealth began the process of finalizing its accountable care strategy, in preparation of drafting an update to the 1115 Waiver. The MassHealth Stakeholder Work Group initiative drew to a close, with most work groups holding their final meeting of this phase in December 2015 or in January 2016.
At the end of the year, MassHealth continued development of its accountable care strategy, preparing to draft our proposal for the 1115 Waiver, which was released and posted for public comment on June 15, 2016.

The PCPR program also hit several milestones in FY16. In August, the PCPR technical assistance program was introduced to practice leadership. The UMASS/CWM TA consultant team is led by a director of Practice Transformation and an Executive lead from the UMMS. The program provides a targeted learning collaborative and technical assistance model for practices participating in PCPR. Monthly status reports from the technical assistance team showed gains made in milestones related to integrated care plans and finalization of MOU's with behavioral health providers throughout the year.

We also distributed updated Shared Savings Quality Measure and Claims-based Measures Reports and initiated the second round of member satisfaction surveys. We added behavioral health encounters to the medical and pharmacy claims feeds we provide participants, fulfilling a long-standing request. In addition, the PCPR team collected, aggregated, and determined measurement for reporting results of 18 month contract compliance requirements.

Infrastructure and Capacity Building Grants (ICB)

Pursuant to the MassHealth 1115 Demonstration 11-W-00030/1, the Commonwealth distributed $20,000,000 in Infrastructure and Capacity Building (ICB) grants for Fiscal Year (FY) 2015 in accordance with Special Term and Condition (STC) 49(d), STC 50(b), Charts A and B of Attachment E, and Expenditure Authority Section IV.d.

The purpose of this program is to help providers establish integrated delivery systems that provide more effective and cost-efficient care to patients in need. Through these projects, EOHHS continues the development and implementation of best practices, cost containment and quality improvement initiatives. The grants also encourage and support Mass HIway participation and health exchange information.

The FY15 budget included an appropriation of up to $30 million to enhance the ability of hospitals and Community Health Centers (CHCs) to serve populations in need more efficiently and effectively. EOHHS released a Request for Responses (RFR) in October 2015 and received 95 applications from 52 unique bidders. After reviewing responses, EOHHS Evaluation Committee recommended 80 projects totaling $20 million. The payments were made to eligible hospitals and CHCs in accordance with the above-cited provisions and all applicable limits pursuant to a Request for Responses (RFR) issued in October 2015. The contracts for FY15 began on December 20, 2015 and will end on June 30, 2016, but may be extended at the discretion of EOHHS in any increment through December 31, 2016.

Upon receiving the award, each grantee was asked to revise the original budget and work plan to align with the approved grant amount while maintaining the overall goals of the original proposal and complying with all contracted terms. The revised budget and work plan also needed to include a marked up version of the original budget and work plan, indicating the proposed changes. These changes were due and submitted on January 15, 2016. Seventy-eight total projects moved forward, as two projects' bidders declined the award and returned the funds. Thus, ultimately a total of $19,274,288 was distributed. From January to March 2016, awardees began performing their projects. They are set to conclude on June 30, 2016, unless an extension is obtained.

Seventy-eight ICB projects began in December 2015. Throughout Q1 and Q2 CY2016, grantees sought to accomplish their goals with a projected end date of June 30, 2016. EOHHS allows ICB grantees to extend their projects until December 31, 2016 if necessary, as long as the requests are made before April 30, 2016. In Q2, EOHHS granted 45 ICB projects extensions, with extension end dates ranging from July to December 2016, with the majority (34) receiving

extensions until September 30, 2016. Grantees requesting extensions submitted an extension request, progress report, and updated budget. EOHHS reviewed the documents to determine whether an extension was necessary. Reasons included:

- Additional time needed to collaborate with Constituent Partners;
- Hiring process or procurement of vendors taking longer than expected;
- Technological delays;
- Research leading to new information that altered the planning and timing of grant activities; and
- Additional time to collect necessary data and reports

EOHHS had several conversations with grantees concerning their extensions, which resulted in changes to some of the requests. EOHHS validated and approved all requests.

The grantees' progress reports and updated budgets illustrate the success of the projects thus far. For instance, one grantee, whose primary population speaks Spanish, hired bilingual nurses, navigators, and a social worker with experience in behavioral health to provide culturally and linguistically appropriate care (Project C1; see below for more details on project category). Another grantee is working to adopt an analytics server that will integrate with existing databases and provide a platform that makes it easier to maintain/distribute reports and provide interactive features to medical care teams. Providers will soon have access to dashboards supported by real-time data to assist with care management. (Project A1; see below). A grantee also utilized different educational tools to teach staff how to better care for patients with diabetes (Project C3; see below).

A final grantee has been working to provide safe care transitions for vulnerable patient populations and to avoid unnecessary readmissions. The grantee developed a multi-stakeholder Cross Continuum Transition Team and focused on targeted interventions such as medication reconciliation and outreach, post-acute care navigation services, and discharge education (Project C4; see below). The grantee has taken an innovative, multi-disciplinary approach to care transitions, enlisting resources in nutrition, medicine, financial coordination, occupational therapy, social services, mental health, and churches to support discharged patients in the community. As a result, the provider has developed realistic and achievable plans for meeting the needs of patients at high-risk for readmission.

Thirty-two grantees, who did not request extensions, submitted their final reports on June 30, 2016 as required.[1] EOHHS will compile an internal team to review the final reports once the majority of extension final reports are submitted.

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[1] One grantee was provided additional time to submit the report for medical reasons.

The FY2015 ICB grant program centered on aligning ICB funding with EOHHS' payment reform goals. ICB awardees were approved to conduct projects in the following specific categories:

A.   Enhanced Data Integration, Clinical Informatics, and Population-Based Analytics:
 1. Data integration and analytics across the continuum of care: The goal of Project A1 is to develop concrete analytic and data-sharing capabilities and resources that directly enable and support integrated and patient-centered care across providers. Responses proposing Project A1 were required to focus on at least one of the following: a) Population-level analytics; b) Population Disease Registry; or c) Provider Dashboards capable of interacting with EMR systems and integrating medical and behavioral health information and data across the continuum of care.

2. Data Warehousing and Reporting: The goal of Project A2 is to enhance data warehouse and reporting capabilities that directly enable and support alternative payment methodologies (APMs), including but not limited to pay-for-quality, prospective payment, capitation, shared savings and risk arrangements, and utilization-driven pay-for-performance. Responses proposing Project A2 were required to focus on at least one of the following: a) Data Warehouse purchase, design, or implement new data warehouse functionality; b) Analytics capabilities that support financial management and APMs; or c) Reporting infrastructure for internal and payer-facing reporting capabilities compatible with APMs.

3. Mass HIway Connection and Utilization: The goal of Project A3 is to improve providers' capability to enroll in and connect to the Mass HIway and to use the Mass HIway Direct Messaging and Query and Retrieve services. Responses proposing Project A3 were required to include a plan to enable the bidder (and any team members) to sign a Mass HIway Participation Agreement and/or connect to and use the Mass HIway for secure medical record exchange through Direct Messaging and/or Query and Retrieve services.

B. Shared Governance and Enhanced Organizational Integration: The goal of Project B is to develop, expand, or enhance shared governance structures and organizational integration strategies linking providers across the continuum of care. Awardees will pursue shared governance structures and organizational integration strategies necessary for the formation of accountable care organizations (ACOs). Funding for Project B will support, for instance, developing the necessary articles and bylaws to establish ACOs and the requisite governing bodies, developing contracts between providers governing the distribution of funds and responsibilities under APM contracts, developing APM contracts between providers and payers, reorganizing medical staff, identifying new roles and responsibilities for senior staff, and hiring new staff dedicated to project management and coordination of clinical and financial initiatives under ACO contracts.

C. Enhanced Clinical Integration:

1. **Implement Primary Care Based System of Complex Care Management for High-Risk Population(s):** The goal of Project C1 is to develop and implement a Primary Care-based

system of complex Care Management to improve patient health and reduce unnecessary costs for patients determined to be at high risk. Primary care-based care management or complex care management teams funded under Project C1 will provide complex care management of medical conditions and behavioral health conditions as well as coordinate a range of social service supports such as effective patient engagement, housing, transportation, nutrition. These teams will also coordinate with inpatient, emergency department (ED), and post-acute Care Management systems to facilitate a seamless care transition experience for patients.

2. **Redirect Non-emergent Emergency Department (ED) Visits (Hospitals only):** The goal of Project C2 is to design, conduct, and evaluate projects to redirect individuals who visit a Hospital's ED with non-emergent conditions to nearby CHCs and community based primary care. These projects will include the formation or enhancement of relationships with CHCs and other community based primary care within the hospital's immediate service area, as well as a focus on frequent ED users for medical and behavioral health (substance abuse conditions).

3. **Reduce Variations in Inpatient Care for Patients with High-Risk Conditions:** The goal of Project C3 is to develop and implement evidence-based clinical care pathways to reduce variations in inpatient care, improve health outcomes, and engage patients in disease management.

4. **Implement Improvements in Care Transitions:** The goal of Project C4 is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions.

5. **Develop Clinical Integrated Acute and Post-Acute Network Across the Continuum of Care:** The goal of Project C5 is to integrate patient care between acute and post-acute care settings to enhance coordination of care, improve the quality of care transitions, reduce readmissions, and develop a fully integrated delivery system capable of providing care in the most effective setting.

6. **Design and Implement a Practice Support Center:** The goal of Project C6 is to design and implement a dedicated practice support call center to improve the patient experience in the primary care setting, improve patient satisfaction, reduce "no-show" appointments, and provide critical primary care practice support to clinicians. Funding for this project will support technology and staff to develop scheduling protocols and work flows, improve appointment scheduling and efficient incoming call triage, and support care coordination and perform outreach functions for patients.

D. Outreach and Enrollment: The goal of Project D is to design, implement, and document enrollment, outreach and health care access projects for individuals who may be eligible for public subsidized and non-subsidized health insurance programs and who may require individualized support due to geography, ethnicity, race, culture, immigration, disability, or disease status. Funding for this project will support outreach and marketing, information and education, and screening and enrolling or referring patients to appropriate programs, and assisting applicants and current enrollees to gather and submit all necessary verifications or requests for information during the application and annual review/annual open enrollment processes.

E. Catalyst Grants for Integration: The goal of Project E is to facilitate planning for providers who wish to engage other providers and to prepare for APMs through eventual completion of projects like those described in Projects A, B, and C. Funding for this project will support specific planning activities and the projects such planning might facilitate. Such planning activities may include, for example, facilitating meetings, developing integrated work plans, and drafting memoranda of understanding.

Operational/Issues

During the beginning of the fiscal year, MassHealth continued to process redeterminations for members in our legacy eligibility system to transition them to ACA-compliant coverage through our new HIX system. MassHealth worked with the Health Connector and our systems integration vendor to enhance functionality in the HIX system, including implementation of Verified Lawful Presence (VLP) functionality, application of verification timeclocks expiration rules for certain eligibility factors and enhancements to logic for correct triggering for Request for Information (RFI) notices.

MassHealth implemented logic in the HIX system to conduct annual renewals for MassHealth members. The HIX system will perform an auto renewal for households who have information that is reasonably compatible with electronic data sources, and based upon the information all members will either remain in existing benefits or will be upgraded. For households who cannot be auto renewed because either data is not available or the information would result in downgrade or termination of benefits, a pre-populated renewal form will be sent. The household has 45 days to respond and report any changes. If a household does not respond within the deadline, MassHealth will re-determine eligibility based upon information available from electronic data sources. Additionally, MassHealth continued to finalize requirements for the Asset Verification System to conduct checks of financial institutions for members subject to an asset test for eligibility.

MassHealth operations for the Traditional Medicaid population (Aged, Blind, Disabled) continued as normal through the year.

Policy Development/Issues

Aside from the policy developments that were discussed in the sections on Payment Reform, DSTI and ICB, the Commonwealth prepared a new 1115 waiver proposal which proposed significant changes to the demonstration. The waiver proposal discussed implementing a new ACO program, which would shift the Commonwealth's delivery system to more integrated and efficient care for its members. After Navigant's review of the Safety Net Care Pool and their subsequent report, the Commonwealth restructured its Safety Net Care Pool to be more sustainable. The proposal was posted for public comment on June 15, 2016 and the Commonwealth held two listening sessions for stakeholders and the public.

Financial/Budget Neutrality Development/Issues

The attached budget neutrality (BN) statement includes actual expenditures and member months through state fiscal year (SFY) 2016 as reported through the quarter ending June 30, 2016 (QE 06/30/16). SFY 2017 expenditures and member months are projected by annualizing actual data from quarters 1-4, as reported through the quarter ending June 30, 2016 (QE 06/30/16). These data are combined with the MassHealth budget forecast as of June 30, 2016 for SFY 2016-2017 and Commonwealth Care and Health Safety Net (HSN) information provided by the state agencies that manage those programs.

This BN demonstration includes actual expenditure figures, updated according to the most recent complete data available for SFY 2014, SFY 2015, and SFY 2016. The enrollment data for the years SFY 2010 through SFY 2016 were updated based on actual enrollment through mid-August 2016.

Safety Net Care Pool (SNCP)
The three-year SNCP target is based on projected expenditures for SFY 2016-2019. The changes for SFY 2016 will continue to be updated as the fiscal year progresses.

Budget neutrality - summary
In sum, the total projected budget neutrality cushion is $36.1 billion for the period SFY 2015 through SFY 2019 and $48.0 billion for the period SFY 2009 through SFY 2019. We will continue to update CMS through quarterly reports as updated information is available.

Consumer Issues

Mass. CAP
The Mass. Consumer Assistance Program (CAP) in partnership between the Massachusetts Executive Office of Health and Human Services (EOHHS) and Health Care For All provided direct outreach to MassHealth members, consumer advocacy, and education and training to community-based application assisting organizations that provided enrollment and reenrollment assistance to particularly the most vulnerable populations such as the homeless. Some activities included an outbound calling campaign, using text messaging and email to alert

consumers of the need to renew their existing health coverage, as well as media outreach to community-based local ethnic media.

As a result the Mass. CAP provided legal advice and referrals to 163 consumers regarding private health plan appeals process and other concerns related to access to health care. The Mass. CAP offered comprehensive legal services to 86 of these consumers (53%) who had incomes less than 300% of the Federal Poverty Level (FPL). The Mass. CAP obtained $183,147 worth of recovered benefits and/or forgiven medical debt for low-income consumers.

The Mass. CAP was able to provide health care coverage renewal training to 496 individuals from 174 organizations during the grant year. Through participant evaluations, feedback suggest participants were highly satisfied with the trainings and having in-person presentations increased the confidence levels of attendees about helping someone to apply for health coverage and that participating in the presentation increased their professional knowledge.

MassHealth In-Person Enrollment Events

In June 2015, MassHealth, working with each of the four MassHealth Enrollment Centers (MECs), as well as MassHealth's Central Processing Unit (CPU), began to coordinate and hold renewal/enrollment events with community partners throughout the Commonwealth. During the months of January/February, 2016, MassHealth held a series of four enrollment events to assist those receiving 2016 MassHealth renewal notices submit their renewals and those who wished to apply for health coverage.

Each of these MassHealth events are located throughout the Commonwealth, with each MEC/CPU leading an event with assistance from Community Health Centers, enrollment Assisters, Navigators and others. MassHealth staff provides identity proofing support, account lookups/unlocks, and generally offers the same services that a member could find at a MassHealth Enrollment center, (including assistance with coverage for those age 65 and over) as well as assisting them through the online application process.

Responsibility for publicizing events is split between MassHealth and the partnering Community Health Center. MassHealth develops individual event fliers and posters (in Spanish, English and other additional languages) containing all pertinent information for each event, as well as the logo of the partnering facility, and distributes them to the MEC/CPU offices. From there, they are distributed throughout as much of the event area as possible, including posting at the MEC/CPU offices.   These documents are posted on the MassHealth website, as well as included as an informational flyer (in Spanish and English), listing all event dates and locations, with the MassHealth renewal mailing packets that are mailed to members.

A link to our website is included in the Health Connector and University of Massachusetts Medical School websites, with UMass publicizing the events at the quarterly MassHealth Training Forums, held throughout the Commonwealth.

Additionally, a social media communications plan has been implemented and added to MassHealth's event publicity tools that include pre-event tweets, reminder tweets and tweet blogs during event series interims, as well live tweeting during the events. It is planned to also begin preparing event press releases to local community newspapers, to be distributed in both hardcopy and digital media.

The community partner publicizes the events as well, mentioning the events to their walk-ins/patients, and through e-mails, local television and radio, as well as distributing flyers to homeless shelters, hospitals and any other applicable facility.
MassHealth enrollment events are slated to continue through calendar year 2016/17, roughly every quarter, in conjunction with the mailing of renewal notices.

Quality Assurance/Monitoring Activity

Quality activities for the 2016 fiscal year cover the following topics:
- Managed care quality monitoring activities
    - One Care Program quality monitoring activities
    - Managed Care Program quality monitoring activities
    - Senior Care Options (SCO) Program quality monitoring activities
    - External Quality Review Organization (EQRO) Activities
- Payment Reform Quality Activities
    - Primary Care Payment Reform quality monitoring activities
    - MassHealth Quality Committee
    - Accountable Care Organization (ACO) Quality Workgroup
- CMS Quality Grant activities
    - CMS Adult Medicaid Quality grant
    - Contraceptive Use grant
    - Managed Care Quality Activities

Managed Care Program (under 65, non-disabled)

During the fiscal year, monthly meetings with Plan quality managers continued. Discussion topics included quality improvement goals, projects and performance improvement projects. Calendar year 2015 was the end-cycle reporting period for several quality related projects. However, in early 2016 a decision was made to implement an extended cycle for the QI goals. As they continue to work on an extended cycle for the QI goal requirements, plans will submit information about their interventions and associated QI activities in the fall of 2016.

Plans received their 2015 External Quality Review reports from our vendor APS/KEPRO early in 2016. These reports help plans prepare for subsequent QI cycles, and provide guidance on how to improve future performance.

Plans began the process of gathering data for the 2016 External Quality Review cycle and received a request for information from the EQRO in May 2016. Additionally, the EQRO scheduled site visits and telephone calls to discuss the performance measure validation and performance improvement project validation respectively. The site visits will be happening throughout the summer and early fall.

One Care Program (under 65, disabled)

On an ongoing basis, quality and other performance measures continue to be addressed with plans on the bi-weekly contract management check-in calls. These phone calls allow MassHealth and CMS contract managers to touch frequently on quality related questions, and provide targeted guidance to the individual plan. Ongoing activities often discussed on the bi-weekly contract management phone calls include HEDIS submissions, CAHPS surveys, state specific measures, CORE measures, appeals, and grievance activities.

One Care Plans received their annual external quality review reports from the EQRO. These reports help plans prepare for subsequent QI cycles, and provide guidance on how to improve future performance. Additionally, plans have received a request for information from the EQRO and are working to pull together the requested information for review slated to occur in the Fall (2016).

SCO Program (65 and over)

SCO plans began the process of gathering data for the 2016 External Quality Review cycle. Plans received a request for information from the External Quality Review Organization (EQRO) in May 2016. Additionally the EQRO scheduled site visits and telephone calls to discuss the performance measure validation and performance improvement project validation respectively. The site visits will be happening throughout the summer and early fall.

External Quality Review Activities

The MCO and SCO EQR technical reports were finalized in March and distributed to the individual plans. Plans were given the opportunity to participate in phone calls and provide feedback on the technical reports to the EQR vendor prior to the reports being finalized. The One Care EQR technical reports were finalized in April and distributed to the individual plans. Plans were given the opportunity to participate in phone calls and provide feedback on the technical reports to the EQR vendor prior to the reports being finalized. Additionally, the EQRO held a kick off meeting for the 2016 EQR review cycle in May and sent out a request for information to all plans. Submissions from MCO and SCO plans are due in July 2016 and submissions form One Care plans were due in September 2016.

Payment Reform Activities

Primary Care Payment Reform (PCPR)

There were 24 practices that received targeted Technical Assistance in order to improve their compliance with the contract milestones related to Multidisciplinary Care teams and Behavioral Health integration. As of June 2016, 100% of the practices achieved 93% compliance in the identified milestones reaching the PCPR benchmark of 93% for contract compliance.

The Member Experience Survey for Cycle 2 was completed (12/ 2015 – 4/ 2016) and the performance reports were distributed to the practices. The survey sample included over 28,000 adults and children from 61 PCPR practices and had a response rate of 35%. There were 3 Adult and 3 Child P4Q measures that showed significant improvements from baseline Cycle 1 (2015).

Pay for Quality Update: Pay for Reporting increased by 15% between Year 1 and Year 2 with 81% of practicing reporting >90% of the measures in Year 1 and 93% of the practices reporting >90% of the measures in Year 2.

Pay for Quality showed significant improvement in 11 of 18 (61%) record-based quality measures from Q4 2014 to Q4 2015. The measures with significant improvement included 5 Adult measures and 6 Child measures.

MassHealth Quality Committee

The MassHealth Quality Committee was suspended during this fiscal year to free up staff time to support the Assistant Secretary's work on ACO development. As small subset of the committee continues to meet to ensure that quality related activities are aligned across programs. The MassHealth Quality Committee is slated to restart in October 2016.

ACO Quality Workgroup

As mentioned in the previous quarterly report, the ACO quality workgroup, which consisted of 40 external stakeholders, continued to meet through early 2016. The focus of this workgroup was to:
- Identify a Quality Improvement Performance measurement approach for ACO quality of care;
- Coordinate with multi-payers around ACO metrics, and
- Improve standardization of ACO reporting.

The workgroup made significant recommendations with regard to the optimal measurement for accountability and payment for ACOs and developed a draft ACO measure slate.

CMS Grant Activities

CHIPRA

The CHIPRA demonstration grant funded the testing of the usefulness and relevance of the core set of measures (Category A), implementation of a medical home model for pediatric practices (Category C) and development of a child health coalition to oversee measure development in gap areas (Category E). The CHIPRA grant used its No Cost Extension period to finish outstanding Technical Reports and prepare a final, summary report.

CMS Adult Core Quality Grant

The Adult Core Grant included three aims: Calculate at least 15 of the Adult Core Measures, conduct two quality improvement projects related to the Core Set, develop MassHealth capacity to collect, calculate and act on quality measures. During the second quarter of the No Cost Extension, MassHealth conducted multiple training sessions, specifically in SAS, SQL, statistics and Cognos to further develop the skills of existing users and to develop new users.

All activities related to Aims 1 and 2 were completed in December 2015. Work on Aim 3 continued into this quarter and focused on building capacity and infrastructure at MassHealth to gather and use data.

Results for the adult and child core measure sets which were voluntarily calculated by MassHealth were reviewed and approved by CMS.

Contraceptive Use Grant

MassHealth applied for funding to "Improve the Collection of Data about Contraceptive Use among Women in MassHealth." This RFP was under the Maternal and Child Health grant program. MassHealth was notified that it received funding for this project. Results for the contraceptive measure were calculated and submitted to and approved by CMS.

Work on the qualitative component of the grant, interviewing Title X family planning sites about their billing practices, was initiated. In total 5 sites were interviewed. Data was coded and analyzed using Atlas ti., a qualitative data analysis software. Results will be reported to the grant management team in September 2016. Additionally, a data request was submitted to obtain data from the regional Title X family planning database. This data will be used to calculate the contraceptive measure and its associated sub-measure. The rates calculated from the Title X database will then be compared rates calculated using MassHealth claims data to determine the most accurate way calculate the measures.

Demonstration Evaluation

During the fiscal year, the Commonwealth contracted with University of Massachusetts Medical School, Commonwealth Medicine to conduct its demonstration evaluation during the period of 2014 – 2017. This evaluation covers the same time period as the authority of the Safety Net Care Pool, as some of the programs encompassed by the SNCP will end or be restructured for SFY 2018.

The Commonwealth submitted an evaluation design to CMS in January 2016, and Commonwealth Medicine conducted its evaluation in accordance with the design. An interim evaluation was submitted to CMS, along with the 1115 waiver proposal, on July 22, 2017. We anticipate having final results of this demonstration period in December 2017.

HCBS Report

Introduction

MassHealth covers enhanced early intervention program services including medically necessary Applied Behavioral Analysis-based (ABA) treatment services that address the core symptoms of Autism Spectrum Disorders (ASD) through the MassHealth 1115 Demonstration (Project Number II-W-00030/1). Such services were available to children ages birth to three years with a confirmed diagnosis of Autism Spectrum Disorder (ASD) who were eligible for Early Intervention (EI) and MassHealth for the reporting periods of SFY 2014 and SFY 2015. These children were not enrolled in the state's 1915(c) Home and Community Based Services waiver entitled "Children's Autism Spectrum Disorder Waiver," administered through the Department of Developmental Services (DDS). A waiting list for EI services was not allowed and there was no annual maximum benefit. ABA-based treatment services are provided through the fee-for-service Early Intervention providers certified by the Massachusetts Department of Public Health (DPH). Children enrolled in a MassHealth contracted managed care organization (MCO) received the EI services as a "wrap" to the MassHealth covered services provided through the MCO.

Children with an ASD diagnosis who are enrolled and receive intensive specialty services through Early Intervention Programs may access Applied Behavior Analysis as well as additional benefits. Based on the core values of respect, individualization, family-centeredness, community, team collaboration and life-long learning, the service model utilizes a team approach that includes early intervention specialists, family members, specialty service providers, community members and advocates. Together this team develops the Individualized Family Service Plan (IFSP) to identify outcomes and strategies that will be addressed by all disciplines providing services to the child. Services utilizing this family-driven approach occur in natural settings such as the home, child care settings and community settings, providing numerous opportunities for generalizing skills within the child's daily routine, with familiar people and places. Children needing services after age three will be supported by the IFSP

team to transition to the educational setting, through existing collaborations with the community and Local Education Authority.

Description of each ABA-based treatment

Objective scientific studies have confirmed the benefits of two methods of comprehensive behavioral early intervention for children with ASD. They are the Lovaas Model based on Applied Behavior Analysis (ABA) and the Early Start Denver Model (ESDM).
Both models deliver structured, therapeutic activities for significant numbers of hours per week and share the following characteristics:

- The therapy is guided by specific and well-defined learning objectives and the child's progress in meeting these objectives is regularly evaluated and recorded.
- The intervention focuses on the core areas affected by autism. These include social skills, language and communication, imitation, play skills, daily living, and motor skills.
- The program actively engages parents in the intervention, both in decision making and the delivery of treatment.
- Highly trained clinicians assess the child, design and oversee the treatment plan, and supervise well-trained providers in the delivery of the intervention

Applied Behavior Analysis is the use of techniques for increasing useful behaviors and reducing those that may cause harm or interfere with learning to bring about meaningful and positive change in behavior. Intervention is customized to each learner's skills, needs, interests, preferences and family situation. Treatment goals and instruction are developmentally appropriate. The program encompasses a developmental curriculum that defines the skills to be taught and a set of teaching procedures used to deliver this content.

The Early Start Denver Model is specifically for very young learners. It integrates a relationship-focused developmental model with the teaching practices of ABA. Its core features include: naturalistic applied behavioral analytic strategies, deep parental involvement, a focus on interpersonal exchange and positive affect, sensitivity to normal developmental sequences, shared engagement with joint activities and language and communication taught inside a positive, affect-based relationship.

ABA-based treatment services include: assessment of the child's functional skills across domains impacted by ASD; development of an individualized treatment plan; direct child instruction to teach new skills; functional behavioral assessment and support to decrease problematic behavior and increase appropriate behavior when indicated; and guidance to the family to assist generalization of skills into the child's natural routines.

Overarching QAI Strategy that assures the health and welfare of enrollees

Enrollee's person-centered individual service plan development and monitoring

The Massachusetts Early Intervention system utilizes a universal Individualized Family Service Plan (IFSP), a child-centered and family-directed planning process to identify the strengths, capacities, preferences, needs, and desired outcomes for the child. The IFSP is a written plan that is developed for each eligible infant and toddler according to the Part C regulations under the IDEA. Each child in the Demonstration had an IFSP signed by a parent or guardian that identified ABA-based treatment as an element of the service delivery plan, specified who would provide it, and defined the frequency and intensity of that service. Measureable outcomes and the criteria and timelines to determine progress toward achieving the outcomes were identified in IFSP and reviews occur at any time, but at a minimum, every six months.

All children enrolled in the MA Early Intervention system must have an IFSP in place within 45 days of referral. The date of parent signature of the IFSP is electronically reported to the DPH Early Intervention Information System (EIIS). The system produces error reports that identify any noncompliance with this standard and DPH staffs follow up to ensure correction.

Specific eligibility criteria for Home and Community Based Services

All children in the Demonstration meet the following eligibility criteria:
- ages 0 through three years
- a confirmed diagnosis of an Autism Spectrum Disorder according to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (the DSM-5.

A written diagnostic report, confirming that a child has an autism spectrum disorder and recommending medically necessary intensive behavioral services, is obtained by the Early Intervention Program before the provision of ABA- based intensive services can begin. A screen on the EIIS that captures diagnostic information must be completed before claims for these services can be submitted. Ongoing monitoring through review of the EIIS screens and on-site record verification visits is conducted by DPH staff.

Data Sources: The Massachusetts Data Sources consist of the Early Intervention Information System (EIIS) which captures specific client based registration, evaluation, IFSP and Discharge data; the client based service delivery system which captures service payer, discipline, type of service, etc.; the Annual Report/Self-Assessment (submitted by the EI specialty programs to DPH), which is a key piece of data gathering for the State Performance Plan and Annual Performance Report; Focused Monitoring onsite visits by DPH of direct service contracted providers, which summarize results and findings in the priority compliance areas. The Specialty Service Provider database has been integrated with the EIIS system to capture information important for monitoring aspects of the EI program within the 1115 demonstration waiver (e.g., identification of name and specialty of diagnostician, specific diagnosis, autism service provider). Early Intervention Programs complete a Checklist to determine eligibility for the EI 1115 demonstration waiver program for all enrolled children diagnosed with ASD before submitting any intensive behavioral intervention claims to MassHealth.

Provider qualifications and/or licensure

DPH requires that all direct care personnel in the EI system attain Provisional Certification from DPH before they provide services. College transcripts, resumes, and relevant licensure/certification are reviewed by DPH for all providers entering the system and must conform to requirements specified in the EI Operational Standards. During this reporting period the state of Massachusetts did not license Board Certified Behavior Analysts (BCBAs). Supervision in ABA-based programs is provided by BCBAs and clinicians who have completed ABA coursework and show evidence of prior experience in its application.

Health and safety

DPH Early Intervention Health and Safety Standards include, but are not limited to, policies re: Plans for infection control; preventative health care procedures; procedures for reporting suspected child abuse or neglect to the Department of Children and Families; staff health and safety requirements; required Criminal Offender Record Checks; and site and equipment safety requirements. Early Intervention providers complete facility checklists and affirm that program health and safety policies conform to all DPH Health and Safety Standards annually.

Financial oversight between state and federal programs

DPH staff provides day-to-day oversight of fiscal matters to ensure that all state and federal regulations related to Early Intervention services are followed. EI services in MA are funded by public and private health plans as well as by state allocation. All claims for EI enrolled children are reported to DPH through a practice management system that is monitored to ensure compliance with billing regulations.

Administrative oversight by the State Medicaid agency

MassHealth issued a Transmittal Letter to Early Intervention Providers to instruct them in the requirements of the Demonstration and the accompanying revisions in the Early Intervention Program Manual. MassHealth personnel conducted a monthly meeting with DPH staff for ongoing discussion of the Demonstration project.

An update on services used by enrollees

All children in the Demonstration receive an assessment of their functional skills across domains impacted by ASD. All receive an individualized treatment plan to teach new skills. All receive child instruction to teach new skills delivered on a one to one basis, primarily in one to one sessions. All children who display challenging behaviors that interfere with learning or are problematic in the home are supported with a functional behavioral assessment and support plan to increase appropriate behavior. Family training is available to assist the family, extended

family, and non-paid caregivers in generalization of skills into the child's natural routines and in management of behavior. Many parents actively participate in every session, learning carry over techniques; others choose to participate in parent groups or in one to one sessions with autism specialists that focus on particular challenging behaviors, such as resistance to bedtime or frequent tantrums. All ABA-based providers who work with children in the Demonstration receive regular direct supervision to ensure consistency in instructional practices, data collection accuracy, and to make program adjustments as needed.

MassHealth enrolled 926 children who received Autism Specialty Services through EI in SFY14 and 1,023 MassHealth enrolled children received Autism Specialty Services through EI in SFY15. Total gross spending costs for Autism Specialty Services through EI to MassHealth enrolled children was $7,752,830 in SFY14 and $9,281,694 in SFY15. These figures represent a modest underestimate of service/cost data because all EI Programs do not always submit timely claims, accordingly this figure and future reports, will be adjusted as more accurate data becomes available.

The various treatment modalities employed by the State, including any emerging treatments, updated service models, opportunities for self-directions, etc.

The treatment modalities employed by the state are described in section 2: Lovaas Model based on Applied Behavior Analysis (ABA) and the Early Start Denver Model (ESDM). These modalities have the strongest evidence base for young children at this time. Emerging treatments, such as those that use parent-mediated programming for very young children, are of interest but are not yet sanctioned as treatment modalities.

Specific examples of how the services have been used to assist Demonstration enrollees:

Children have learned to lay the foundation for developing communication, social skills, and age appropriate interests and play skills. Progress is variable, but reflects a range of skills, such as:

- Name Recognition
- Show increase eye contact with adults and other children
- Imitation of motor movements, sounds, and/or words of another person
- Intentional communicate by using single words, selecting an appropriate picture, or signing to make a request rather than by screaming or crying
- Use of single words to greet others, label objects and to indicate needs
- Use of 2 – 3 word phrases to make requests
- Participation in daily living skills such as hand washing and tooth brushing
- Imitation of appropriate play with a toy rather than banging or mouthing it
- Following a few basic directions in a group setting and tolerate the proximity of other children

Some parents have been able to increase the variety of foods their child will accept, learned to structure bedtime in a way to reduce stress for all family members, and use play situations to elicit language and turn taking that is the basis for social interactions.

A description of the intersection between demonstration ABA-based treatment and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditure.

In light of the July 2014 CMS guidance regarding the clarification of Medicaid coverage of services to children with autism, MassHealth is currently seeking state plan approval for services provided by applied behavior analysts and is in the process of seeking state plan approval for additional services. MassHealth is evaluating whether this demonstration authority is required, given the CMS guidance.

Other topics of mutual interest between CMS and the State related to the ABA-based treatment

A number of Massachusetts colleges are developing or expanding certification and/or degree programs that address the needs of people with ASD. This is significant because there is insufficient workforce capacity to appropriately serve this population.

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