

## **CENTERS FOR MEDICARE & MEDICAID SERVICES**

### **SPECIAL TERMS AND CONDITIONS**

**NUMBER:** 11-W-00030/1 and 21-W-00071/1

**TITLE:** MassHealth Medicaid and Children’s Health Insurance Program (CHIP) Section 1115 Demonstration

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

#### **1. PREFACE**

The following are the Special Terms and Conditions (STCs) for the “MassHealth” section 1115(a) Medicaid and Children’s Health Insurance Program (CHIP) demonstration (hereinafter “demonstration”), to enable the Massachusetts Executive Office of Health and Human Services (which is the single state agency that oversees the MassHealth program), to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the Commonwealth of Massachusetts (referred to herein as the state or the State/Commonwealth) waivers of requirements under section 1902(a) and 2102(b)(2) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the Commonwealth’s obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs are effective as of October 1, 2022 through December 31, 2027, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the Commonwealth’s expenditures relating to dates of service during this demonstration extension, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment
5. Demonstration Programs and Benefits
6. Opioid Use Disorder/Substance Use Disorder (SUD)
7. Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)
8. Delivery System
9. Cost Sharing
10. Marketplace Subsidies
11. The Safety Net Care Pool
12. Delivery System Reform Incentive Payment (DSRIP)
13. Workforce Initiatives

14. Hospital Quality and Equity Initiative
15. Health-Related Social Needs
16. Monitoring and Reporting Requirements
17. Evaluation of the Demonstration
18. General Financial Requirements under Title XIX
19. Monitoring Budget Neutrality for the Demonstration
20. Monitoring Allotment Neutrality
21. Provider Rate Increase Requirements
22. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A. Preparing the Evaluation Design
- Attachment B. Preparing the Interim and Summative Evaluation Reports
- Attachment C. Cost Sharing
- Attachment D. SUD Health IT Plan
- Attachment E. Safety Net Care Pool Payments
- Attachment F. SMI/SED Implementation Plan
- Attachment G. SUD and SMI/SED Monitoring Protocol (Reserved)
- Attachment H. Safety Net Care Pool Uncompensated Care Cost Limit Protocol (Reserved)
- Attachment I. Uncompensated Care Payment Protocol (Reserved)
- Attachment J. Hospital Quality and Equity Initiative Implementation Plan
- Attachment K. Monitoring Protocol for Other Policies (Reserved)
- Attachment L. Pricing Methodology for Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs)
- Attachment M. DSRIP Protocol
- Attachment N. Safety Net Hospital Provider Payment Eligibility and Allocation Protocol
- Attachment O. Continuous Eligibility Implementation Plan
- Attachment P. Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications (Reserved)
- Attachment Q. Medicaid Managed Care Entity/ACO Performance-Based Payment Mechanisms
- Attachment R. DSRIP Flexible Services Protocol
- Attachment S. Evaluation Design (Reserved)
- Attachment T. HRSN Implementation Plan
- Attachment U. Primary Care Payment Protocol (Reserved)
- Attachment V. Provider Rate Increase Attestation Table (Reserved)

## **2. PROGRAM DESCRIPTION AND OBJECTIVES**

In the extension of the demonstration awarded on November 4, 2016, the Commonwealth and CMS agreed to implement major new demonstration components to support a value-based restructuring of MassHealth's health care delivery and payment system, including a new

Accountable Care Organization (ACO) initiative and Delivery System Reform Incentive Payment (DSRIP) Program to transition the Massachusetts delivery system into accountable care models. The Safety Net Care Pool (SNCP) aligns funding with MassHealth's broader accountable care strategies and expectations and to establish a more sustainable structure for necessary and ongoing funding support to safety net providers.

As of October 1, 2022, CMS approved an extension of the demonstration to enable the Commonwealth to achieve the following goals:

- Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model;
- Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care;
- Continue to improve access to and quality and equity of care, with a focus on initiatives addressing health-related social needs and specific improvement areas relating to health quality and equity, including maternal health and health care for justice-involved individuals who are in the community;
- Support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care; and
- Maintain near-universal coverage including updates to eligibility policies to support coverage and equity.

### 3. GENERAL PROGRAM REQUIREMENTS

- 3.1. **Compliance with Federal Non-Discrimination Statutes.** The Commonwealth must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The Commonwealth must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being

changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the Commonwealth to submit an amendment to the demonstration under STC 3.7. CMS will notify the Commonwealth 30 days in advance of the expected approval date of the amended STCs to allow the Commonwealth to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The Commonwealth must accept the changes in writing.

**3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the Commonwealth must adopt, subject to CMS approval, a modified budget neutrality agreement and/or a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality and/or modified allotment neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the Commonwealth may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.
- b. If mandated changes in the federal law, regulation, or policy require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

**3.5. State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

**3.6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements authorized through these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The Commonwealth must not implement or begin operational changes to these demonstration elements without prior approval. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available for amendments to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3 or as otherwise specified in the STCs.

- 3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the Commonwealth to submit required elements of a complete amendment request as described in this STC, and failure by the Commonwealth to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public notice process used by the Commonwealth, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the Commonwealth in the final amendment request submitted to CMS;
  - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
  - c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
  - d. An up-to-date CHIP allotment worksheet, if necessary;
  - e. The Commonwealth must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
- 3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR § 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.
- 3.9. **Demonstration Phase-Out.** The Commonwealth may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. **Notification of Suspension or Termination.** The Commonwealth must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The Commonwealth must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration’s suspension or

termination. Prior to submitting the draft transition and phase-out plan to CMS, the Commonwealth must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the Commonwealth must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the Commonwealth must provide a summary of the issues raised by the public during the comment period and how the Commonwealth considered the comments received when developing the revised transition and phase-out plan.

- b. **Transition and Phase-out Plan Requirements.** The Commonwealth must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the Commonwealth will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the Commonwealth will undertake to notify affected beneficiaries, including community resources that are available.
- c. **Transition and Phase-out Plan Approval.** The Commonwealth must obtain CMS approval of the transition and phase-out plan prior to the implementation of the transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d. **Transition and Phase-out Procedures.** The Commonwealth must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1) or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid and CHIP, the Commonwealth must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The Commonwealth must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to a review consistent with 42 CFR 457.1180. In addition, the Commonwealth must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the Commonwealth must maintain Medicaid benefits as required in 42 CFR §431.230.
- e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

- f. **Enrollment Limitation during Demonstration Phase-Out.** If the Commonwealth elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the Commonwealth's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
  - g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers are suspended by the Commonwealth, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.
- 3.10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the Commonwealth has materially failed to comply with the terms of the project. CMS must promptly notify the Commonwealth in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- 3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the Commonwealth in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the Commonwealth an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.
- 3.12. **Adequacy of Infrastructure.** The Commonwealth will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The Commonwealth must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the Commonwealth must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The Commonwealth must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the

consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers in accordance with 42 CFR §431.408(b)(2).

- 3.14. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 3.15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care plans, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 3.16. **Common Rule Exemption.** The Commonwealth shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects that are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs; procedures for obtaining Medicaid or CHIP benefits or services; possible changes in or alternatives to those Medicaid or CHIP programs or and procedures; or possible changes in methods or levels of payment for Medicaid and CHIP benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

#### 4. ELIGIBILITY AND ENROLLMENT

- 4.1. **Eligible Populations.** This demonstration affects mandatory and optional Medicaid and CHIP State plan populations as well as populations eligible for benefits only through the demonstration. Table 2 of section 4 of the STCs shows each specific group of individuals; under what authority they are made eligible for the demonstration; the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed; and the corresponding demonstration program under which benefits are provided.
  - a. Eligibility is determined based on an application by the beneficiary or without an application for eligibility groups enrolled based on receipt of benefits under another program.
  - b. MassHealth defines the age of a dependent child for purposes of the parent/caretaker relative coverage type as a child who is younger than age 19. A caretaker relative is eligible under this provision only if the parent is not living in the household.



- 4.2. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance with STC 8.13 and Table 9. except that pregnant individuals and children up to the age of 19, of any eligible income level, are eligible for retroactive coverage up to the first day of the third month prior to the date of application for individuals that meet these definitions. The Commonwealth shall implement this STC by July 1, 2023.
- 4.3. **Calculation of Financial Eligibility.** Financial eligibility for demonstration programs is determined by comparing the family's Modified Adjusted Gross Income (MAGI) with the applicable income standard for the specific coverage type, with the exception of adults aged 19 and above who are determined eligible on the basis of disability and whose financial eligibility is determined as described below. MAGI income counting methodologies will also be applied to disabled adults in determining eligibility for MassHealth Standard and CommonHealth; however, household composition for disabled adults will always be determined using non-tax filer rules, regardless of whether the individual files income taxes or is claimed as a dependent on another person's income taxes. In determining eligibility and making related calculations of deductibles and cost sharing for MassHealth Standard and CommonHealth for disabled adults, the Commonwealth may consider state veteran annuity as non-countable income as described below, and apply the five percent income disregard that is also applied to non-disabled adults.
- a. Section 6b of Chapter 115 of Massachusetts General Law authorizes a state veteran annuity payment to eligible disabled veterans and surviving Gold Star parents and spouses who have lost their child or spouse in combat. Except as described in the next sentence, the Commonwealth may consider such payment as non-countable income for purposes of determining eligibility for MassHealth Standard, MassHealth CarePlus, MassHealth Family Assistance and MassHealth Limited benefits for individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income, provided that, except with respect to disabled individuals and Programs of All-Inclusive Care for the Elderly (PACE) enrollees described in the next two sentences, individuals described above are not otherwise eligible to receive comparable coverage on the state exchange. The Commonwealth may consider such payment as non-countable income for purposes of determining eligibility for MassHealth Standard and MassHealth CommonHealth benefits for disabled individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income. In addition, the Commonwealth may consider the state veteran annuity as non-countable income for purposes of determining eligibility for individuals who would be eligible to enroll in PACE but for the receipt of a state veteran annuity or but for the inclusion of such annuity in the household income. The Commonwealth will not count the state veteran annuity when calculating a beneficiary's premium, deductible, and/or other cost sharing obligations. The Commonwealth may treat the state veteran annuity as non-countable income in making calculations related to the post-eligibility treatment of income (PETI) rules as described in 42 C.F.R. 435.700 et seq. as applicable for all MassHealth members.

- 4.4. **Streamlined Redeterminations.** Under the streamlined renewal process, enrollees are not required to return an annual eligibility review form if they are asked to attest whether they have any changes in circumstances (including household size and income) and do not have any changes in circumstances reported to MassHealth. The process applies to the following populations:
- a. Families with children under the age of 19 who have gross income as verified by MassHealth at or below 150 percent FPL and who are receiving SNAP benefits with SNAP verified income at or below 180 percent FPL.
  - b. Families with children under age 21 whose SNAP verified income is at or below 180 percent FPL, effective to the extent that the state uses an Express Lane eligibility process under its state plan for children under age 21.
  - c. Childless adults whose SNAP verified income is at or below 163 percent FPL.
  - d. The authority to use streamlined eligibility redetermination procedures will also remain in effect for families with children notwithstanding sunset dates for Express Lane Eligibility applicable to the companion state plan amendments.
- 4.5. **EAEDC Recipients.** The Medicaid agency shall extend MassHealth eligibility to individuals receiving Emergency Aid to Elders, Disabled and Children. MassHealth eligibility for individuals in this demonstration population does not involve an income determination, but is based on receipt of EAEDC benefits. Individuals in this demonstration population would not be described in the Adult Group, because that is a group defined by an income determination. Therefore, the enhanced increased federal match for individuals in the Adult Group is not available for this population. If an individual loses his/her EAEDC eligibility then he/she must apply for MassHealth benefits and receive an income eligibility determination in order to receive MassHealth benefits.
- 4.6. **Hospital-Determined Presumptive Eligibility for Additional Eligibility Groups.** Qualified hospitals that elect to do so may make presumptive eligibility determinations for individuals who appear eligible for HIV-Family Assistance or the Breast and Cervical Cancer Demonstration Program under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan.
- a. The hospital determined presumptive eligibility benefit for pregnant individuals and unborn children (as authorized under the Title XXI State Plan) is a full MassHealth Standard benefit.
- 4.7. **Provisional Eligibility.** MassHealth will accept self-attestation for all eligibility factors, except for disability status, immigration and citizenship status and, for certain individuals described below, income, in order to determine eligibility, and may require post-eligibility (after determination of financial or categorical eligibility) verification from the applicant. If MassHealth is unable to verify eligibility through federal and state data hubs, or if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, MassHealth can provide individuals with a 90-day

“provisional eligibility period,” during which MassHealth will require further verifications from the applicant.

Applicants whose self-attested income is not otherwise verified through data hubs are eligible to receive provisional eligibility consistent with the previous paragraph only if they fall within any one of the following populations:

- a. Pregnant individuals with comprehensive coverage and regardless of attested modified adjusted gross income (MAGI);
- b. Adults 21 through 64 years of age who are HIV positive and have attested MAGI income at or below 200 percent of the FPL;
- c. Individuals with breast and cervical cancer who are under 65 years of age and have attested MAGI income at or below 250 percent of the FPL; and
- d. Children under age 21.

Necessary verifications are required within 90 days of the date the individual receives notice of the provisional eligibility determination in order to maintain enrollment. The date the notice is received is considered to be five days after the date the notice is sent, unless the notice recipient shows otherwise. The reasonable opportunity period for applicants pending verification of citizenship or immigration status aligns with the 90-day provisional eligibility period for applicants pending verification of other eligibility criteria, such that benefits provided may begin prospectively with respect to all applicants as early as the date of application. For individuals not eligible for provisional eligibility as described in the previous paragraph, income verifications are required within 90 days of the date the individual receives notice requesting income verification in order to maintain original application date.

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

Benefits for all other individuals who have been determined provisionally eligible begin on the date that MassHealth sends the notice of the provisional eligibility determination. If all required verifications are received before the end of the provisional eligibility period or before the end of the 90-day verification period for those not receiving provisional

eligibility, retroactive coverage is provided for the verified coverage type in accordance with Table 9. The Commonwealth must not provide retroactive coverage for individuals age 21 and over or for non-pregnant adults until eligibility has been verified through federal and state data hubs or, if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, until MassHealth has obtained further verifications from the applicant verifying eligibility during the retroactive period. For individuals eligible for the New Adult Group, the Commonwealth may not claim the expansion state Federal Medical Assistance Percentage (FMAP) for individuals whose eligibility has not been verified within the provisional eligibility period, but may claim the regular FMAP for those individuals for no longer than a 90 day plus a five-day notice period of benefits (unless the individual can demonstrate that he or she did not receive the notice within five days, in which case benefits would be extended).

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

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

For individuals who indicate on the application that they have breast or cervical cancer or HIV, a determination of eligibility will be made in accordance with the procedures described in STC 4.7. Persons who have not submitted verification of breast cancer, cervical cancer, or HIV diagnosis within 90 days of the eligibility determination will subsequently have their eligibility redetermined as if they did not have breast cancer, cervical cancer, or HIV.

**4.9. Eligibility Exclusions.** Notwithstanding the criteria outlined in this section or in Table 2, the following individuals are excluded from this demonstration. Payments or expenditures related to uncompensated care for such individuals as defined in section 11, and as described in STC 10.1, however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP). In addition, SUD services described in section 6, diversionary behavioral health services described in STC 5.11, and SMI/SED services described in section 7 provided to MassHealth eligible individuals age 65 and over as well as benefits provided to recipients of state veteran annuities, regardless of age, described in the expenditure authority, may be included as an allowable expenditure under the demonstration.

- a. Individuals 65 years and older, to the extent that such an exclusion is authorized by MGL Ch118E Sec 9A, except for individuals eligible in accordance within 42 CFR 435.110.

- b. Participants in Program of All-Inclusive Care of the Elderly (PACE), except as otherwise described at STC 4.3(a).
- c. Refugees served through the Refugee Resettlement Program.
- d. Individuals 65 years and older who are eligible for coverage under the State Plan except for individuals eligible for cost sharing assistance in accordance with STCs 5.3(c) and 5.6(a).

#### 4.10. **Continuous Eligibility Period.**

- a. **Continuous Eligibility Duration.** The Commonwealth is authorized to provide continuous eligibility for the populations and associated durations specified in Table 1 below, regardless of the delivery system through which these populations receive Medicaid benefits.
  - i. For individuals who are released from a correctional institution, each individual's 12-month continuous eligibility period shall begin at the date of their release and will extend through the end of the 12th month following release. Eligible individuals for whom an eligibility determination is made after their release date but before 12 months after their release date shall be eligible for continuous eligibility through the end of the 12th month following release. This may result in continuous eligibility periods of less than 12 months for some individuals.
  - ii. For individuals experiencing homelessness who qualify for 24 months of continuous eligibility, the continuous eligibility period begins on the effective date of the individual's Medicaid eligibility under 42 CFR §435.915 or CHIP eligibility under 42 CFR 457.340(g) or effective date of the most recent renewal of eligibility. Given these individuals are continuously eligible regardless of changes in circumstances, the Commonwealth will conduct renewals of eligibility consistent with 42 CFR §§ 435.916 and 457.343 for individuals who qualify for 24 months of continuous eligibility at the end of the continuous eligibility period.
- b. **Continuous Eligibility Exceptions.** Notwithstanding subparagraph (a) and Table 1, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be terminated, suspended or re-determined, as the state determines is appropriate:
  - i. The individual is no longer a Massachusetts resident
  - ii. The individual requests termination of eligibility
  - iii. The individual dies

- iv. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual

Except as specified in subparagraph (b), continuous eligibility applies to individuals in all eligibility categories who meet the criteria in this table:

<b>Table 1: Eligible Populations and Associated Duration for Continuous Eligibility</b>	
<b>Population</b>	<b>Duration of Continuous Eligibility</b>
Individuals released from a correctional institution, defined as County Correctional Facilities (CCFs), state Department of Corrections (DOC) Facilities, and Department of Youth Services (DYS) juvenile justice facilities	12 months following release
Individuals who are experiencing homelessness (i.e., individuals with a confirmed status of homelessness for at least 6 months from the Statewide Homeless Management Information System Data Warehouse or from the Department of Housing and Community Development Emergency Assistance shelter system for families experiencing homelessness.)	24 months

- c. **Beneficiary-Reported Information and Periodic Data Checks.** The Commonwealth must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information potentially relevant to the state's evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. Additionally, the state must attempt to confirm the individual is not deceased at least once every 12 months, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d) and 42 CFR 457.380. The state must continue to redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j) or 42 CFR 457.380.

- d. As part of a deliverable titled Continuous Eligibility Implementation Plan (see STC 4.11), the Commonwealth must submit a description of the processes to perform the verifications described above. Furthermore, the Commonwealth is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such

verifications. The information can be provided in the demonstration's Annual Monitoring Reports (see STC 16.5).

- e. **Annual Updates to Beneficiary Information.** For all continuous eligibility periods longer than 12 months, the Commonwealth will be required to attempt to update beneficiary information on an annual basis. The Commonwealth must have procedures and processes in place to accept and update beneficiary contact information and attempt to update beneficiary contact information on an annual basis, which could include annually checking data sources and partnering with managed care organizations (MCOs), Behavioral Health Prepaid Inpatient Health Plan (BH PIHP), Primary Care ACOs (PCACOs), and Accountable Care Partnership Plans (ACPPs) to encourage beneficiaries to update their contact information. This must include procedures to annually check data sources and to partner with MCO, BH PIHP, PCACOs, and ACPPs to encourage beneficiaries to update their contact information. The Commonwealth is reminded that updated contact information from third-party sources with an in-state address is not an indication of a change affecting eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to State residency, but without additional follow up by the Commonwealth per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination as to whether beneficiaries no longer meet State residency requirements.
  - f. The Commonwealth must submit a description of the processes to update beneficiary contact information on an annual basis in an Implementation Plan, as described in STC 4.11. Furthermore, each demonstration year, through the Annual Monitoring Reports (see STC 16.5), the Commonwealth must submit to CMS a summary of activities and outcomes from these efforts.
- 4.11. **Continuous Eligibility Implementation Plan.** The Commonwealth must submit to CMS no later than 90 days after the approval of the demonstration extension a Continuous Eligibility Implementation Plan describing the timeline for implementation, the processes to perform verifications on beneficiary residency or other checks and to update beneficiary contact information on an annual basis, as described in STCs 4.10(c)-(d). The Commonwealth is required to submit a revised Implementation Plan if CMS provides any feedback on the original submission no later than 60 days after receiving CMS's comments. Once approved, the Implementation Plan will become affixed to the STCs as Attachment O.
- 4.12. **Mandatory and Optional State Plan Groups.** Massachusetts includes in the demonstration almost all the mandatory and optional populations under age 65 eligible under the state plan. The Massachusetts title XIX and XXI state plans establish and define all covered eligibility groups that do not derive their eligibility authority from this demonstration. Benefits are described in the title XIX and XXI state plans and these STCs. All MassHealth Standard, CommonHealth, CarePlus and Family Assistance members who have access to qualifying private health insurance may receive premium assistance plus wrap-around benefits.

Coverage for mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in the waiver list as further detailed in these STCs, or as made inapplicable to the expenditure authorities for this demonstration that may provide demonstration-only benefits to state plan groups. Any Medicaid SPAs modifying the eligibility standards and methodologies for these eligibility groups will apply to this demonstration. Massachusetts includes in the demonstration Lawfully Present infants, children under age 21, and pregnant individuals eligible under any coverage type in this demonstration, one of the state plans, or both.

- 4.13. **Other Demonstration Expansion Populations.** Coverage for these populations, which derive their eligibility from this demonstration, is subject to all applicable Medicaid laws and regulations, except as expressly not applicable to the relevant expenditure authority, as further detailed in the STCs. This includes the application of modified adjusted gross income (MAGI) based methodologies and exceptions for non-MAGI based methodologies, as appropriate, used to determine financial eligibility for expansion populations. The general categories of populations affected, or made eligible, by the demonstration are:



Table 2: MassHealth State Plan Base Populations					
Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
AFDC-Poverty Level infants	< Age 1: 0 through 185%	Title XIX	Base Families	Standard	
Medicaid Expansion infants	< Age 1: 185.1 through 200%	<ul style="list-style-type: none"> <li>Title XIX if insured at the time of application</li> <li>Title XXI if uninsured at the time of application, as a Medicaid Expansion Child</li> <li>Funded through title XIX if title XXI is exhausted</li> </ul>	1902(r)(2) Children  1902(r)(2) XXI RO	Standard	Medicaid Expansion child is described both in the Title XXI plan and authorized under this 1115 demonstration, including premium assistance for ESI or direct benefits.
AFDC-Poverty Level Children and Independent Foster Care Adolescents	Age 1 - 5: 0 through 133%  Age 6 - 17: 0 through 114%  Independent Foster Care Adolescents aged out of DCF up to age 21 without regard to income or assets	Title XIX	Base Families	Standard	

Table 2: MassHealth State Plan Base Populations					
Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
	Former Foster Care Children up to age 26 without regard to income or assets				
AFDC-Poverty Level Children  Medicaid Expansion Children I	Age 6 - 17: 114.1% through 133%  Age 18: 0 through 133%	<ul style="list-style-type: none"> <li>Title XIX if insured at the time of application</li> <li>Title XXI if uninsured at the time of application as a Medicaid Expansion Child</li> <li>Funded through title XIX if title XXI is exhausted</li> </ul>	Base Families  Base Fam XXI RO	Standard	Medicaid Expansion child is described both in the Title XXI plan and authorized under this 1115 demonstration, including premium assistance for ESI or direct benefits.
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	<ul style="list-style-type: none"> <li>Title XIX if insured at the time of application</li> <li>Title XXI if uninsured at the time of application, as a Medicaid expansion child</li> </ul>	1902(r)(2) Children  1902(r)(2) XXI RO	Standard	Medicaid Expansion child is described both in the Title XXI plan and authorized under this 1115 demonstration including premium assistance for ESI or direct benefits.

<b>Table 2: MassHealth State Plan Base Populations</b>					
<b>Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)</b>	<b>Federal Poverty Level (FPL) and/or Other Qualifying Criteria</b>	<b>Funding Stream</b>	<b>Expenditure and Eligibility Group (EG) Reporting</b>	<b>MassHealth Demonstration Program</b>	<b>Comments</b>
		<ul style="list-style-type: none"> <li>Funded through title XIX if title XXI is exhausted</li> </ul>			
Medicaid Expansion Children II	Ages 19 and 20: 133.1 through 150%	Title XIX	1902(r)(2) Children	Standard	
5 year bar and other non-qualified lawfully present infants and children	< Age 1: 0-200% Age 1-18: 0-150%	Title XXI CHIP Medicaid expansion funding at option of state agency, as authorized under the Title XXI State Plan	1902(r)(2) Children 1902(r)(2) XXI RO	Standard	
Pregnant individuals	0 through 185%	Title XIX	Base Families	Standard	Pregnant individuals
Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance	0 through 133%	Title XIX	Base Families	Standard	Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance
Disabled children under age 19	0 through 150%	Title XIX	Base Disabled	Standard	
Disabled adults ages 19 through 64	0 through 114%	Title XIX	Base Disabled	Standard	
Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	Base Disabled	CommonHealth	
Pregnant individuals	185.1 through 200%	Title XIX	1902(r)(2) Children	Standard	
“Non-qualified Aliens” or “Protected Aliens”	Otherwise eligible for Medicaid under the State Plan	Title XIX	Base Families	Limited	Member eligible for emergency services only

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

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

**Table 3: Demonstration Expansion Populations**

Population Name	Population Description	Benefits
CommonHealth Adults	<p>Adults aged 19 through 64 who are totally and permanently disabled and not eligible for comprehensive coverage under the Massachusetts state plan. For 19 and 20 year olds, income is above 150% of the FPL. Income above 133% FPL for adults aged 21 through 64. Individuals who have retained CommonHealth coverage for at least 10 years may retain coverage after age 65, regardless of employment status. These individuals must meet eligibility requirements for MassHealth Standard (or be subject to a spend down to qualify for MassHealth Standard).</p> <p>Adults aged 65 and over who are not eligible for comprehensive coverage under the Massachusetts state plan, with disabilities that would meet the federal definition of “permanent and total disability” if these adults were under the age of 65. Net income above 100% FPL and/or Assets &gt;\$2,000.</p>	<p>CommonHealth benefits as described in these STCs. Individuals aged 21-64 who met the asset test under the State plan receive MassHealth Standard, individuals aged 19 and 20 must also meet the deductible requirements. For adults aged 65 and over, no deductible and no asset test, provided they are first determined to be ineligible for MassHealth Standard under non MAGI eligibility rules (which includes an asset test).</p> <p>Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.</p>

Population Name	Population Description	Benefits
CommonHealth Children	<p>Children from birth through age 18 who are totally and permanently disabled with incomes greater than 150% of the FPL and who are not eligible for comprehensive coverage under the Medicaid state plan due to income or under the CHIP state plan due to having insurance at application, or if the Title XXI allotment is exhausted</p> <p>Higher income children with disabilities if insured at the time of application or when Title XXI funding is exhausted:</p> <ul style="list-style-type: none"> <li>• &lt; Age 1: 200.1% through 300% FPL</li> <li>• Ages 1 - 18: 150.1% through 300% FPL</li> </ul> <p>Higher income children (above 300% FPL) with disabilities ages 0 through 18</p>	<p>CommonHealth benefits as described in the CHIP state plan and benefits described in these STCs.</p> <p>Certain children derive eligibility from both the authority granted under this demonstration and the separate XXI program, including premium assistance for ESI or direct benefits. These are disabled children with income over Medicaid and up to 300% who are uninsured at application. They are eligible under the CHIP State Plan but also use the authorities granted under the 1115 demonstration.</p> <p>Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.</p>
Out-of-state Former Foster Care Youth	<p>Youth under age 26 who were in foster care under the responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18 (or a higher age at which the state's or Tribe's foster care assistance ends), and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.</p>	<p>MassHealth Standard benefits, as described in the Medicaid state plan and Section 5 of these STCs.</p>

Population Name	Population Description	Benefits
Family Assistance Children	<p>Non-disabled children with incomes above 150% through 300% of the FPL, if insured at the time of application or Title XXI funding is exhausted, who are not otherwise eligible under the Medicaid state plan due to family income or under the CHIP state plan due to having insurance at application.</p> <ul style="list-style-type: none"> <li>• Children ages 1 through 18: above 150% through 300% FPL</li> <li>• Children less than age 1: Above 200% through 300% FPL</li> </ul>	<p>Family Assistance benefits as described in the CHIP state plan and Section 5 of these STCs.</p> <p>Children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration and the XXI program including premium assistance for ESI or direct benefits. The premium assistance payments and FFP will be based on the children's eligibility. Parents are covered incidental to the child.</p> <p>A benefit wrap is provided for MassHealth covered services not provided through the ESI</p>
Family Assistance HIV/AIDs	<p>Individuals with HIV not otherwise eligible under the Medicaid state plan with income above 133% through 200% FPL.</p>	<p>Family Assistance benefits as described in Section 5 of these STCs. This includes expenditures for health care services furnished during the 90-day period between the time an individual submits an application and the time that the individual provides to the Commonwealth proof of HIV-positive health status.</p> <p>Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.</p>



Population Name	Population Description	Benefits
		Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.
EAEDC	Individuals who receive Emergency Aid to Elders, Disabled and Children (EAEDC). Individuals in this eligibility group are eligible for MassHealth Standard based on receipt of EAEDC benefits, not an income determination.	MassHealth Standard
Provisional Eligibility	Self-Attested income level to qualify for other group, pending verification. Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority in accordance with STC 4.7.	Benefits are based on self-attested information

Population Name	Population Description	Benefits
End of Month Coverage	Beneficiaries determined eligible for subsidized Qualified Health Plan (QHP) coverage through the Massachusetts Health Connector but not enrolled in a QHP. The individuals are ineligible for MassHealth Standard and are eligible for QHP up to 400% FPL. Effective January 1, 2014, expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP, during the period specified in STC 5.1.	
Breast and Cervical Cancer Demonstration Program (BCCDP)	Individuals determined eligible for the BCCDP under the demonstration with income above 133.1% of the FPL through 250% of the FPL	MassHealth Standard (ABP)
Presumptively Eligible	Individuals determined presumptively eligible for HIV-Family Assistance (with income above 133% FPL through 200% FPL) or the BCCDP (with income above 133% through 250% FPL) under the demonstration by qualified hospitals that elect to do so.	MassHealth Standard (ABP) (BCCDP) Family Assistance (HIV)

Population Name	Population Description	Benefits
Continuous Eligibility	<p>Individuals released from a correctional facility who no longer would be eligible for Medicaid or CHIP if subject to redetermination but are still within a 12-month continuous eligibility period following the date of the individual's release.</p> <p>Individuals who are experiencing homelessness as defined in Table 1 of STC 4.10(b) who would no longer be eligible for Medicaid or CHIP if subject to redetermination but are still within a 24-month continuous eligibility period.</p>	Benefits by CHIP or Medicaid eligibility group according to most recent eligibility determination.

## 5. DEMONSTRATION PROGRAMS AND BENEFITS

- 5.1. **End of Month Coverage for Members Eligible for Subsidized Coverage through the Massachusetts Health Connector.** When a MassHealth member's enrollment is being terminated due to a change in circumstance that makes the member ineligible for MassHealth but eligible for subsidized coverage through the Health Connector, MassHealth will extend the member's last day of coverage to the end of the month before Health Connector coverage may feasibly become effective. If the termination otherwise would have been effective on or before the 15th of a given month, then MassHealth coverage will be extended to the end of that month. If the termination otherwise would have been effective on or after the 16th of a given month, then MassHealth coverage will be extended to the end of the following month.
- 5.2. **Demonstration Program Benefits.** Massachusetts provides health care benefits through specific benefit programs. The benefit program for which an individual is eligible is based on the criteria outlined in Tables 2 and 3 of Section 4 of the STCs. Table 4 in STC 5.10, provides a side-by-side analysis of the benefits offered through these MassHealth programs.
- 5.3. **MassHealth Standard.** Individuals enrolled in MassHealth Standard receive state plan services including for individuals under age 21, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. In addition, individuals enrolled in Standard receive additional demonstration benefits specifically authorized in demonstration expenditure authorities.
- MassHealth's Standard Alternative Benefit Plan (ABP) is for individuals in the Adult Group who are ages 19-20, as well as individuals 21-64 who are HIV positive, have breast or cervical cancer or are receiving services from the Department of Mental Health or who are on a waiting list to receive such services. Individuals enrolled in the Standard ABP receive the same benefits offered in Standard and benefits are provided in the same manner as outlined below.
  - MassHealth Standard benefits will be provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished as described in STC 8.13.
  - MassHealth Standard benefits include, for individuals who are also eligible for Medicare, (1) payment of monthly Medicare Part B premiums, including through the Qualifying Individual program for individuals with incomes at or below 165 percent of FPL (2) payment of hospital insurance premiums under Medicare Part A for individuals with incomes at or below 133 percent of FPL; and, (3) payment of deductibles and co-insurance under Medicare Part A and B for individuals with incomes at or below 133 percent of FPL. The Commonwealth may establish eligibility for this coverage without applying an asset test. These benefits will begin on the first day of the month following the date of the MassHealth eligibility determination.

- 5.4. **MassHealth CarePlus.** MassHealth's CarePlus ABP is for individuals in the Adult Group ages 21-64 who are not otherwise eligible for MassHealth Standard ABP. CarePlus provides medical and behavioral health services, including diversionary behavioral health service and non-emergency medical transportation, but does not include long term services and supports. Benefits are provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished as described in STC 8.13.
- 5.5. **MassHealth Breast and Cervical Cancer Demonstration Program (BCCDP).** The BCCDP is a health benefits program for individuals in need of treatment for breast or cervical cancer. This program offers MassHealth Standard benefits to individuals under 65 who do not otherwise qualify for MassHealth and are uninsured according to the Commonwealth.
- 5.6. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under MassHealth Standard; individuals under age 21 receive EPSDT services as well. In addition, individuals enrolled in CommonHealth receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished as described in STC 8.13. These benefits shall begin on the first day of the month following the date of the MassHealth eligibility determination. The Commonwealth may establish eligibility for this coverage for children, including those eligible under the Title XXI State Plan if uninsured at application and for adults under age 65 without applying an asset test. Effective no later than July 1, 2023, individuals over 65 that have retained coverage for at least 10 years are not subject to paid employment hours restrictions;
- a. For CommonHealth members with gross income up to 135 percent FPL who are also eligible for Medicare, the Commonwealth may pay the cost of the monthly Medicare Part B premium until June 30, 2026; provided, however, that the Commonwealth may continue to accept new applicants or re-applicants into the program who apply or reapply on or before December 30, 2025, and any member determined eligible for the program prior June 30, 2026 may continue to be enrolled until June 30, 2026, provided that they continue to meet all other eligibility requirements. Effective July 1, 2026, the Commonwealth must either discontinue the program, or have submitted and received approval of an amendment to the demonstration for a Part B premium subsidy design that is consistent with all applicable federal legal requirements. Should the Commonwealth decide to discontinue the program, it must follow the phase-out rules as described in STC 3.9, and all applicable statutory and regulatory requirements.
- 5.7. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under MassHealth Standard. Among other things, individuals enrolled in Family Assistance receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. The Commonwealth may waive its requirement for children with access to ESI to enroll in ESI if the

Commonwealth determines it is more cost effective to provide benefits under direct Family Assistance coverage than to provide premium assistance. For individuals who derive their Family Assistance benefits via the 1115 demonstration and who are on direct coverage, premium assistance will be furnished in accordance with STC 8.13 and Table 9. There are two separate categories of eligibility under Family Assistance:

- a. **Family Assistance-HIV/AIDS.** As referenced in Table 3 above, for persons with HIV/AIDS whose income is above 133 percent and less than or equal to 200 percent of the FPL would be eligible for the Adult Group (MassHealth CarePlus) but for the income limit. Unlike other coverage types, persons with HIV who have access to ESI do not have to enroll in available ESI; however, if they choose to receive premium assistance, the Commonwealth will provide covered services that are not available from the ESI plan on a fee-for-service (FFS) basis.
- b. **Family Assistance-Children.** As referenced in table 3 above, children can be enrolled in Family Assistance if their family's income is above 150 percent and less than or equal to 300 percent FPL under the Title XXI State Plan if uninsured at application, and under the 1115 Demonstration if insured at application or when the CHIP allotment has been exhausted. Benefits are provided either through direct coverage or cost-effective premium assistance. Direct coverage Family Assistance under the title XXI program is provided through an MCO, ACO, or the PCC plan for children without access to ESI. Premium Assistance benefits are limited to premium assistance for ESI, to the extent that ESI is available to these children that is cost-effective, meets a basic benefit level (BBL), and for which the employer contributes at least 50 percent of the premium cost. Premium assistance may exceed the cost of child-only coverage and include family coverage if cost effective based on the child's coverage. Direct coverage is provided for children with access to cost effective ESI that meets the BBL only during the provisional eligibility period and the time span while the Commonwealth is investigating availability of and enrolling the child in ESI.

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

5.9. **Former Foster Care Youth.** Individuals enrolled as "Former Foster Care Youth" (both in- and out-of-state former foster care youth) as described in Table 3 above are eligible to receive MassHealth Standard.

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

Table 4: Summary of MassHealth Direct Coverage Benefits				
Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
EPSDT	X	X		
Inpatient Acute Hospital	X	X	X	X
Adult Day Health	X	X		
Adult Foster Care**	X	X		
Ambulance (emergency)	X	X	X	X
Audiologist Services	X	X	X	X
Behavioral Health Services (mental health and substance abuse)	X	X	X	X
Chapter 766 Home Assessment***	X	X	X	
Chiropractic Care	X	X	X	X
Chronic Disease and Rehabilitation Hospital Inpatient	X	X	Limited	X
Chronic Disease and Rehabilitation Hospital Outpatient	X	X	X	X
Community Health Center (includes FQHC and RHC services)	X	X	X	X
Day Habilitation****	X	X		
Dental Services	X	X	X	X
Diversionary Behavioral Health Services	X	X	X	X
Durable Medical Equipment and Supplies	X	X	X	X
Early Intervention	X	X	X	

Table 4: Summary of MassHealth Direct Coverage Benefits				
Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
Family Planning	X	X	X	X
Group Adult Foster Care	X	X		
Hearing Aids	X	X	X	X
Home Health	X	X	X	X
Hospice	X	X	X	X
Laboratory/X- ray/ Imaging	X	X	X	X
Medically Necessary Non- Emergency Transport	X	X		X
Nurse Midwife Services	X	X	X	X
Nurse Practitioner Services	X	X	X	X
Orthotic Services	X	X	X	X
Outpatient Hospital	X	X	X	X
Outpatient Surgery	X	X	X	X
Oxygen and Respiratory Therapy Equipment	X	X	X	X
Personal Care	X	X		
Pharmacy	X	X	X	X
Physician	X	X	X	X
Podiatry	X	X	X	X
Private Duty Nursing	X	X		
Prosthetics	X	X	X	X
Rehabilitation	X	X	X	X
Renal Dialysis Services	X	X	X	X
Skilled Nursing Facility	X	X	Limited	Limited



Table 4: Summary of MassHealth Direct Coverage Benefits				
Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
Speech and Hearing Services	X	X	X	X
Targeted Case Management	X	X		X
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X
Vision Care	X	X	X	X
<i>Chart Notes</i>				
<b>**Adult Foster Care Services:</b> These services are state plan services and the definition of these services may vary contingent upon the approved state plan. In general, the services are assistance with activities of daily living and instrumental activities daily living, supportive services, nursing oversight and care management provided in a qualified private home by a principal caregiver who lives in the home. Adult foster care is furnished to adults who receive the services in conjunction with residing in the home. The number of individuals living in the home unrelated to the principal caregiver may not exceed three. Adult foster care does not include payment for room and board or payments to spouses, parents of minor children and other legally responsible relatives				
<b>*** Chapter 766 Home Assessments:</b> These services may be provided by a social worker, nurse or counselor. The purpose of the home assessment is to identify and address behavioral needs that can be obtained by direct observation of the child in the home setting.				
<b>**** Day Habilitation Services:</b> These services are state plan services and the definition of these services may vary contingent upon the approved state plan. In general, the services are assistance with skill acquisition in the following developmental need areas: self-help, sensorimotor, communication, independent living, affective, behavior, socialization and adaptive skills. Services are provided in non-residential settings or Skilled Nursing Facilities when recommended through the PASRR process. Services include nursing, therapy and developmental skills training in environments designed to foster skill acquisition and greater independence. A day habilitation plan sets forth measurable goals and objectives, and prescribes an integrated program of developmental skills training and therapies necessary to reach the stated goals and objectives.				

**5.11. Diversionary Behavioral Health Services.** Diversionary behavioral health services are home and community-based mental health and substance use disorder services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and substance use disorder services in more community-based, less structured environments. Diversionary services are also provided to support an individual's return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided on an outpatient basis in a non-24-hour setting or facility. Generally, 24-hour and non- 24-hour diversionary behavioral health services are provided by free-standing (community-based) or hospital-based programs licensed by the Department of Mental Health or the Department of Public

Health. No Diversionary Behavioral Health Services under this STC 5.11 may be provided within an institution for mental disease (IMD), except when Program of Assertive Community Treatment (PACT) or Community Support Program (CSP) services are provided in an IMD as part of a beneficiary's discharge planning from the IMD to the community.

Diversionary services are offered to provide interventions and stabilization to persons experiencing mental health or substance abuse crises in order to divert from acute inpatient hospitalization or to stabilize after discharge. These services do not include residential programs involving long-term residential stays.

- a. Any MassHealth member under the demonstration who is enrolled in managed care may receive diversionary services, dependent on their clinical need for the services. Managed Care Organizations (i.e., MassHealth MCOs and Accountable Care Partnership Plans), and the Behavioral Health Prepaid Inpatient Health Plan (PIHP) may identify appropriate individuals to receive diversionary services. Managed care plans maintain a network of diversionary services and arrange, coordinate, and oversee the provision of medically necessary diversionary services, as described in Table 5. Diversionary services are included in risk-based capitation rates in accordance with 42 CFR 438.
- b. MassHealth members enrolled in fee for service (FFS) may receive Community Support Program (CSP), Program of Assertive Community Treatment, Structured Outpatient Addiction Program, and Intensive Outpatient Program services, as well as the state plan services, described in Table 5, dependent on their clinical need for the services.

<b>Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration</b>		
<b>Diversionary Behavioral Health</b>	<b>Setting</b>	<b>Description of Services</b>
Community Support Program (CSP)	Non-24-hour facility, and/or discharge planning provided in a 24 hour facility, including a facility that qualifies as an IMD	<p>All CSP services will be provided as described in this STC 5.11 under the Diversionary Behavioral Health authority through 3/31/23. Specialized CSP services will be provided as described in this STC 5.11 as of 4/1/23, under the HRSN authority, see details in Section 15.</p> <p>An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long-standing history of a psychiatric or substance use</p>

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	Setting	Description of Services
		<p>disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting.</p> <p>Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.</p> <p>When provided to chronically homeless individuals or individuals with justice involvement living in the community<sup>1</sup>, CSP services fall into the following domains, as applicable to the individual's needs:</p> <ul style="list-style-type: none"> <li>• Assisting Members in enhancing daily living skills; <ul style="list-style-type: none"> <li>○ Identifying and addressing barriers to attaining and maintaining community tenure</li> <li>○ Supporting members to mitigate barriers to community tenure, including coaching and connection with social services that assist them with issues such as credit history, presence of criminal record, and poor housing history</li> <li>○ Coaching members on budget strategies and/or supporting Members to connect with money</li> </ul> </li> </ul>

<sup>1</sup> Individuals with justice involvement living in the community are covered individuals released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	Setting	Description of Services
		<p>management services, including financial counselors and representative payees</p> <ul style="list-style-type: none"> <li>○ Support to gather documentation such as government identification documents, medical records</li> <li>○ Linkages to education, vocational training/services</li> <li>● Providing service coordination and linkages; <ul style="list-style-type: none"> <li>○ Referrals to healthcare providers</li> <li>○ Providers make reasonable efforts to assist Members identify and/or facilitate transportation options, including community-based transportation resources, such as public transportation and/or community- or publicly-subsidized transportation options</li> <li>○ Collaborating with state agencies, outpatient or community-based providers, Emergency Services Programs (ESPs), criminal justice entities, or other significant entities on service and discharge planning.</li> <li>○ Discharge planning that involves collaterals as appropriate. Collaterals include state agencies, community-based programs, criminal justice entities, and other non-health care community supports</li> <li>○ Provider coordinates care with Members' primary</li> </ul> </li> </ul>

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	Setting	Description of Services
		<p>care providers to be knowledgeable of medical conditions, to assess Members' compliance with medical treatment, and to assist with mitigating related barriers</p> <ul style="list-style-type: none"> <li>Assisting Members with obtaining benefits, housing, and health care; <ul style="list-style-type: none"> <li>Providers work with housing agencies to obtain documentation of housing status</li> <li>Working with Members to identify transitional supports for move-in</li> <li>Connecting Members to housing search assistance, and helping to coordinate search(es)</li> <li>Linkages to primary and preventive health services</li> <li>Linkages to behavioral health and substance use disorder treatment</li> <li>Assistance with enrolling in community benefits (Social Security benefits, SNAP, VA benefits, MassHealth, Medicare, etc.) including obtaining needed documentation and helping to complete applications and attend appointments</li> <li>Working with Member to identify resources for home modifications as needed</li> </ul> </li> <li>Developing a crisis plan in the event of a psychiatric crisis; <ul style="list-style-type: none"> <li>Refer the Member to outpatient provider</li> <li>Refer the Member to an ESP</li> </ul> </li> </ul>

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	Setting	Description of Services
		<ul style="list-style-type: none"> <li>○ Implement other interventions such as Member's safety plan</li> <li>○ Collaborate with providers (including ESPs) and natural supports</li> <li>● Providing prevention and intervention; <ul style="list-style-type: none"> <li>○ Comprehensive assessment of needs (behavioral health, medical, substance use, developmental, and social history; linguistic and cultural background; mental status examination; medications and allergies; barriers to housing; diagnosis and clinical formulation supported by the clinical data gathered, rationale for treatment, and recommendations; level of functioning; justice involvement; criminogenic needs; and key providers) to identify ways to mitigate barriers to accessing clinical treatment and attaining the skills to obtain and maintain community tenure</li> <li>○ Developing a service plan/treatment plan (linkages to health, behavioral health, and substance use treatment; and addressing criminogenic needs)</li> <li>○ Assisting Members to prepare for transition to permanent supportive housing by linking Members to entities that provide transitional assistance resources. This</li> </ul> </li> </ul>

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	Setting	Description of Services
		<p>may include referrals to houses of worship, local housing authorities and non-profit agencies. Transitional assistance includes non-recurring household set-up expenses</p> <ul style="list-style-type: none"> <li>○ Discharge planning that involves collaterals</li> <li>○ Early intervention for potential issues/behavior intervention affecting tenancy or community tenure</li> <li>● Fostering empowerment and recovery, including linkages to peer support and self-help groups <ul style="list-style-type: none"> <li>○ Recovery, wellness and empowerment principles and practices are incorporated in service delivery, trainings, and quality improvement activities</li> <li>○ Facilitates the use of formal and informal resources including community and natural support systems, wellness programs, vocational assistance programs, and peer and self-help supports and services</li> <li>○ Provider educates Members and their natural supports about substance use and psychiatric disorders, recovery and medications, and links with regular health services</li> </ul> </li> </ul>
Partial Hospitalization*	Non-24-hour facility	An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of

<b>Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration</b>		
<b>Diversionary Behavioral Health</b>	<b>Setting</b>	<b>Description of Services</b>
		therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.
Transitional Care Unit Services addressing the needs of children and adolescents, under age 19, in the custody of the Department of Children and Families (DCF), who need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care.	24-hour facility	A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu**, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.
Psychiatric Day Treatment*	Non-24-hour facility	Services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.
Intensive Outpatient Program (IOP)*	Non-24-hour facility	A clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.
Structured Outpatient Addiction Program (SOAP)*	Non-24-hour facility	Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use



Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	Setting	Description of Services
		disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant individuals, adolescents and adults requiring 24-hour monitoring.
Program of Assertive Community Treatment (PACT)	Non-24-hour facility, and/or discharge planning provided in a 24 hour facility, including a facility that qualifies as an IMD	<p>A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community.</p> <p>Services are provided in the community and are available, as needed by the individual, 24 hours per day, seven days per week, 365 days per year.</p>
Emergency Services Program (to be renamed Mobile Crisis Intervention as of January 2023)*	Non-24-hour facility	Services provided through designated contracted ESPs / Mobile Crisis Intervention providers, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.
<i>Chart Notes</i>		
* This service is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment. The state intends to submit state plan amendments to include IOP and SOAP in the state plan on or after January 1, 2023.		

Table 5: Diversionary Behavioral Health Services Provided Under the Demonstration		
Diversionary Behavioral Health	Setting	Description of Services
** In this context, “therapeutic milieu” refers to a structured, sub-acute setting, in which clinical services (therapies) are provided at both the individual and group level, and in which the common social/interpersonal interactions between each patient, and all others who are present in the setting, are incorporated into the treatment approach.		

## 6. OPIOID USE DISORDER/SUBSTANCE USE DISORDER

Since 2016, the Commonwealth has provided access to Substance Use Disorder (SUD) treatment services and ongoing recovery support to improve beneficiary health and increase rates of long-term recovery. During the MassHealth demonstration period, the Commonwealth seeks to continue achieving the following goals:

- Increase rates of identification, initiation, and engagement in treatment for SUD;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improve access to care for physical health conditions among beneficiaries with SUD.

**6.1. Opioid Use Disorder (OUD)/Substance Use Disorder Program (SUD).** Under this demonstration component, MassHealth members, except those in MassHealth Limited, will continue to have access to high-quality, evidence-based OUD and other SUD treatment services including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise reimbursable expenditures under section 1903 of the Act. The Commonwealth will continue to be eligible to receive FFP for Medicaid beneficiaries residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be reimbursable if the beneficiary were not residing in an IMD. The Commonwealth will continue to aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 6.5 below, to ensure short-term residential treatment stays.

The OUD/SUD benefits, as outlined in the table below, reflect a continuum of care that ensures that clients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. The American

Society of Addiction Medicine (ASAM) Criteria Assessment shall continue to be used for all beneficiaries to determine placement into the appropriate level of care. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

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

<b>Table 6: SUD Services</b>			
<b>Service for People with SUD</b>	<b>Population</b>	<b>Setting</b>	<b>Definition of Service</b>
Clinically Managed Population-Specific High- Intensity Residential Services ASAM Level 3.3 (Specialized 24-hour treatment services to meet more complex needs)	All MassHealth Members, except those in MassHealth Limited	24-hour facility, including IMDs	Treats patients in a 24-hour setting where the effects of the substance use, other addictive disorder, or co-occurring disorder resulting in cognitive impairment on the individual's life are so significant and the resulting level of impairment so great that other levels of 24-hour or outpatient care are not feasible or effective. Includes day programming and individual and group services.  This service will be implemented on or after July 1, 2018.
Clinically Managed Low- Intensity Residential Services ASAM Level 3.1 (24-hour Transitional Support Services)	All MassHealth members, except those in MassHealth Limited	24-hour facility, including IMDs	Services provided to an individual with a substance use disorder in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to ensure safety for the individual, while providing active treatment and reassessment. Includes 4 hours of nursing services.
Clinically Managed Low- Intensity Residential Services ASAM Level 3.1 (24-hour Residential Rehabilitation Services and 24-hour community-based family SUD treatment services)	All MassHealth members, except those in MassHealth Limited	24-hour facility, including IMDs	Services provided to an individual with a substance use disorder in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to ensure safety for the individual, while providing active treatment and reassessment. Through this service MassHealth will provide ASAM Level 3.1 services to adults, families, and adolescents.

Table 6: SUD Services			
Service for People with SUD	Population	Setting	Definition of Service
			Residential Rehabilitation Services includes day programming and individual and group services.
Recovery support navigator services	All MassHealth members, except those in MassHealth Limited		Under this service, a Recovery Support Navigator develops and monitors a recovery plan in conjunction with the member, coordinates all clinical and non-clinical services, participates in discharge planning from acute treatment programs, works with the member to ensure adherence to the discharge plan, and assists the member in pursuing his or her health management goals.
Recovery coach services	All MassHealth members, except those in MassHealth Limited		Under this service, a Recovery Coach (a person with SUD lived experience) will serve as a recovery guide and role model. Recovery Coaches provide nonjudgmental problem solving and advocacy to help members meet their recovery goals.
Clinical Stabilization Services	All MassHealth members, except those in MassHealth Limited	24-hour facility, including IMDs	24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant individuals receive coordination of their obstetrical care.
Acute treatment services	All MassHealth members, except those in MassHealth Limited	24-hour facility, including IMDs	24-hour, seven days per week, medically monitored addiction treatment services that provide evaluation and withdrawal management.  Detoxification services are delivered by nursing and counseling staff under a

Table 6: SUD Services			
Service for People with SUD	Population	Setting	Definition of Service
			<p>physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning.</p> <p>Pregnant individuals receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs, and ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.</p>
Inpatient treatment services*	All MassHealth members, except those in MassHealth Limited	Hospitals, including IMDs	Medically managed addiction treatment services that provides 24 hour nursing care and daily physician care. (ASAM Level 4)
<i>Chart Notes</i>			
<p>MassHealth Members receiving services on a FFS basis will receive all medically necessary Transitional Support Services (TSS), and up to the first 90 days of a medically necessary stay in Residential Rehabilitation Services (RRS). MassHealth Members who are enrolled in an MCO, ACO or the PCC Plan, will receive all medically necessary TSS and RRS from an MCO, ACO, or the behavioral health PIHP. The Commonwealth's average length of stay (ALOS) in SUD treatment for persons admitted into all DPH-licensed by or contracted ASAM Level 3.7, 3.5 and 3.1 programs during state fiscal year 2015 was 16.1 days.</p>			
<p>* This is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment.</p>			

**6.2. SUD Program Requirements** The following requirements that reflect key goals and objectives of this SUD project apply to this demonstration:

- a. **Access to Critical Levels of Care for OUD and other SUDs.** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of

Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management.

- b. **Use of Evidence-based SUD-specific Patient Placement Criteria.** Providers will assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines
- c. **Patient Placement.** The state will continue to employ a utilization management approach, in accordance with state law, such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.
- d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** Residential treatment providers must align with the program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. Residential treatment providers must also be in compliance with state licensure requirements for substance use disorder treatment programs.
- e. **Standards of Care for Residential Treatment Settings.** The state will review residential treatment providers to ensure that providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.
- f. **Standards of Care for Medication Assisted Treatment.** Residential treatment providers must offer Medication Assisted Treatment (MAT) on-site or facilitate access to MAT off-site.
- g. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OD.** The state must ensure sufficient provider capacity in the critical levels of care throughout the state, including those that offer MAT.
- h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OD.** The state has implemented opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

- i. **Improved Care Coordination and Transitions between levels of care.** The state will continue to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.
- j. **SUD Health IT Plan.** Implementation of the milestones and metrics as detailed in STC 6.3 and Attachment D.

6.3. **SUD Health Information Technology Plan (“SUD Health IT Plan”).** The SUD Health IT plan applies to all states where the health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable SUD Health IT Plan(s), to be included as Attachment D to the STCs, to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

- a. The SUD Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD Health IT Plan(s) will also be used to identify areas of health IT ecosystem improvement. The SUD Health IT Plan must include implementation milestones and projected dates for achieving them (see Attachment D), and must be aligned with the Commonwealth’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the Commonwealth’s SMI IT Health Plan.
- b. The Commonwealth must include in its Monitoring Protocol (see STC 6.5) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.
- c. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Report (see STC 16.5).
- d. As applicable, the Commonwealth should advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SUD health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
- e. Where there are opportunities at the state and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the Commonwealth should use the federally-recognized standards, barring another compelling state interest.
- f. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the Commonwealth should use the federally-recognized ISA standards, barring no other compelling state interest.

g. Components of the SUD Health IT Plan include:

- i. The SUD Health IT Plan must describe the Commonwealth's goals, each DY, to enhance the Commonwealth's prescription drug monitoring program (PDMP).<sup>2</sup>
- ii. The SUD Health IT Plan must address how the Commonwealth's PDMP will enhance ease of use for prescribers and other Commonwealth and federal stakeholders.<sup>3</sup> This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the Commonwealth will support clinicians in consulting the PDMP and reviewing the patients' history of controlled substance prescriptions prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
- iii. The SUD Health IT Plan will, as applicable, describe the Commonwealth's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the Health IT Plan must describe current and future capabilities regarding PDMP queries—and the Commonwealth's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The Commonwealth will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
- iv. The SUD Health IT Plan will describe how the activities described in STC 6.3(a) through (c) above will support broader Commonwealth and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.<sup>4</sup>
- v. The SUD Health IT Plan will describe the Commonwealth's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
- vi. In developing the SUD Health IT Plan, states should use the following resources:
  1. States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to "Behavioral Health and Physical Health Integration" and

---

<sup>2</sup> Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

<sup>3</sup> *Ibid.*

<sup>4</sup> Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.



“Section 34: Opioid Epidemic and Health IT”  
(<https://www.healthit.gov/playbook/health-information-exchange/>).

2. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6.4. **SUD Transition Period.** To avoid service disruption for beneficiaries as the Commonwealth aligns with expectations in SMDL #17-003 and these STCs, CMS is authorizing a SUD transition period until March 31, 2023. During this period, the Commonwealth can continue to claim FFP for services authorized under the demonstration. The SUD Health IT Plan must be submitted to CMS no later than 60 days after the demonstration effective date and must be approved by the end of the transition period in order for the Commonwealth to continue claiming FFP after March 31, 2023.

6.5. **SUD Monitoring Protocol.** The Commonwealth must submit a Monitoring Protocol for the SUD programs authorized by this demonstration within 150 calendar days after approval of the demonstration. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The Commonwealth must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS’s comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs as Attachment G. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the SUD Monitoring Protocol must include:

- a. An assurance of the Commonwealth’s commitment and ability to report information relevant to each of the program implementation areas listed in STC 6.2 and reporting relevant information to the Commonwealth’s SUD Health IT Plan described in STC 6.3;
- b. A description of the methods of data collection and timeframes for reporting on the Commonwealth’s progress on required measures as part of the monitoring and reporting requirements described in Section 16 of the STCs; and
- c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

- 6.6. **SUD Mid-Point Assessment.** The Commonwealth must contract with an independent entity to conduct an independent Mid-Point Assessment by September 30, 2025. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the Commonwealth should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including SUD treatment providers), beneficiaries, community groups, and other key partners.
- a. The Commonwealth must require that the assessor provide a Mid-Point Assessment Report to the Commonwealth that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The Commonwealth must provide a copy of the report to CMS no later than 60 calendar days after September 30, 2025 and the Commonwealth must brief CMS on the report. The Commonwealth must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.
  - b. For milestones and measure targets at medium to high risk of not being achieved, the Commonwealth must submit to CMS proposed modifications to the SUD Monitoring Protocol, as appropriate, for mitigating these risks. Any modifications to the Monitoring Protocol are subject to CMS approval.
  - c. Elements of the Mid-Point Assessment must include at least:
    - i. An examination of progress toward meeting each milestone and timeframe, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;
    - ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
    - iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
    - iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments, or to other pertinent factors that the Commonwealth can influence that will support improvement; and
    - v. An assessment of whether the Commonwealth is on track to meet the SUD budget neutrality requirements in these STCs.

6.7. **Unallowable Expenditures Under the SUD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the Commonwealth may not receive FFP under any expenditure authority approved under the SUD expenditure authority for any of the following:

- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

## **7. SERIOUS MENTAL ILLNESS (SMI) AND SERIOUS EMOTIONAL DISTURBANCE (SED)**

7.1. **SMI/SED Program Benefits.** FFP is available for otherwise covered Medicaid services, including inpatient psychiatric hospital services, and services authorized under this demonstration, including community crisis stabilization (CCS) services and community based acute treatment for children and adolescents (CBAT), furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) or serious emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an IMD. MassHealth beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI/SED treatment services. These SMI and SED services will range in intensity from short-term acute care in inpatient settings for SMI and SED, to ongoing chronic care for these conditions in cost effective community-based settings. CCS will be available to all MassHealth members, except those in MassHealth Limited. CBAT will be available to children and adolescents enrolled in managed care. The Commonwealth will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The Commonwealth must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration's SMI/SED programs, to be monitored pursuant to the SMI/SED Implementation Plan as outlined in STC 7.2 and STC 7.5 below.

### **7.2. SMI/SED Implementation Plan.**

- a. The Commonwealth must submit the SMI/SED Implementation Plan within 90 calendar days after approval of the SMI/SED amendment to this demonstration. If applicable, the Commonwealth must submit a revised SMI/SED Implementation Plan within 60 calendar days after receipt of CMS's comments. The Commonwealth may not claim FFP for services provided in IMDs to beneficiaries residing in IMDs primarily to receive treatment for SMI/SED under expenditure authority #15 until CMS has approved the SMI/SED Implementation Plan and the SMI/SED Financing Plan described in STC 7.2(d). After approval of the required implementation and financing plan, FFP will be available prospectively, but not retrospectively.
- b. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment F, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan, within 90 calendar days after approval of the SMI/SED amendment to this Demonstration, will be considered a material failure to comply with the terms of the demonstration project

as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this amendment to the demonstration. Once approved, failure to progress in meeting the milestone goals agreed upon by the Commonwealth and CMS will result in a funding deferral as described in STC 7.7.

- c. At a minimum, the SMI/SED Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:
  - i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.
    - 1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI and SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
    - 2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD. Facilities providing Youth Community Crisis Stabilization and Community Based Acute Treatment for Children and Adolescents (CBAT) services must meet these requirements.<sup>5</sup> A transition period to comply with rules is permitted and described in STC 7.9.
    - 3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals

---

<sup>5</sup> Section 2110(b)(2)(A) of the Social Security Act (the Act) excludes children residing in an IMD from being eligible for a separate CHIP at application or renewal, but as long as a child is not applying for, or renewing coverage, while a resident of an IMD, the child remains eligible for CHIP state plan services while in an IMD consistent with the requirements of 42 CFR 457.310(b)(2).

and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements.

4. Use of a utilization review entity (for example, a MCO or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and, in accordance with state law, to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities.
5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues).
6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitioning to Community-Based Care.

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment).
2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals

and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available.

3. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to.
4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers).
5. Implementation of strategies to develop and/or enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

1. Establishment of a process to annually assess the availability of mental health services throughout the Commonwealth, particularly crisis stabilization services, and updates on steps taken to increase availability.
2. Commitment to implementation of the financing plan described in STC 7.2(d).
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible.
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment, Including Through Increased Integration.

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment

sooner, including through supported employment and supported education programs.

2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers.
3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

v. **Health IT Plan.** Implementation of the milestones and metrics as detailed in STC 7.4.

d. **SMI/SED Financing Plan.** As part of the SMI/SED implementation plan required by STC 7.2(a), the Commonwealth must submit, within 90 calendar days after approval of the SMI/SED amendment to this Demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment F and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan within 90 days of the approval of the SMI/SED amendment to this Demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

- i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and
- ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

7.3. **Maintenance of effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding according to the baseline figures provided by the state at the time of application. The annual MOE will be reported and monitored as part of the annual monitoring report described in STC 16.5.

7.4. **SMI/SED Health Information Technology Plan (“SMI/SED Health IT Plan”).** The SMI/SED Health IT plan applies to all states where the health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011, states must submit to CMS the applicable SMI/SED Health IT Plans, to be included as

sections of the associated Implementation Plans (see STC 7.2(c), to develop infrastructure and capabilities consistent with the requirements outlined in the SMI/SED demonstration opportunity).

- a. The SMI/SED Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plans will also be used to identify areas of health IT ecosystem improvement. The SMI/SED Health IT Plan must include implementation milestones and projected dates for achieving them (see Attachment T), and must be aligned with the Commonwealth's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the Commonwealth's Behavioral Health (BH) IT Health Plan.
- b. The Commonwealth must include in its Monitoring Protocol (see STC 7.5) an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.
- c. The Commonwealth must monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Report (see STC 16.5).
- d. As applicable, the Commonwealth should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the Commonwealth's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this SMI/SED amendment to this Demonstration.
- e. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the Commonwealth should use the federally-recognized standards, barring another compelling state interest.
- f. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the Commonwealth should use the federally-recognized ISA standards, barring no other compelling state interest.
- g. Components of the SMI/SED Health IT Plan include:
  - i. The SMI/SED Health IT Plan will describe the Commonwealth's current and future capabilities to support providers implementing or expanding health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.



ii. In developing the SMI/SED Health IT Plan, states should use the following resources:

1. States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).
2. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

**7.5. SMI/SED Monitoring Protocol.** The Commonwealth must submit a Monitoring Protocol for the SMI/SED programs authorized by this demonstration within 150 calendar days after approval of the SMI/SED component (SMI amendment approved August 11, 2022). The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The Commonwealth must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS’s comments. Once approved, the SUD and SMI/SED Monitoring Protocol will be incorporated into the STCs as Attachment G. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports (as required by STC 16.5). Components of the Monitoring Protocol must include:

- a. An assurance of the Commonwealth’s commitment and ability to report information relevant to each of the program implementation areas listed in STC 7.2(c), information relevant to the Commonwealth’s financing plan described in STC 7.2(d), and information relevant to the Commonwealth’s SMI/SED Health IT plan described in STC 7.4;
- b. A description of the methods of data collection and timeframes for reporting on the Commonwealth’s progress on required measures as part of the monitoring and reporting requirements described in Section 16 of the demonstration; and
- c. A description of baselines and targets to be achieved by the end of the SMI/SED amendment to this demonstration. Where possible, baselines will be informed by Commonwealth data, and targets will be benchmarked against performance in best practice settings.

- 7.6. **Availability of FFP for the SMI/SED Services Under the SMI/SED Expenditure Authority #15.** Federal Financial Participation is only available for services provided to beneficiaries during short term stays for acute care in IMDs, including psychiatric hospitals, and CCS, and CBAT facilities. The Commonwealth may claim FFP for services furnished to beneficiaries during IMD stays of up to and including 60 days, as long as the Commonwealth shows at its SMI/SED midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMD exceed 60 days are not eligible for FFP under this demonstration. If the Commonwealth cannot show that it is meeting the 30 day ALOS requirement within one standard deviation at the SMI/SED mid-point assessment, the Commonwealth may only claim FFP for stays up to and including 45 days until such time that the Commonwealth can demonstrate that it is meeting the 30 day ALOS requirement. The Commonwealth will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days – or 45 days, as relevant.
- 7.7. **Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones.** Up to \$5,000,000 in FFP for SMI/SED services in IMDs may be deferred if the Commonwealth is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the SMI/SED Implementation Plans and the required performance measures in the Monitoring Plan agreed upon by the Commonwealth and CMS. Once CMS determines the Commonwealth has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The deferral process is not considered a final agency action, and may be appealed by the Commonwealth following the process specified in 42 CFR 430.30-48. The Commonwealth is expected to meet the milestones by the end of the first two years of the SMI/SED amendment to the demonstration.
- 7.8. **SMI/SED Mid-Point Assessment.** The Commonwealth must contract with an independent entity to conduct an independent Mid-Point Assessment by September 30, 2025; this takes the place of the SMI/SED Mid-Point Assessment originally due August 11, 2025 (established in the August 11, 2022 approval of the SMI component), whether or not the demonstration is renewed. If the demonstration is not extended or is extended for a term that ends on or before this date, then this mid-point assessment must address the entire term for which the SMI/SED Program under this demonstration was authorized. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the Commonwealth should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid-Point Assessment, the Commonwealth must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including SMI/SED treatment providers), and beneficiaries, community groups, and other key partners.

- a. The Commonwealth must require that the assessor provide a Mid-Point Assessment Report to the Commonwealth that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The Commonwealth must provide a copy of the report to CMS no later than 60 calendar days after September 30, 2025 and the Commonwealth must brief CMS on the report. The Commonwealth must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.
- b. For milestones and measure targets at medium to high risk of not being achieved, the Commonwealth must submit to CMS proposed modifications to the SMI/SED Implementation Plan, the SMI/SED Financing Plan, and the SMI/SED Monitoring Protocol, as appropriate, for mitigating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and/or Monitoring Protocol are subject to CMS approval.
- c. Elements of the Mid-Point Assessment must include at least:
  - i. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED Implementation Plan, the SMI/SED Financing Plan, if applicable, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol;
  - ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
  - iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
  - iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the Commonwealth's SMI/SED Implementation Plans and/or SMI/SED Financing Plan or to other pertinent factors that the Commonwealth can influence that will support improvement; and
  - v. An assessment of whether the Commonwealth is on track to meet the SMI/SED budget neutrality requirements in these STCs.

**7.9. Transition Period.** To avoid service disruption for beneficiaries receiving Community Crisis Stabilization (CCS) and Community Based Acute Treatment for Children and Adolescents (CBAT) in facilities that meet the definition of an IMD, as the Commonwealth aligns with expectations in SMDL #18-011, CMS is authorizing a transition period until December 31, 2023 for the state to come into alignment with the requirements and expectations as discussed in that guidance. During this period, the Commonwealth can continue to claim FFP for CCS and CBAT services authorized under the demonstration, but must ensure that facilities that meet the definition of an IMD work

to meet applicable requirements, including accreditation, under federal requirements to qualify to furnish Inpatient Psychiatric Services for Individuals under Age 21 services.

**7.10. Unallowable Expenditures Under the SMI/SED Expenditure Authority #15.** In addition to the other unallowable costs and caveats already outlined in these STCs, the Commonwealth may not receive FFP under expenditure authority #15 approved under this demonstration for any of the following:

- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
- b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
- c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
- d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G, except as temporarily provided for in STC 7.9.

## **8. DELIVERY SYSTEM**

The MassHealth section 1115 demonstration provides benefits through multiple delivery systems and programs. A fundamental philosophy of MassHealth is that the Commonwealth will enable beneficiaries to take advantage of available and qualified employer-sponsored insurance (ESI) if cost effective. These circumstances include the availability of ESI, the employer’s contribution level meeting a state-specified minimum, and its cost-effectiveness.

MassHealth pays for medical benefits directly (direct coverage) only if no other source of payment is available and cost-effective. Beneficiaries are required, as a condition of eligibility under some coverage types, to obtain or maintain private health insurance if MassHealth determines it is cost effective to do so, with the premium assistance necessary to make it affordable for the beneficiary. All demonstration programs, except MassHealth Limited, have a premium assistance component.

**8.1. Direct Coverage and Eligibility for Managed Care.** MassHealth benefits provided through direct coverage are delivered through the following delivery systems under the demonstration, grouped into four categories:

- a. Fee for service (FFS);
- b. A behavioral health contractor (which is a PIHP);
- c. Two primary care case management (PCCM) delivery systems: the PCC Plan; and Primary Care ACOs (which are PCCM entities); and

- d. Two MCO-based delivery systems: the MassHealth MCOs; and Accountable Care Partnership Plans

Together, all of these delivery systems, except for FFS, (i.e., the PCC Plan, the Behavioral Health PIHP, Primary Care ACOs, MassHealth MCOs, and Accountable Care Partnership Plans) are referred to as “Managed Care.” Additional detail on these Managed Care delivery systems is provided in STC 8.3-8.6. Both Medicaid and CHIP beneficiaries enroll in the managed care programs described in this demonstration. MassHealth may require Medicaid or CHIP beneficiaries eligible for direct coverage under any of the following categories to enroll in one of the Managed Care options described above: Standard, Standard ABP, Family Assistance, CarePlus, or CommonHealth members with no third party liability.

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

However, Former Foster Care Youth (including Out of State Former Foster Care Youth as described above in Table 3) are required to enroll in Managed Care, subject to all other applicable provisions of Section 8: Delivery System.

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

See Table 9 below for additional details on Managed Care eligibility and enrollment rules.

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

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

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

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

**8.3. Managed Care Delivery Systems.** MassHealth’s Managed Care delivery systems include two categories as described above: (1) PCCM and PCCM entity delivery systems (which includes the PCC Plan (PCCM) and Primary Care ACOs (PCCM entities)); and (2) MCO-based delivery systems (which includes the MassHealth MCOs and Partnership Plans). Table 7 below provides an overview of these delivery systems.

<b>Table 7: Overview of Managed Care Delivery Systems</b>			
<b>PCCM and PCCM entity delivery systems</b>		<b>MCO-based delivery systems</b>	
PCC Plan (PCCM)	Primary Care ACOs (PCCM Entities) (a.k.a. “Model B ACOs”)	MassHealth MCOs	Partnership Plans (a.k.a. “Model A ACOs”)

#### **8.4. PCCM and PCCM Entity Delivery Systems:**

- a. **The PCC Plan.** The PCC Plan is a PCCM operated by MassHealth. Members enrolled in the PCC Plan are also enrolled in a single Behavioral Health Program (BHP) contractor, which is a Prepaid Inpatient Health Plan (PIHP), for behavioral health coverage. Members enrolled in the PCC Plan access other services from MassHealth’s FFS network, subject to PCC referral and other utilization management requirements. Each member enrolled in the PCC Plan is assigned to a designated primary care provider (a “Primary Care Clinician,” or “PCC”) from among the PCC Plan’s available PCCs, who provides primary care case management. A member’s PCC provides most primary and preventive care and is responsible for providing referrals for most specialty services and for otherwise coordinating the member’s services. PCC Plan members may receive family planning services from any provider without consulting their PCC or obtaining prior approval from MassHealth. Members enrolled in the PCC Plan do not experience fixed enrollment, and may enroll in another Managed Care delivery system (i.e., a Primary Care ACO, a MassHealth MCO, or a Partnership Plan) at any time.
  - i. **Primary Care Clinician Payments.** MassHealth may establish payments to Primary Care Clinicians for coordination of the care delivered to their enrolled PCC plan members. MassHealth may also establish pay-for-performance incentives using payment arrangements for achieving certain quality of care

benchmarks, for demonstrating certain levels of improvement for selected Healthcare Effectiveness Data and Information Set (HEDIS) or other quality indicators, and for implementing practice infrastructure designed to support the delivery of high-quality health care services to enrolled members. Monitoring of these benchmarks is subject to the requirements in STC 16.5.

- b. **Primary Care ACOs.** MassHealth contracts with Primary Care ACOs to serve as PCCM entities. Members enrolled in Primary Care ACOs are also enrolled in MassHealth's Behavioral Health PIHP for behavioral health coverage and access other services from MassHealth's FFS network, subject to primary care referral and other utilization management requirements. Each member enrolled in a Primary Care ACO is assigned to a primary care provider from among the Primary Care ACO's participating primary care providers. Primary Care ACO enrollees may receive family planning services from any provider without consulting their primary care provider or their Primary Care ACO, or obtaining prior approval from MassHealth.
- i. The State may limit disenrollment for Primary Care ACO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
  - ii. MassHealth may establish Referral Circles for Primary Care ACOs; Referral Circles are groups of providers within MassHealth's FFS network, for which MassHealth will eliminate the need for otherwise-required primary care referrals for Primary Care ACO enrollees, in order to facilitate increased access and coordinated care.
  - iii. MassHealth will hold Primary Care ACOs financially accountable for cost and quality of care through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings may exceed potential shared losses). Additionally, MassHealth may pay Primary Care ACOs an administrative rate for functions, consistent with 42 CFR 438.2, that will be set forth in the Primary Care ACO contracts that are submitted to CMS. See Attachment L and Attachment U for additional detail on the pricing methodology for Primary Care ACOs.
  - iv. MassHealth may make quality improvement payments to pay Primary Care ACOs in relation to quality performance. Quality performance payments would be federally matched at the 50 percent administrative matching rate.
  - v. MassHealth may also pay an enhanced case management fee, directly to providers in Primary Care ACO, per terms in Attachment L. The Commonwealth will ensure there is no duplication in payment for this enhanced case management fee.
  - vi. Primary Care ACOs may be paid for the provision of payments to certain primary care providers on behalf of the state as described in STC 8.7.
  - vii. As of April 1, 2023, Primary Care ACOs may be required to contract with Community Partners (CPs) for the provision of care coordination to certain enrollees with behavioral health or LTSS needs. Payments to CPs are

permissible as an administrative cost. See STC 8.11 for further details. MassHealth may specify the administrative rates and payment methodologies through which Primary Care ACOs pay CPs.

- viii. Primary Care ACOs may be required to implement payment arrangements in their contracts with their participating primary care providers that may include minimum levels and/or frequency of risk sharing, as set forth in the applicable contracts.
- ix. MassHealth competitively procures Primary Care ACOs. Primary Care ACOs are PCCM entities under 42 CFR 438.

**c. Other features of MassHealth's PCCM and PCCM entity delivery systems.**

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

**8.5. Primary Care Payment Through the Primary Care ACOs.** The Commonwealth may prospectively pay Primary Care ACOs for certain primary care services and may require Primary Care ACOs to make prospective, per member per month (PMPM) payments that vary from state plan rates to participating primary care providers on behalf of the state. Such payments will be in lieu of fee-for-service state plan payments to participating primary care providers for certain primary care services in order to focus providers on improving clinical outcomes and reducing total cost of care for their attributed members, and to shift provider incentives away from volume. This payment meets Category 4 Population-Based Payment as described in the Alternative Payment Model (APM) Framework.<sup>6</sup>

- a. Payments by Primary Care ACOs to their participating primary care providers will be developed and calculated on a prospective per member per month (PMPM) basis, and will be based on the utilization of services of the primary care provider's attributed population. These payments may be developed based on clinical tiers specifying service delivery expectations and other factors defined by the Commonwealth. Primary Care ACO-participating primary care providers will continue to submit claims to MassHealth for primary care services that are included within the prospective PMPM payment for data collection purposes; all claims for services covered under the payment model will be adjudicated and zero-paid. The payments to Primary Care ACOs or to providers do not need to be reconciled to actual utilization during applicable periods.
- b. The source of the non-federal share for these payments must be the Commonwealth's general fund.
- c. The primary care payment rates and methodology paid to primary care providers participating in the Primary Care ACOs and Accountable Care Partnership Plans

---

<sup>6</sup> APM Framework: <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.



must be equitable. Any differences in the assumptions, methodologies, or factors used to develop the payment rates for the covered populations included in these two programs must also be based on valid payment standards that represent actual cost differences in providing the primary care services.

- d. No less than annually, the Commonwealth must submit the primary care payment rates and methodology to CMS for approval via PMDA as Attachment U, Primary Care Payment Protocol, at least 90 days prior to implementation, concurrent with the managed care contract submissions for the Primary Care ACOs that include the associated payment rates and methodology. The Commonwealth may be subject to deferrals or disallowances if it makes payments in excess of the payments approved by CMS.
- e. The primary care payment rates and methodology, submitted to CMS at least 90 days prior to implementation for review and prior approval, must include at least the following detail:
  - i. A description of the data and methodology the Commonwealth utilized to develop the primary care payment rates for Primary Care ACO-participating primary care providers, including the Commonwealth's approach to accounting for variations in factors such as, historical fee schedules, provider types, attributed members and populations, clinical care delivery tiers, and service delivery expectations.
  - ii. A description of any payment requirements or flexibilities the Commonwealth may place on Primary Care ACOs related to primary care payments, including any specific requirements related to payments to participating FQHCs and RHCs.
  - iii. Confirmation that the source of the non-federal share for such payments is the Commonwealth's general fund.
  - iv. Documentation, certified by the Commonwealth's actuary, that the primary care payment rates in the Primary Care ACOs and Accountable Care Partnership Plans are equitable.
  - v. A plan for monitoring, oversight, and program integrity efforts of the primary care payment program, including the Commonwealth's annual program integrity and oversight findings and any actions the Commonwealth has taken due to noncompliance with service or payment requirements must be included in the Annual Monitoring Report.
  - vi. Any additional information CMS deems necessary to determine these primary care payment rates and methodology are economic and efficient.
- f. MassHealth will ensure that there is no duplication of payment to primary care providers. Specifically and without limitation, MassHealth will ensure that FFS payments are not made to providers that duplicate payments, defined in this STC, made to the provider for furnishing primary care services to attributed beneficiaries.

## 8.6. MCO-based delivery systems:

- a. **MassHealth MCOs.** MCOs provide comprehensive health coverage, including behavioral health services, to enrollees. Some Direct Coverage services are not provided by the MCOs but are instead covered directly by MassHealth for members enrolled in MCOs<sup>7</sup>. Members enrolled in MCOs may receive family planning services from any provider without consulting their PCP or MCO and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in a member's MCO network, MassHealth reimburses the provider on a fee-for-service basis and recoups the funds from the MCO.
  - i. The State may limit disenrollment for MCO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
  - ii. MCO contracts will include requirements to use alternative payment methodologies and other arrangements described in Attachment Q, to increase accountability for cost and quality of care
  - iii. As of April 1, 2023, MCOs may be required to contract with Community Partners (CPs) for the provision of care coordination to certain enrollees with behavioral health or LTSS needs. MassHealth may specify the administrative rates and payment methodologies through which MCOs pay CPs. Payments to CPs are permissible as an administrative cost within the risk-based capitation rates paid to the MCOs. See STC 8.11 for further details.
  - iv. MassHealth competitively procures MCOs. MassHealth MCOs are defined as MCOs under 42 CFR part 438.
- b. **Accountable Care Partnership Plans (“Partnership Plans”).** Partnership Plans are MCOs that provide comprehensive health coverage, including behavioral health services, to enrollees. Some Direct Coverage services are not provided by the Partnership Plans but are instead paid on a fee for service basis in accordance with the State plan by MassHealth for members enrolled in Partnership Plans. Members enrolled in Partnership Plans may receive family planning services from any provider without consulting their PCP or Partnership Plan and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in a member's Partnership Plan network, MassHealth reimburses the provider on a fee-for-service basis and recoups the funds from the Partnership Plan.
  - i. The state may limit disenrollment for Partnership Plan enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
  - ii. Partnership Plans may have certain additional requirements such as requirements to partner with an ACO-based provider network to deliver

---

<sup>7</sup> See Appendix C of MassHealth MCO and ACPP contracts for a discussion of services.

services and coordinate care for enrollees, and to hold such ACO and providers financially accountable for the cost and quality of care under a MassHealth-approved framework that may include minimum levels and/or frequency of risk sharing.

- iii. As of April 1, 2023, Partnership Plans may be required to contract with Community Partners for the provision of care coordination to certain enrollees with behavioral health or LTSS needs. MassHealth may specify the administrative rates and payment methodologies through which Partnership Plans pay CPs. Payments to CPs are permissible as an administrative cost within the risk-based capitation rates paid to the Partnership Plans. See STC 8.11 for further details.
  - iv. MassHealth competitively procures Partnership Plans. Partnership Plans are MCOs under 42 CFR Part 438.
- c. **State Oversight of Medical Loss Ratio (MLR):** For risk-based plans under the demonstration (i.e., MCOs, and the PIHP), the Commonwealth must submit the plan generated MLR reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov).
- i. For managed care plans that delegate risk to subcontractors, the Commonwealth's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to third-party vendors; see <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf>. The Commonwealth must submit its plan to operationalize STC 8.6(c) to CMS for review and approval, at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov), no later than April 1, 2023. The workplan must outline key deliverables and timelines to meet the requirements of STC 8.6(c).
  - ii. Effective January 1, 2024, the Commonwealth must require risk-based plans contracted with the Commonwealth to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.
  - iii. No later than January 1, 2025, the Commonwealth must require risk-based plans contracted with the Commonwealth to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities. Commonwealth.
  - iv. STC 8.6(c)(i), 8.6(c)(ii), and 8.6(c)(iii) must apply for all of the following entities:
    - 1. Risk-based plans for which the Commonwealth receives federal financial participation for associated expenditures;
    - 2. Full and partially delegated plans;

3. Other subcontractors, as applicable, that assume delegated risk from either the prime managed care plan contracted with the Commonwealth, or plans referenced in STC 8.6(b)(iv)(2); and
  4. Other subcontractors, as applicable, that assume delegated risk from entities, referenced in STC 8.6(b)(iv)(3).
- v. The Commonwealth must work with CMS to effectuate an audit of the MLR data covering all years of this 1115 demonstration renewal package. The audit must occur no sooner than April 1, 2026, and ideally later in 2027 to allow the Commonwealth time to review and finalize the calendar year 2026 MLRs.
- 8.7. **Primary Care Exclusivity.** MassHealth will establish rules to require the exclusivity of primary care providers for certain Managed Care delivery systems, in order to ensure that accountability for cost and quality can accurately be assigned, and to facilitate members' choice among delivery systems options if members wish to choose based on their preferred primary care provider. Specifically, MassHealth will require, except in limited circumstances with MassHealth approval (e.g. Special Kids Special Care program members, geographically isolated areas), Primary Care ACOs, and Partnership Plans (both of which are financially accountable for the cost and quality of attributed members) to each ensure that their participating primary care providers do not simultaneously participate in any other delivery system option, as follows:
- a. A primary care provider participating with a Primary Care ACO may not simultaneously participate with another Primary Care ACO, or with a Partnership Plan. This primary care provider also may not serve as a PCC in the PCC Plan or a network PCP in the network of a MassHealth MCO. This primary care provider will exclusively serve as a primary care provider for enrollees in the Primary Care ACO.
  - b. A primary care provider participating with a Partnership Plan may not simultaneously participate with a Primary Care ACO, or with another Partnership Plan. This primary care provider also may not serve as a PCC in the PCC Plan or a network PCP in the network of a MassHealth MCO. This primary care provider will exclusively serve as a primary care provider for enrollees in the Partnership Plan.

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

- 8.8. **Community Partners Program.** Community Partners (CPs) are community-based organizations that provide care coordination and offer members linkages and support to community resources that facilitate a coordinated, holistic approach to care. CPs provide supports such as person-centered care coordination, assessments, care planning, navigation to social and community services, and health promotion and wellness activities to their enrolled members. Behavioral Health (BH) CPs are responsible for providing supports to certain managed care enrolled members with serious mental illness (SMI),

serious emotional disturbance (SED), and/or substance use disorder (SUD). Long Term Services and Supports (LTSS) CPs are responsible for providing supports to certain managed care enrolled members with LTSS needs including physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD). ACOs and MCOs identify members for enrollment with CPs. MassHealth may also identify members to ACOs and MCOs for enrollment with CPs. As of April 1, 2023, ACOs and MassHealth MCOs will be required to contract with CPs for the provision of CP supports and will pay CPs directly based on enrollment and quality performance. MassHealth may specify the rates and payment methodologies through which ACOs and MCOs pay CPs.

- a. Pursuant to expenditure authority, MassHealth may also provide up to \$20 million in additional payments to LTSS CPs (paid directly through the Commonwealth) to support LTSS CPs enhanced care coordination responsibilities including technology, workforce, ramp up, and operations. LTSS CPs will have substantially higher expectations than in the prior demonstration increasing their scope of responsibilities to align with the expectations of the BH CP model. These net new activities will include support of members with complex BH needs, technological integration with BH systems including psychiatric Emergency Notification Systems (ENS) and new organizational partnerships with Independent Living Centers (ILCs) and Aging Services Access Points (ASAPs), Electronic Health Record (EHR) enhancements to allow for clinical assessment, hiring and training staff for clinical assessment, clinical staffing with minimum staff to member ratios, and new expectations for hiring, training and supervision of staff with BH expertise. This funding is separate and distinct from the payment the state makes to the applicable managed care plans for CPs. The Commonwealth must ensure there is no duplication of CP funds. This funding must be claimed at the administrative match rate.
- b. Subject to the total payments of \$20 million in this demonstration period described in STC 8.8(a), the State may carry forward prior year LTSS CP enhanced care coordination expenditure authority from one year to the next. The State must notify CMS of any changes to annual amounts from STC 19.4 in the quarterly and annual monitoring reports.

- 8.9. **State Directed Payments.** MassHealth may make periodic payments of the types described in Attachment Q to managed care plans, including MCOs, Partnership Plans and the Behavioral Health PIHP, and direct that these payments be made to providers in the plans' networks. Such payments will be consistent with 42 CFR 438.6(c). These STC do not constitute any direct approval of any state directed payment arrangement.
- 8.10. **Data Collection and Reporting.** The Beneficiary Support System shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. The state must include relevant information in its Quarterly and Annual Monitoring Reports, as described further in STC 16.6.

#### 8.11. **Contracts.**

- a. **Managed Care Contracts.** Managed care programs outlined in these STCs (e.g., MCOs, PIHPs, PCCMs and PCCM entities) must comply with 42 CFR Part 438 unless expressly granted expenditure or waiver authority.
- b. **Capitation Rate Development.** Capitation rates for risk-based managed care plans (i.e., MCOs and PIHPs) must comply with the rate development and certification standards in 42 CFR § 438, including but not limited to 42 CFR §§ 438.4, 438.5, and 438.7.

8.12. **MassHealth Premium Assistance.** For most individuals eligible for MassHealth, the Commonwealth may require as a condition of receiving benefits, enrollment in available insurance coverage. In that case (and in cases when members voluntarily enroll in qualifying ESI), Massachusetts may provide a contribution through reimbursement or direct payment to the beneficiary, employer, or insurance plan administrator toward an individual's share of the premium for an employer sponsored health insurance plan which meets a basic benefit level (BBL). The Commonwealth has identified the features of a qualified health insurance product, including covered benefits, deductibles and co-payments, which constitute the BBL. Each private health insurance plan is measured against the BBL, and a determination is then made regarding the cost-effectiveness of providing premium assistance. If available and cost effective, the Commonwealth will provide premium assistance on behalf of individuals eligible for Standard (including ABP 1), CarePlus, Family Assistance, or CommonHealth coverage, to assist them in the purchase of private health insurance coverage. The Commonwealth will also provide coverage for additional services required to ensure that such individuals are receiving no less than the benefits they would receive through direct coverage under the state plan. This coverage will be furnished, at the Commonwealth's option, on either a FFS basis or through managed care arrangements. These individuals are not required to contribute more towards the cost of their private health insurance than they would otherwise pay for MassHealth Standard (including ABP 1), CarePlus, Family Assistance, or CommonHealth coverage. Cooperation with the Commonwealth to obtain or maintain available health insurance will be treated as a condition of eligibility for all of those in the family group, except those who are eligible for MassHealth Standard or CommonHealth and under the age of 21 or pregnant.

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

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
<i>Standard/Standard ABP*</i>					
Individuals with no third party liability (TPL)	Managed Care (PCC Plan, MCO, Primary Care ACO (PCACO) or Accountable Care Partnership Plan (ACPP))**  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Adults with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Children with TPL	Receive wrap benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with FFS wrap benefits			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
	Behavioral health is typically		X		Kaileigh Mulligan - may be retroactive to first day of third month before month of application, if covered medical services were received during such period, and

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
Kaileigh Mulligan eligible children and children receiving title IV-E adoption assistance	provided via BHP PIHP, although a FFS alternative must be available; all other services are offered via Managed Care or FFS.				the applicant would have been eligible at the time services were provided.”  Title IV-E adoption assistance - start date of adoption
Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF	Services are offered via Managed Care or FFS, with the exception of behavioral health which is provided via mandatory enrollment in BHP PIHP unless the child enrolls in an MCO (including Special Kids Special Care program if medically complex in the care/custody of DCF) or Accountable Care Partnership Plan in which case, behavioral health is provided through the	X	X	X	Start date of state care/custody



<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
	MCO or Accountable Care Partnership Plan  Certain services provided by FFS				
Provisionally eligible pregnant individuals and children, for an up to 90-day period, before self-attested family income is verified	FFS			X	10 days prior to date of application if citizenship/immigration status is verified
Individuals in the Breast and Cervical Cancer Demonstration Program without TPL	Managed Care	X			10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Home and Community-Based Waiver, under age 65	Generally FFS, but also available through voluntary Managed Care		X		May be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided.
<i>CommonHealth*</i>					
Individuals with no TPL	Managed Care ** (PCC Plan, MCO, PCACO, or ACPP)**  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
Adults with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with FFS benefits wrap			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>Family Assistance for HIV/AIDS*</i>					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP)  **  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
Individuals with qualifying ESI	Premium assistance with benefits wrap			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>Family Assistance for Children*</i>					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP) ** **  Certain services provided via FFS	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with benefits wrap				10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>CarePlus*</i>					
Individuals with no TPL	Managed Care (PCC Plan, MCO, PCACO or ACPP) **  Certain services	X		X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)

<b>Table 9: Delivery System and Coverage for Individuals under 65 in MassHealth Demonstration Programs</b>					
<b>Coverage Type</b>	<b>Delivery System Type</b>	<b>Mandatory</b>	<b>Voluntary</b>	<b>FFS Only</b>	<b>Start Date of Coverage***</b>
	provided via FFS				
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Individuals with qualifying ESI	Premium assistance with benefits wrap			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
<i>Limited</i>					
Individuals receiving emergency services only	FFS			X	10 days prior to date of application (except for populations listed in STC 4.2 whose start date of coverage may be up to the first day of the third month prior to the date of application.)
Health Connector Subsidies	Premium and cost sharing assistance	X			Start date of Health Connector benefits
<i>Chart Notes</i>					
*TPL wrap could include premium payments					
** FFS until member selects or is auto-assigned to MCO, ACO or PCC Plan					
*** All retroactive eligibility is made on a FFS basis.					

## 9. COST SHARING

- 9.1. **Cost sharing.** Cost sharing and premiums imposed upon individuals enrolled in the demonstration and eligible under the state plan or in a “hypothetical” eligibility group is consistent with the provisions of the approved state plan except where expressly made not applicable in the demonstration expenditure authorities. Cost sharing for individuals eligible only through the demonstration may vary across delivery systems, demonstration programs and by FPL, except that no co-payments are charged for any benefits rendered to children under age 21 or pregnant individuals. Additionally, no premium payments are required for any individual enrolled in the demonstration whose gross income is less than 150 percent of the FPL. The Commonwealth will ensure that cost sharing and premiums

abide all regulatory and statutory restrictions for all state-plan eligible populations, including those receiving premium assistance for cost-effective private insurance available to beneficiaries. Please see Attachment C for a full description of cost sharing and premiums under the demonstration for MassHealth- administered programs. Attachment C will be updated to match cost sharing and premiums imposed by approved state plan amendments, as applicable.

## **10. MARKETPLACE SUBSIDIES.**

- 10.1. The Commonwealth may claim as allowable expenditures under the demonstration ConnectorCare subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-operated program to provide premium and cost sharing subsidies for individuals with incomes at or below 300 percent of the FPL who purchase health insurance through the Health Connector. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid or CHIP eligible; and (2) whose income is at or below 300 percent of the FPL ; and (3) who are eligible for coverage with APTC.
  - a. The state may also claim as allowable expenditures under the demonstration the payments made through its state-operated Health Safety Net (HSN) program to provide gap coverage for individuals eligible for coverage through the Health Connector with incomes at or below 300 percent of the FPL. HSN-Health Connector gap coverage is provided to eligible individuals during the time designated to select and enroll in a plan through the Health Connector. Connector gap coverage takes the form of fee-for-service payment to providers for services rendered to an individual during this Health Connector gap period.
  - b. Federal financial participation for the premium assistance, gap coverage, and cost-sharing portions of ConnectorCare subsidies for citizens and eligible qualified non-citizens will be provided through the expenditure authority corresponding to this STC. Federal financial participation is only available with respect to payments for eligible citizens or qualified non-citizens.
  - c. **Reporting for Connector Care.** The state must provide data regarding the operation of this subsidy program in the Annual Monitoring Report required per STC 16.5. This data must, at a minimum, include:
    - i. The number of individuals served by the program;
    - ii. The size of the subsidies; and
    - iii. A comparison of projected costs with actual costs.

## **11. THE SAFETY NET CARE POOL (SNCP)**

- 11.1. **Description.** The Safety Net Care Pool (SNCP) was established effective July 1, 2005 for the purpose of reducing the rate of uninsurance in the Commonwealth while providing residual provider funding for uncompensated care, and care for Medicaid FFS, Medicaid

managed care, Commonwealth Care and low-income uninsured individuals, as well as infrastructure expenditures and access to certain state health programs related to vulnerable individuals, including low-income populations as described in Attachment E. As the Commonwealth has achieved significant progress in increasing access to health coverage, the SNCP has evolved to also support delivery system transformation and infrastructure expenditures, both aimed at improving health care delivery systems and thereby improving access to effective, quality care. During the current extension period, the SNCP now includes the following expenditure categories:

- a. **DSH-like Pool.** Payments that offset Medicaid FFS and managed care underpayment, and uncompensated care for uninsured and underinsured (DSH – shortfall and uninsured).
- b. **UC Pool.** Uncompensated care pool restricted to charity care for uninsured and underinsured, aligned with CMS uncompensated care pool policy as applied in other states (UCC – uninsured care). CMS will only make changes to the base methodology during the negotiation of another demonstration extension with the Commonwealth.
- c. **DSRIP.** Final performance period of the DSRIP program, ending March 31, 2023, and close-out activities that phase down over the course of the demonstration period.
- d. **Safety Net Provider Payments (SNPP).** Close-out payments associated with the prior demonstration period and tied to DSRIP accountability to be paid to hospitals eligible during the prior demonstration period.
- e. **Public Hospital Transformation and Incentive Initiatives (PHTII).** Close-out payments associated with the prior demonstration period and tied to DSRIP accountability during the prior demonstration period to be paid to Cambridge Health Alliance.

11.2. **Expenditures Authorized under the SNCP.** The Commonwealth is authorized to claim as allowable expenditures under the demonstration, to the extent permitted under the SNCP limits under STC 11.4, for the following categories of payments and expenditures. The Commonwealth must identify the provider and the source of non-federal share for each component of the SNCP. Federally-approved payments and expenditures within these categories are specified in Attachment E. The Commonwealth must only claim expenditures at the regular FMAP for these programs.

- a. **Disproportionate Share Hospital-like (DSH-like) Pool.** As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the demonstration, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, and low-income uninsured individuals consistent with the definition of uncompensated care in 42 CFR 447.299, except that provider incentive payments will not be included as patient care revenues for this purpose. The Commonwealth may also claim as allowable expenditures

payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease. Payments to providers other than community health centers are limited to uncompensated care costs incurred by providers and verified in cost reports or other cost records, in serving individuals who are eligible for Medicaid, or have no health care insurance for the service. These payments are subject to the SNCP limits under STC 11.4. The DSH-like Pool may include expenditures for:

- i. Public Service Hospital Safety Net Care payments to hospitals for care provided to eligible low income uninsured and underinsured patients;
- ii. Health Safety Net Trust Fund payments to hospitals and community health centers for care provided to eligible low income uninsured and underinsured patients;
- iii. Payments to Institutions for Mental Disease (IMDs) for care provided to MassHealth Members, to the extent these expenditures are not claimed under the Diversionary Behavioral Health authority described in STC 5.11, the SUD authority described in Section 6 or the SMI authority described in Section 7;
- iv. Certified public expenditures for uncompensated care provided by Department of Public Health (DPH) and Department of Mental Health (DMH) hospitals; and
- v. Safety Net Provider Payments to qualifying hospitals, as described in (2) below, and close-out Safety Net Provider Payments.

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

- i. The Commonwealth will determine, based on the eligibility criteria listed below, the hospitals that are eligible to receive the Safety Net Provider Payments. The eligibility criteria below use hospitals' fiscal year 2019 Center for Health Information and Analysis (CHIA) hospital cost reports.
- ii. To be eligible, the hospital must meet the following four criteria:
  1. Medicaid and Uninsured payer mix by charges of at least 20.00%;
  2. Commercial payer mix by charges of less than 50.00%;
  3. Is not a MassHealth Essential hospital as defined in Massachusetts' approved State Plan; and

4. Is not a critical access hospital with fewer than 30 beds upon issuance of the 2019 CHIA hospital cost report.

- iii. Hospitals that qualify for Safety Net Provider payments because they meet these eligibility criteria and have a demonstrated Medicaid and Uninsured shortfall are listed in Attachment N. Safety Net Provider Payments to any provider may not exceed the amount of documented uncompensated care indicated on these reports.
- iv. Safety Net Provider Payments will have accountability requirements, aligned with the Commonwealth's overall delivery system and payment reform goals. In each year of the demonstration extension period, hospitals that receive Safety Net Provider Payments must participate in one of MassHealth's ACO models. In addition, a portion of Safety Net Provider Payments each year of the demonstration extension period will be tied to ACO performance measures. Twenty percent (20%) of each provider's total Safety Net Provider Payments will be at risk per demonstration year. The benchmarks for ACO performance and methodology for calculating the ACO Accountability Score and associated payment are described in Attachment N. For ACO performance that may rely on claims and/or other lagged sources of data, EOHHS may make estimated payment to participating hospitals, which will be subject to final reconciliation outlined in Attachment N.

11.3. **Uncompensated Care (UC) Pool.** Payments from this pool may be used to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to uninsured individuals as charity care by hospitals, clinics, or by other provider types, as specified at subparagraph (c) below, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association. Annual UC Pool payments are limited to \$100 million per demonstration year (total computable), as specified in STC 19.4. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form in Attachment I. The methodology used by the state to determine UC payments will ensure that payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to source of non-federal share, as specified in Attachment I. UC payments are not associated with particular individuals and are not a form of health coverage or any other benefit inuring to individuals. UC payments may employ substantively identical methodologies as payments authorized under the DSH-like Pool as further described in Attachment E, and subject to any additional limitations set forth in Attachment I.

- a. **UC Application.** To qualify for a UC Payment, a provider must submit to the Commonwealth a UC Application (or substantively equivalent report, referred to interchangeably herein as "UC Application" or "application") that will collect cost and payment data on services eligible for reimbursement under the UC Pool. Data collected from the application will form the basis for UC Payments made to



individual hospitals and non-hospital providers. The state must require hospitals to report data in a manner that is consistent with the Medicare Form 2552-10 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles.

Cost and payment data included on the application must be based on the Medicare 2552-10 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles. For hospitals not required to report charity care uncompensated costs on their cost reports, the hospital must report the required data in the tool approved by CMS and included in Attachment I. Any overpayments identified in the reconciliation process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS, except that during the reconciliation process, if a provider demonstrates that it has allowable uncompensated costs consistent with the protocol that were not reimbursed through the initial UC Payment (based on application figures), and the state has available UC Pool funding for the year in which the costs accrued, the state may provide reimbursement for those actual documented unreimbursed UC costs through a prior period of adjustment.

- i. Any provider that meets the criteria specified in Attachment I may submit a UC Application.
  1. All providers must have an executed indigent care affiliation agreement on file with the state, or be subject to a substantially similar requirement through other appropriate means (e.g., state regulation).
- ii. When submitting the UC Application, providers may request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs, resulting from changes in operations or circumstances. A provider may request that:
  1. Costs and revenue not reflected on the filed cost report, but which would be incurred for the program year, be included when calculating payment amounts; or
  2. Costs and revenue reflected on the filed cost report, but which would not be incurred for the program year, be excluded when calculating payment amounts.
  3. Adjustments described in subparagraphs (1) and (2) above cannot be considered as part of the reconciliation of a prior year payment. Such costs must be properly documented by the provider, and are subject to review by the State. Such costs are subject to reconciliation to ensure that providers actually incurred such eligible uncompensated costs.
- iii. All applicable inpatient and outpatient hospital UC payments received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue. Hospitals receiving both Safety Net Care Pool and UC

Payments cannot receive total payments under the Safety Net Care Pool and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs for those services. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments. All reimbursements must be made in accordance with CMS approved Cost-Limit Protocol.

- b. **UC Payment Protocol.** The UC Payment Protocol establishes rules and guidelines for the State to claim FFP for UC Payments. The UC Payment Protocol will be appended into these STCs as Attachment I, which will be approved subsequent to this extension award. Prior to claiming FFP for the UC pool, the state must submit for CMS approval a funding and reimbursement protocol that will establish rules and guidelines for the State to claim FFP for UC Payments. The state cannot claim FFP for any UC Payments until the UC Protocol is approved by CMS. The UC Payment Protocol must include precise definitions of eligible uncompensated provider charity care costs (consistent with the Medicare cost reporting principles and revenues that must be included in the calculation of uncompensated charity care cost for the purpose of reconciling UC payments to unreimbursed charity care cost). The Protocol will also identify the allowable source documents to support costs; it will include detailed instructions regarding the calculation and documentation of eligible costs, the tool used by the State and providers to apply for UC Payments, and a timetable and reconciliation of payments against actual charity care cost documentation. This process will align the application process to the reconciliation process, as further described in Attachment I. The Protocol will contain not only allowable costs and revenues, it will also indicate the twelve (12) month period for which the costs will apply.
- c. **UC Payment Treatment.** UC Payments are considered to be Medicaid payments to providers and must be treated as Medicaid revenue when determining total title XIX funding received, in particular for any provider utilizing certified public expenditures as the non-Federal share of a Medicaid payment.
- d. **Reporting Requirements for UC Payments.** The state will submit to CMS, within ninety (90) days after the end of each Demonstration year:
  - i. Any UC Payment applications submitted by eligible providers; and
  - ii. A chart of actual UC payments to each provider for the previous DY.

#### 11.4. Expenditure Limits under the SNCP.

- a. **Aggregate SNCP Cap.** For October 1, 2022 through December 31, 2027 (SNCP extension period), the SNCP will be subject to an aggregate cap of up to \$759.6 million (total computable) added to the provider cap for the DSH-like pool described in STC 11.4(b) below, as well as the overall budget neutrality limit established in section 19 of the STCs. Because the aggregate SNCP cap is based, in part, on an

amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate SNCP cap, and a corresponding change to the provider cap as described in subparagraph (b). Such a change shall be reflected in STC 11.2(b), and shall not require a demonstration amendment.

- b. **Provider Cap for the DSH-like Pool.** The Commonwealth may expend an amount for purposes specified in STC 11.2(a) equal to no more than the cumulative amount of the Commonwealth's annual DSH allotments for the SNCP extension period. Any change in the Commonwealth's federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate amount available for the DSH-like pool. Such change shall not require a demonstration amendment. The DSH-like Pool funding is based on the amount equal to the state's entire DSH allotment as set forth in section 1923(f) of the Act. In order to align DSH amounts with each SFY, the state's DSH allotment for the federal fiscal year will be pro-rated. In any year to which reductions to Massachusetts' DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to the SNCP in a given DY shall be reduced consistent with CMS guidelines. The funding limit does not apply to expenditures under the UC Pool, though the Commonwealth may only claim expenditures under the UC Pool to the extent that the DSH-like Pool has been fully expended.
- c. **Budget Neutrality Reconciliation.** The Commonwealth is bound by the budget neutrality agreement described in section 19 of the STCs. The Commonwealth agrees to reduce spending in the SNCP to comply with budget neutrality in the event that expenditures under the demonstration exceed the budget neutrality ceiling outlined in section 19, STC 19.1.

- 11.5. **Cost for Uncompensated Care following Cost Limit Protocol.** The DSH-Like pool payments support providers for furnishing uncompensated care, using definitions that generally parallel those used in traditional DSH funding. Massachusetts' Cost Limit Protocol ensures that payments to providers other than community health centers for uncompensated care will be limited on a provider-specific basis to the cost of providing Medicaid state plan services and any other additional allowable uncompensated costs of care provided to Medicaid eligible individuals and uninsured individuals, less payment received by or on behalf of such individuals for such services. Provider incentive payments authorized through this demonstration will not be considered to be patient care revenues for this purpose along with other revenues as described in Massachusetts' Cost Limit Protocol approved by CMS in December 2013. Notwithstanding the generality of the foregoing, Critical Access Hospitals may receive 101 percent of the cost of providing Medicaid services, and 100 percent of uncompensated care costs as specified by the provisions of Section 1923(g) of the Act as implemented by 447.295(d).

11.6. **SNCP Additional Reporting Requirements.** All SNCP expenditures must be reported as specified in section 11, STC 11.2. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

- a. **Charts A – B of Attachment E.** The Commonwealth must submit to CMS for approval, updates to Charts A – B of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Years (SFYs) 2023-2028, and identify the non-federal share for each line item, no later than 45 business days after enactment of the State budget for each SFY. CMS shall approve the Commonwealth's projected SNCP payments and expenditures within 30 business days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 11.4.
- b. Before it can claim FFP, the Commonwealth must notify CMS and receive CMS approval, for any SNCP payments and expenditures outlined in Charts A-B of Attachment E that are in excess of the approved projected SNCP payments and expenditures by a variance greater than 10 percent. Any variance in SNCP payments and expenditures must adhere to the SNCP expenditure limits pursuant to STC 11.4. The Commonwealth must submit to CMS for approval updates to Charts A – B that include these variations in projected SNCP payments and expenditures. CMS shall approve the Commonwealth's revised projected SNCP payments and expenditures within 30 business days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 11.4.
- c. The Commonwealth must submit to CMS for approval updates to Charts A – B of Attachment E that reflect actual payments and expenditures for each SFY, within 180 calendar days after the close of the SFY. CMS shall approve the Commonwealth's actual SNCP expenditures within 45 business days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in STC 11.4.
- d. The Commonwealth must submit to CMS for approval further updates to any or all of these charts as part of the quarterly operational report and at such other times as may be required to reflect projected or actual changes in SNCP payments and expenditures.
- e. CMS must approve the Commonwealth's updated charts within 45 business days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable limits specified in STC 11.4.
- f. No demonstration amendment is required to update Charts A - B in Attachment E, with the exception of any new types of payments or expenditures in Charts A - B, or for any increase to the Public Service Hospital Safety Net Care payments.
- g. **DSRIP Protocol.** DSRIP reporting is required as specified in Section 12 and the approved Protocol.

h. **UC Payments.** UC payment reporting is required as specified in STC 11.3(d).

## **12. DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP)**

- 12.1. **Delivery System Reform Incentive Program (DSRIP).** The expenditure authority authorized under this extension permits the state to use DSRIP funds remaining from the previous demonstration period. It does not increase the Commonwealth's total expenditure authority as previously authorized. The state may claim, as authorized expenditures under the demonstration, up to \$253.2 million (total computable) over the demonstration period, for the completion of DSRIP incentive payments (including ACO Startup/Ongoing, ACO Flexible Services, CP Infrastructure and Capacity Building, and CP Care Coordination) and associated close out costs. DSRIP payments are an incentive for successfully meeting associated metrics and outcomes rather than payment of claims for the provision of medical care. For this reason, DSRIP payments shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the Safety Net Care Pool Uncompensated Care Cost Limit Protocol under demonstration authority. DSRIP will be a time limited program, and Massachusetts' efforts undertaken through DSRIP will be sustainable after the demonstration period concludes.

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

Massachusetts may also claim as allowable expenditures under the demonstration payments for state implementation and robust oversight of the DSRIP program as described below in STC 12.12(b).

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

- 12.2. **Funding Sources.** MassHealth must use a permissible source of non-federal share to support the DSRIP program. FFP is only available for DSRIP payments to Participant ACOs and CPs that comply with the DSRIP Protocol and Participation Plans; or to other

entities that receive funding through the DSRIP statewide investments or DSRIP-supported state operations and implementation funding streams. The Commonwealth may claim FFP for up to two years after the calendar quarter in which the State made DSRIP payments to eligible entities. MassHealth's DSRIP expenditures are subject to availability of funds.

12.3. **Expenditure Limits.** The Commonwealth may claim FFP for up to \$253.2 million in DSRIP expenditures.

- a. The State's expenditure authority will be reduced based on the State's DSRIP Accountability Score (See STC 12.16). MassHealth will reduce DSRIP payments in proportion to the reduced expenditure authority.

12.4. **Funding Allocation and Methodologies.** The funding table below shows anticipated amounts of funding per DSRIP funding stream by waiver demonstration year. The State and CMS recognize that these funding amounts may vary due to a variety of reasons, including fluctuations in the number of members who require BH and LTSS CP services and the timing of the final calculations required for DSRIP Accountability scoring. As such, the state may reallocate funding amounts between funding streams and Demonstration Years at its discretion. If the actual funding amounts per DSRIP funding stream and per Demonstration Year vary by more than 15% from the amounts provided in the table below, the state must notify CMS 60 calendar days prior to the effective reallocation of funds. CMS reserves the right to disapprove any such reallocations.

<b>Table 10: DSRIP Funding Allocation Total Computable (in millions)</b>							
	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>	<b>Total</b>
<b>Total</b>	\$45.7M	\$124.2M	\$48.6M	\$34.2M	\$0.5M	\$0	\$253.2M

12.5. **DSRIP Protocol.** The DSRIP protocol is incorporated as Attachment M of these STCs, and may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. The Protocol lays out the permissible uses of DSRIP specific funding for ACO, CP, and statewide investments, as well as state implementation and oversight of the DSRIP program. Changes to the Protocol will apply prospectively, unless otherwise indicated in the Protocols. DSRIP payments for each participating entity or organization are contingent on fully meeting requirements as specified in the DSRIP Protocol. In order to receive incentive funding the entity must submit all required reporting, as outlined in the DSRIP Protocol.

- a. **Protocol Purpose.** The Commonwealth may only claim FFP for DSRIP expenditures in accordance with the DSRIP Protocol. The DSRIP Protocol:
  - i. Outlines the context, goals, and outcomes that the Commonwealth seeks to achieve through payment reform;

- ii. Specifies the allowed uses for DSRIP funding, and the methodologies/process by which the Commonwealth will determine how to distribute DSRIP funding and ensure robust oversight of said funds;
  - iii. Specifies requirements for the DSRIP Participation Plans and Budgets that ACOs and CPs are required to submit and have approved by the Commonwealth;
  - iv. Specifies requirements for how the Commonwealth will procure and oversee any statewide investments in support of the key goals of the demonstration.
- b. **Review and Approval of Modifications to DSRIP Protocol.** Massachusetts has the right to modify the DSRIP Protocol over time with CMS approval, taking into account evidence and learnings from experience; unforeseen circumstances; or other good cause.
- i. CMS and Massachusetts agree to a targeted approval date of 60 business days after submission of the DSRIP Protocol modification.
  - ii. If CMS determines that the DSRIP Protocol modifications are not ready for approval by the target date, CMS will notify Massachusetts of its determination, and CMS and Massachusetts will then work collaboratively together to address the reasons provided by CMS for not granting approval.

12.6. **ACO & CP DSRIP Participation Plans.** In order to receive DSRIP funding, ACOs must submit their Participation Plan, Budget, and Budget Narratives to MassHealth, and receive MassHealth approval. The Participation Plans must describe how the ACO will use DSRIP funding to support the transition to the new MassHealth ACO models.

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

- 12.7. **Accountable Care Organizations.** The Commonwealth will provide DSRIP investment funds to its contracted ACOs, which are generally provider-led health systems or organizations that focus on integration of physical health, Behavioral Health, Long Term Services and Supports, and social service needs; ACOs will be financially accountable for the cost and quality of their members' care. MassHealth's ACO models are described in STC 8.4 and 8.6 above and in MassHealth's prior demonstration.
- a. **Eligibility.** ACO entities that are eligible to receive DSRIP payments from MassHealth are entities that have signed contracts to be MassHealth ACOs (i.e., Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Contracted ACOs).
  - b. **Funding Use.** MassHealth may pay ACOs under the DSRIP expenditure authority for the following:
    - i. ACO startup/ongoing support
    - ii. Support for DSRIP flexible services. These services are delineated in the DSRIP Flexible Services Protocol. The protocol includes eligibility criteria and service definitions, payment methodologies, specific interventions, a description of the methodology used to identify the target population(s) including data analyses and a needs assessment of the target population, the nature of the individualized determination that would need to be made to determine potential for institutional placement and description of services that will be made available to beneficiaries including medical, behavioral, social and non-medical services. The State may provide a portion of flexible services funding directly to social service organizations to help them build infrastructure and capacity to better support ACOs in delivering flexible services, subject to expenditure limits set forth in the Flexible Services Protocol. Flexible services include:
      - 1. Transition services for individuals transitioning from institutional settings into community settings consistent with the guidance provided on the provision of transition services as a home and community based service.
      - 2. Home and Community-Based Services to divert individuals from institutional placements.
      - 3. Services to maintain a safe and healthy living environment.
      - 4. Physical activity and nutrition.
      - 5. Experience of violence support.
      - 6. Other individual goods and services.
      - 7. Address medical needs and provide direct benefit and support specific outcomes that are identified in the individual waiver participant's care plan; and



8. Promote the delivery of covered services in community settings;
  9. Decrease the need for other Medicaid services;
  10. Reduce the reliance on paid support; or
  11. Are directly related to the health and safety of the member in his/her/their home or community; or
  12. Satisfy the other criteria listed below
- iii. These flexible services must satisfy the following criteria:
1. Must be health-related
  2. Not covered benefits under the MassHealth State Plan, the 1115 demonstration Expenditure Authority, or a home and community based waiver the member is enrolled in.
  3. Must be consistent with and documented in member's care plan
  4. Determined to be cost effective services that are informed by evidence that the service is related to health outcomes.
  5. May include, but are not limited to, classes, programs, equipment, appliances or special clothing or footwear likely to improve health outcomes, prevent or delay health deterioration.
  6. Other criteria established by MassHealth and approved by CMS.
- c. **Limitations on FFP for DSRIP Flexible Services.** The state must provide detailed information, as part of its quarterly report, on the exact flexible service, number and dollar amounts provided by each ACO during the quarter. If during the course of the demonstration CMS finds that flexible services provided by an ACO are outside of the scope of the STCs or other CMS federal policy guidance, CMS reserves the right to modify and/or terminate the expenditure authority for flexible services only.
- d. **Additional Limitations on DSRIP Flexible Services.** Flexible service dollars may not be used to fund or pay for the following:
- i. State Plan, 1115 demonstration services, or services available through a Home and Community Based waiver in which the member is enrolled
  - ii. Services that a member is eligible to receive from another state agency
  - iii. Services that a member is eligible for, and able to, receive from a publicly funded program (recognizing that certain public programs, periodically run out of funds)
  - iv. Services that are duplicative of services a member is already receiving
  - v. Services where other funding sources are available.
  - vi. Alternative medicine services (e.g., reiki)

- vii. Medical marijuana
- viii. Copayments
- ix. Premiums
- x. Ongoing rent or mortgage payments
- xi. Room and board, including capital and operational expenses of housing
- xii. Ongoing utility payments
- xiii. Cable/television bill payments
- xiv. Gift cards or other cash equivalents with the exception of nutrition related vouchers or nutrition prescriptions
- xv. Student loan payments
- xvi. Credit card payments
- xvii. Memberships not associated with one of the allowable domains
- xviii. Licenses (drivers, professional, or vocational)
- xix. Services outside of the allowable domains. For example:
  - xx. Educational supports
  - xxi. Vocational training
  - xxii. Child care not used to support attendance of medical or other health-related appointments
  - xxiii. Social activities not related to the health of an individual
  - xxiv. Hobbies (materials or courses)
  - xxv. Clothing (beyond specialized clothing necessary for fitness)
  - xxvi. Auto repairs not related to accessibility
- e. **At-Risk DSRIP Funding.** A portion of DSRIP ACO startup/ongoing funds and glide path funding will be at-risk. An ACO's DSRIP Accountability Score will determine the amount of at-risk funding that is earned (STC 12.11).
- f. **Startup/ongoing support.** The PMPM amount for startup/ongoing funds varies for each ACO, depending on adjustments based on the following factors, as determined by MassHealth: the ACO's payer revenue mix, the ACO model and risk track selected and the number of ACO members attributed to community health centers (see DSRIP Protocol Section 4.4.1).
- g. **DSRIP Flexible services support.** The PMPM amount for DSRIP flexible services is the same for every ACO.

- 12.8. **Community Partners.** The following description applies to the Community Partners program under DSRIP. See STC 8.11 for information about the Community Partners program as of April 1, 2023. Certified Community Partners (CPs) are community-based organizations that offer members linkages and support to community resources that facilitate a coordinated, holistic approach to care.

Behavioral Health (BH) CPs are responsible for providing certain supports for members over age 18 with serious mental illness (SMI), serious emotional disturbance (SED), and/or serious and persistent substance use disorder (SUD).

LTSS CPs are responsible for providing certain supports to members with LTSS needs including physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD).

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

12. Other activities to help promote integration across physical health, behavioral health, LTSS and health-related social needs for BH CP members, as agreed upon by the care team.
- iii. The CP may not bill Mass Health, MCOs or ACOs for activities funded through DSRIP. MassHealth will also ensure that there is no duplication of payment to Community Partners. An LTSS CP may utilize DSRIP funding for the following purposes, including but not limited to:
    1. LTSS assessments and counseling on available options;
    2. Support for person-centered care management, care plan support and care coordination activities, including but not limited to:
    3. Screening to identify current or unmet LTSS needs;
    4. Review of members' existing LTSS assessment and current LTSS services;
    5. Independent assessment for LTSS functional and clinical needs;
    6. Choice counseling including navigation on LTSS service options and member education on range of LTSS providers;
    7. Care transition assistance;
    8. Provide LTSS-specific input to the member care plan and care team;
    9. Coordination (e.g., scheduling) across multiple LTSS providers; coordination of LTSS with medical and BH providers/services as appropriate;
    10. Member engagement regarding LTSS;
    11. Health promotion; and
    12. Other activities to help promote integration across physical health, behavioral health, LTSS and health-related social needs for LTSS CP members, as agreed upon by the care team.
  - iv. Infrastructure and capacity building
  - c. **At-Risk DSRIP Funding.** A portion of DSRIP Community Partners funding will be at-risk. A CP's DSRIP Accountability Score will determine the amount of at-risk funding that is earned (see DSRIP Protocol Section 5.4)).
  - d. **Funding Methodology.** The amount of MassHealth's DSRIP payment any CP receives will be based on the total number of members that the CP serves each DSRIP year, as well as other funding methodologies, such as a needs-based grant program for infrastructure and capacity building support. DSRIP payments will be adjusted for at-risk performance.

12.9. **ACO & CP DSRIP Reporting Requirements.** The reporting requirements set forth in this STC apply to the period prior to March 31, 2023. ACOs and CPs must submit

semiannual progress reports, including expenditures for the semiannual periods upon which the semiannual progress reports are based.

- a. ACOs must also annually submit clinical quality data to the Commonwealth for quality evaluation purposes; and their ACO revenue payer mix, for safety net categorization purposes.
- b. CPs must also annually submit clinical quality data to the Commonwealth for quality evaluation purposes.
- c. **State Reporting to CMS.** The State must compile ACO and CP quarterly operational reports to submit to CMS as part of the broader 1115 demonstration Quarterly and Annual Monitoring Reports, as further described in STC 16.5.
- d. **State Reporting to External Stakeholders and Stakeholder Engagement.** The State must compile public-facing annual reports of ACO and CP performance.
  - i. The State must give stakeholders an opportunity to provide feedback on reports

12.10. **Stakeholder Engagement.** The State must allow for stakeholder engagement through meetings, access to web resources, and opportunities to provide feedback.

12.11. **DSRIP Accountability to the State.**

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

12.12. **Statewide Investments.** Statewide investments allow the Commonwealth to efficiently scale up statewide infrastructure and workforce capacity. These Statewide investments are

limited to those provided for by the DSRIP funding pool, and specified in the DSRIP protocol.

- a. Massachusetts will make eight different statewide investments to efficiently scale up statewide infrastructure and workforce capacity, including the following:
  - i. **Student Loan Repayment:** program which repays a portion of a student's loan in exchange for a minimum 18-month commitment (or equivalent in part-time service) as a (1) primary care provider at a community health center; or (2) behavioral health professional or licensed clinical social worker at a community health center, community mental health center, or an Emergency Service Program (ESP).
  - ii. **Primary Care Integration Models and Retention:** program that provides support for community health centers and community mental health centers to allow primary care and behavioral health providers to engage in one-year projects related to accountable care implementation.
  - iii. **Investment in Primary Care Residency Training:** program to help offset the costs of community health center residency slots for both community health centers and hospitals.
  - iv. **Workforce Development Grant Program:** program to support health care workforce development and training to more effectively operate in a new health care system
  - v. **Technical Assistance:** program to provide technical assistance to ACOs, CPs, or their contracted social service organizations as they participate in payment and care delivery reform.
  - vi. **Alternative Payment Methods (APM) Preparation Fund:** program to support providers that are not yet ready to participate in an ACO, but want to take steps towards APM adoption.
  - vii. **Enhanced Diversionary Behavioral Health Activities:** program to support investment in new or enhanced diversionary levels of care that will meet the needs of patients with behavioral health needs at risk for ED boarding within the least restrictive, most clinically appropriate settings.
  - viii. **Improved accessibility for people with disabilities and for whom English is a Second Language:** programs to assist providers in delivering necessary equipment and expertise to meet the needs of person with disabilities and those for whom English is not their primary language.
  - ix. **Information Domains for Each Statewide Investment:** The DSRIP Protocol will provide additional information for each statewide investment regarding the following domains (at a minimum):

1. Eligibility for funding;

2. Amount of funding available;
  3. Allowable funding uses; and
  4. Obligations for entities receiving funding support through the statewide investments.
- b. **State Operations and Implementation.** DSRIP expenditure authority includes necessary state operations and implementation support to help administer and provide robust oversight for the DSRIP program including state employees and vendors to provide the following support:
- i. ACO and CP administration, oversight, and operational support.
  - ii. Statewide investments administration, oversight, and operational support.
  - iii. DSRIP program support (e.g. project management, communications, evaluation and reporting).

#### 12.13. State DSRIP Accountability to CMS

- a. **At-Risk DSRIP Funding.** A portion of the State’s DSRIP expenditure authority will be at-risk. If MassHealth’s DSRIP expenditure authority is reduced based on an Accountability Score that is less than 100%, then MassHealth will reduce DSRIP payments in proportion to the reduced expenditure authority to ensure sufficient state funding to support the program. This mechanism ensures that all recipients of MassHealth DSRIP funding are accountable to the State achieving its performance commitments.
- b. The portion of the State’s DSRIP expenditure authority that is at-risk will follow the same at-risk Budget Period structure as for the ACOs. The Budget Period is January 1 through December 31, except for Budget Period 5 (January 1, 2022 - March 31, 2023). The final 2 quarters of Budget Period 5 (October 1, 2022-March 31, 2023) occur in this demonstration extension. No new DSRIP funding is authorized in this demonstration period, therefore, as authorized in the prior demonstration period, the total Budget Period 5 funds will be at-risk in accordance with the table below:

Table 11: Budget Period 5 At-Risk Funds	
DSRIP Budget Period	January 1, 2022–March 31, 2023
% of Expenditure Authority At- Risk	20%
Actual Expenditure Authority At- Risk	\$22.5M

- c. **State DSRIP Accountability Score.** The State will calculate the State’s DSRIP Accountability Score. See DSRIP Protocol Section 5.2. The State DSRIP Accountability will be based on performance in the following domains:
- i. MassHealth ACO/APM Adoption Rate
  - ii. Reduction in State Spending Growth

iii. ACO Quality and Utilization Performance

- d. Each domain will be assigned a domain weight for each performance year, such that the sum of the domain weights is 100% each year. State performance in each domain will be multiplied by the associated weight, and then summed together to create an aggregate score, namely the State's DSRIP Accountability Score. The State will report its Accountability Score to CMS once it is available, and the score will then be used by the State and CMS to determine whether the State's DSRIP expenditure authority might be reduced.
- e. **Corrective Action Plan for purposes of DSRIP Accountability.** In the event that the State does not achieve a 100% DSRIP Accountability Score, the State will provide CMS with a Corrective Action Plan including steps the State will take to regain any reduction to its DSRIP expenditure authority; and potential modification of accountability targets. The State's Corrective Action Plan will be subject to CMS approval.
- f. **MassHealth ACO/APM Adoption Rate for purposes of DSRIP Accountability.** The State will have target percentages for the number of MassHealth ACO-eligible lives served by ACOs or who receive services from providers paid under APMs. The State will calculate the percentage of ACO-eligible lives served by ACOs or who receive services from providers paid under APMs. The State must meet or surpass its targets in order to earn a 100% score on this domain. If the State does not meet the target, then it will earn a 0% score for that Budget Period.
- g. **Reduction in State Spending Growth for purposes of DSRIP Accountability.** The State and CMS agree to a detailed methodology for calculating the State's reduction in spending growth. In general, the State is, by CY2022, accountable to a 2.1% reduction in PMPMs for the ACO-enrolled population, off of "trended PMPMs" (described below). The State's trend line over the course of the DSRIP program is 4.4% annually, which is the "without waiver" trend rate calculated by CMS based on the 2017 President's Budget Medicaid Baseline smoothed per capita cost trend with all populations combined (2017-2022). This trend rate was applied to the base PMPM rate in CY2017 (i.e. pre-ACO). The trend is compounded over the five Budget Periods, and the percent reduction will be determined according to the following calculation: percent reduction = (trended PMPM minus actual PMPM) / (trended PMPM). Prior to CY2022, the State had target reductions smaller than 2.1% off of the trended PMPM.

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

  - i. Be for the ACO-enrolled population
  - ii. For the population enrolled in MCO-Contracted ACOs, be based on actual MCO expenditures for services to the population attributed to the ACO



(categories to be agreed upon by CMS and the State), and not on the State's capitated payments to the MCO

- iii. Include reductions in DSTI supplemental payments to safety net hospitals
- iv. Exclude Hepatitis C drugs, other high-cost emerging drug therapies (such as cystic fibrosis drugs and biologics), long-term services and supports (LTSS) costs, and other potential categories agreed upon by CMS and the State
- v. Allow for adjustments based on changes in population or acuity mix
- vi. Allow for adjustments based on higher than anticipated growth in MassHealth spending due to economic conditions in the state or nationally, or other reasons as agreed upon by CMS and the State.

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

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

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

i. **Overall Statewide Quality Performance for purposes of DSRIP Accountability.** MassHealth will annually calculate Statewide Quality performance by aggregating quality measure scores of all ACOs. Section 5.2.1.3 of the DSRIP protocol contains a detailed description of this calculation. ACO performance scores are based on preset attainment thresholds and goal benchmarks that have been agreed upon by the State and CMS as described in Section 5.3.1.2 of the DSRIP Protocol.

12.14. **Independent Assessor for purposes of DSRIP.** The state has identified independent entities with expertise in delivery system improvement to assist with DSRIP administration, oversight and monitoring, including an independent assessor and/or evaluator. An independent assessor will review ACO and CP proposals, progress reports and other related documents, to ensure compliance with approved STCs and Protocols, provided that initial ACO and CP proposals are not subject to review from the independent assessor. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to plans to make them approvable.

This entity (or another entity identified by the state) will also assist with the progress reports and any other ongoing reviews of DSRIP project plan; and assist with continuous quality improvement activities. Expenditures for the independent assessor are administrative costs the state incurs associated with the management of DSRIP reports and other data.

The state must describe the functions of each independent entity and their relationship with the state as part of its Quarterly and Annual Monitoring Report requirements, outlined in STC 16.5.

Spending on the independent entities and other administrative cost associated with the DSRIP fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the DSRIP Fund. The State may also claim FFP for expenditures related to these administrative activities using DSRIP expenditure authority.

- 12.15. **DSRIP Advisory Committee.** The state has developed and put into action a committee of stakeholders responsible for supporting the clinical performance improvement cycle of DSRIP activities. Until December 31, 2022, the Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement, and clinical data used in performance improvement initiatives, quality, and best practices.

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

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

- Selection of additional metrics for providers that have reached baseline performance thresholds or exceeded performance targets
  - Assessing the effectiveness of cross-cutting measures to understand how aspects of one system are affecting the other. For example, are BH/SUD/LTSS performance focus areas affecting physical health outcomes?
  - Alignment of measures between systems with purpose, to enable the state to assess the effectiveness in their outcomes across systems
  - Identify actionable new areas of priority,
  - Make systems-based recommendations for initiatives to improve cross-cutting performance.
- a. **Composition of the Committee.** The membership of the committee must consist of between nine to fifteen members with no more than three members employed by Massachusetts hospitals, ACOs or Community Partners. All members will be appointed by MassHealth based on the following composition criteria:
- i. Representation from community health centers serving the Medicaid population.

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

### 13. WORKFORCE INITIATIVES

To support workforce recruitment and retention to promote the increased availability of certain health care practitioners to serve Medicaid and demonstration beneficiaries, the Commonwealth shall implement student loan repayment and family nurse practitioner residency programs. The aim of these programs is to address shortages in qualified providers serving MassHealth members.

**13.1. Behavioral Health Student Loan Repayment.** The Commonwealth will make available the following student loan repayment programs:

- a. Up to \$300,000, per practitioner, for psychiatrists and nurse practitioners with prescribing privileges who make a 4-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 40% MassHealth and/or uninsured members.
- b. Up to \$50,000, per practitioner, for licensed behavioral health clinicians or masters-prepared clinicians (clinicians who have completed masters-level training but do not yet have the necessary licensure to practice independently) intending to obtain behavioral health practitioner licensure within one year of the award who make a 4-year commitment to practice full-time in a community-based setting serving at least 40 percent MassHealth and/or uninsured patients. If the clinicians do not receive licensure within one year of the award, they are ineligible for awards, and funding provided to them must be recouped with the federal share returned to CMS.

**13.2. Primary Care Student Loan Repayment.** The Commonwealth will make available up to \$100,000 for primary care physicians, and up to \$50,000 for advanced practice

registered nurses, pediatric clinical nurse specialists, nurse practitioners, and physician assistants, per practitioner, who make a four-year full-time service commitment in a community-based setting serving at least 40 percent MassHealth and/or uninsured patients.

- 13.3. **Family Nurse Practitioner (FNP) Residency Grant Program.** The Commonwealth will provide up to \$105,000 per residency slot to allow Community Health Centers (CHCs) to support up to 10 FNP residency slots per year for four years. Awards may be made only to CHCs whose patient populations are at least 40 percent of MassHealth beneficiaries. Eligible recipient organizations must demonstrate significant residency training experience and infrastructure, and must align programs with established standards for FNP residency training programs to meet a baseline of quality and standardization.
- 13.4. **Additional Terms and Operations of Student Loan Repayment and FNP Residency Programs.** For the demonstration behavioral health student and primary care student loan repayment programs, and the FNP residency grant program, the following shall apply:
- a. Loan repayments and residency payments may be made directly only to the student loan servicer (or CHC in the case of the FNP Residency Program) by either the Commonwealth or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.
    - i. For both program types, MassHealth will first pay the managing vendor(s), if any, the funds, so that it can then in turn make payments to either the loan servicers or the CHCs sponsoring the FNP residency programs.
    - ii. For the Student Loan Repayment Program, for each individual round of awarded practitioners, the managing vendor will make payments in two equal installments during the first two years of the four-year service obligations.
  - b. For each yearly issuance of funding for the Family Nurse Practitioner residency grant program, the managing vendor will make a single payment to each CHC covering one year's residency slot costs. MassHealth will ensure that the amount of the award does not exceed the cost of operating the slot at the CHC; if the award exceeds the cost of the residency slot, the award will be reduced so that it matches the cost of the slot.
  - c. The Commonwealth may have multiple rounds/cohorts of disbursements (i.e., awards to new individuals each year), so long as it does not expend beyond the applicable authorized level of funding for each program over the course of the demonstration or demonstration year, as applicable.
  - d. The Commonwealth shall have a process for ensuring that practitioners meet the qualifying service commitment. If the service commitment is not met, except in extraordinary circumstances as determined by the Commonwealth (e.g., disability or death), the Commonwealth shall recoup any student loan payments made on the

behalf of practitioners. In the case of recoupment, the Commonwealth shall return federal financial participation in those student loan payments to CMS.

- e. Specific to student loan repayments, the Commonwealth may only pay for each provider an amount up to the student loan amount owed by the provider. It may not pay an amount that exceeds an individual provider's student loan. Provider applicants may be eligible for different amounts of loan repayment based on their discipline and credentialing level, as determined by the Commonwealth. Only the student loan for educational costs associated with the course of study that led to the highest degree earned as a prerequisite to obtaining the relevant clinical credential may qualify for reimbursement under one of the student loan repayment programs.
- 13.5. For Residency Programs, the Commonwealth may only claim FFP for expenditures associated with residency slots that are filled by qualifying providers. In the event that an individual residency slot is not filled for the entirety of a year, the slot payment is pro-rated for the portion of the year that the residency slot was occupied. If the payment is made at the start of the year and the slot becomes unfilled mid-year, MassHealth will provide for recoupment and return of FFP if the slot is not re-filled within one month.
- 13.6. MassHealth may claim expenditures associated with the implementation of the Workforce Investment program, which are matchable as administrative expenditures, until no later than July 1, 2031, so long as the Commonwealth adheres with federal timely filing requirements. The expenditures will continue to be claimed on the CMS 64 on the specified waiver lines if the date where claims are made go beyond the demonstration period as part of this extension period. Allowable administrative expenditures under this authority include the specific costs of student loan repayments and residency slot payments, as well as the costs for monitoring the service commitments of providers for the repayment programs, as applicable. However, no payments for student loans or residency slots may be made following the demonstration period's expiration (December 31, 2027); any claimed expenditures after this date through July 1, 2031 must be only to pay close-out administrative costs of operating the program and monitoring service commitments.
- 13.7. Across all the student loan repayment and residency programs, the Commonwealth will define application criteria and eligibility, and then select awardees through a competitive process that will allow the State to evaluate the applicants relative to the criteria established. MassHealth may prioritize clinicians with cultural and linguistic competence that is likely to reflect and respond to the needs of the MassHealth population. The criteria must follow federal civil rights law and not impermissibly discriminate based on race, ethnicity, national origin, or any other federally protected classes or characteristics.

- 13.8. The funding table below shows the maximum amount of funding for each workforce initiative (including 15% administrative costs) by demonstration year.

Table 12: Workforce Funding by Initiative (in millions)						
	DY 28	DY 29	DY 30	DY 31	DY 32	Total
Behavioral Health Student Loan Repayment	\$0M	\$3.30M	\$6.70M	\$6.70M	\$3.30M	\$20.00M
Primary Care Student Loan Repayment	\$0M	\$3.10M	\$6.10M	\$6.10M	\$3.10M	\$18.40M
Nurse Practitioner Residency	\$1.21M	\$1.21M	\$1.21M	\$1.21M	\$0M	\$4.84M
Total	\$1.21M	\$7.61M	\$14.01M	\$14.01M	\$6.40M	\$43.24M

- 13.9. Subject to the total funding for each initiative in STC 13.8, the State may carry forward prior year workforce expenditure authority from one year to the next. The State must notify CMS of any changes to annual amounts in the quarterly and annual monitoring reports.

#### 14. HOSPITAL QUALITY AND EQUITY INITIATIVE

A key goal of the Commonwealth in this extension period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs and health disparities demonstrated by variation in quality performance. The MassHealth section 1115 demonstration includes expenditure authority for the Hospital Quality and Equity Initiative, which includes two components of the Commonwealth's statewide strategy to advance health quality and equity: specifically, the health quality and equity incentive programs for private acute hospitals and Cambridge Health Alliance (CHA).

- 14.1. **Description.** As specified in Table 13 below, CMS will authorize up to \$400 million (total computable) annually (except DY 27-28) in expenditure authority for participating private acute hospitals to improve health care quality and equity within the Commonwealth, and up to \$90 million (total computable) annually (except DY 27) in expenditure authority for Cambridge Health Alliance to improve health care quality and equity and develop interventions for both its Medicaid population and the uninsured individuals it serves. As part of this initiative, participating hospitals can earn a performance-based incentive payment for meeting data collection requirements, reporting expectations, and achieving quality and equity improvement standards that demonstrate improvement in health care quality and equity. The Commonwealth and participating hospitals will use the data to assess and address areas for improvement in health care quality and equity outcomes, which may include identification of disparities in health care delivery. The Commonwealth will require participating hospitals to conduct a Needs Assessment (defined in the Health Quality and Equity Initiative Implementation Plan) reflecting the healthcare needs of beneficiaries within the state. Participating hospitals may use existing community health needs assessments to inform this Needs Assessment. As part of this program, participating hospitals will also build organizational/workforce competence to

improve quality and health outcomes and reduce disparities, and enhance their ability to provide accessible and culturally appropriate services.

- a. In this program, the Commonwealth will pay hospitals solely based on their achievement on goals and corresponding progress as measured by performance on identified metrics as further described in STCs 14.3, 14.4, and 14.5; no direct funding is available for implementation, such as systems or infrastructure build-out, or for reimbursement of provider costs incurred in implementing the program.
- b. Unexpended incentive payment amounts are forfeited and not recoverable. Authorized expenditure amounts for one performance year cannot be combined, carried, shifted, or otherwise transferred across performance years in any circumstances; however, earned incentive payment based on one performance year may be paid in a subsequent performance year against the expenditure limit for the performance year on which the incentive payment is based, as necessary pursuant to operational processes to determine the final incentive payment amount.

<b>Table 13: Annual Expenditure Limits (in millions, total computable)</b>						
	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>
Private Acute Hospitals	\$80M	\$320M	\$400M	\$400M	\$400M	\$400M
CHA	\$22.5M	\$90M	\$90M	\$90M	\$90M	\$90M
Performance Years (PY)	PY 1		PY 2	PY 3	PY 4	PY 5

**14.2. Overview of Targeted Domains for Improvement.** The Commonwealth and participating hospitals will pursue performance improvements in the domains specified below, as part of the Hospital Quality and Equity Initiative. Details of each domain, including performance metrics, associated interventions (including assurance of compliance with the parameters on the scope of interventions noted in STC 14.12), and reporting expectations, are described further in STCs 14.3-14.5 and will be included within the Hospital Quality and Equity Initiative Implementation Plan that will be an attachment to these STCs.

- a. Domain 1: Demographic and Health-Related Social Needs Data

MassHealth and its participating hospitals will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the Commonwealth's data requirements as described in the Hospital Quality and Equity Initiative Implementation Plan. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, primary language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data

element. Details about the demographic data submission process must be described in the Hospital Quality and Equity Initiative Implementation Plan.

b. Domain 2: Equitable Quality and Access

MassHealth and its participating hospitals will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access; access for individuals with disabilities and/or limited English proficiency; access to preventive, perinatal, and pediatric care services; access to care for chronic diseases and behavioral health; and care coordination, as specified in the Hospital Quality and Equity Initiative Implementation Plan.

c. Domain 3: Capacity and Collaboration

MassHealth and its participating hospitals will be assessed on improvements in metrics such as provider and workforce capacity and collaboration between health system partners to improve quality and reduce health care disparities.

**14.3. Demographic and Health-Related Social Needs Data Collection Domain Goals**

- a. MassHealth will submit to CMS an assessment of beneficiary-reported demographic and health-related social needs data adequacy and completeness for purposes of the Hospital Quality and Equity Initiative by July 1, 2023.
- b. MassHealth and its participating hospitals will be incentivized through annual milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data by the end of PY 3 (DY 30), meaning that the Commonwealth must require participating hospitals to collect and submit data to the Commonwealth in a consistent format for at least 80 percent of beneficiaries who received care at participating hospitals as further defined in the Hospital Quality and Equity Initiative Implementation Plan.
- c. MassHealth and its participating hospitals will be incentivized through annual milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including at least primary language, disability status, sexual orientation and gender identity) by the end of PY 5 (DY 32), meaning that the Commonwealth must require participating hospitals to collect and submit data to the Commonwealth in a consistent format for at least 80 percent of beneficiaries who received care at Massachusetts participating hospitals as further defined in the Hospital Quality and Equity Initiative Implementation Plan.
- d. MassHealth and its participating hospitals will be incentivized to meaningfully improve rates of health-related social needs screenings from the baseline period by the end of PY 5 (DY 32). To meet this goal, hospitals must not only conduct screenings of beneficiaries, but establish the capacity to track and report on screenings and referrals. CMS and the Commonwealth will agree to the specific



annual goal through the Hospital Quality and Equity Initiative Implementation Plan, based on a background assessment of current hospital capacity on these aspects, focusing on aggressive but achievable improvement.

- e. For the purposes of measuring beneficiary-reported data completeness demographic and health-related social needs screening data, beneficiaries who affirmatively decline to provide a response (for example, by indicating in their response “refuse to respond” or “don’t know” or other applicable but consistent value) shall be considered to have reported for purpose of data completeness.

#### **14.4. Equitable Quality and Access Domain Goals**

- a. MassHealth and its participating hospitals will be incentivized for performance on metrics such as those related to access to care (including for individuals with limited English proficiency and/or disability), preventive, perinatal, and pediatric care, care for chronic diseases, behavioral health, care coordination, and/or patient experience. Subject to CMS approval and informed by the Needs Assessments, the Commonwealth will select a subset of measures from the following priority areas, at least three relevant measures from CMS’s Health Equity Measure Slate for hospital performance and at least seven for statewide performance:
  - i. maternal health (except as inapplicable if a hospital has a non-birthing hospital status);
  - ii. care coordination;
  - iii. care for acute and/or chronic conditions;
  - iv. patient experience of and/or access to care.
- b. Metric performance expectations shall be specified further in the Hospital Quality and Equity Initiative Implementation Plan and shall include, at a minimum:
  - i. Reporting on access and quality metric performance, including stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health-related social needs; and/or defined by other individual- or community-level markers or indices of social risk.
  - ii. Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics (including those identified in STC 14.2(b)(i) that account for clinical and social risk factors found through analysis to be associated with lower performance on such metrics and/or other appropriate individual- or community-level markers or indices of social vulnerability. Consistent with 42 CFR 440.262, such interventions may serve to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of sex (including sexual orientation and gender identity), and ensure that all beneficiaries

regardless of their demographic characteristics have access to covered services that are delivered in a manner that meets their unique needs. The interventions must also comply with the limits described in Section 14.11.

- iii. Improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics (including but not limited to those metrics outlined in STC 14.2(b)).
  - 1. For example, the Commonwealth may stratify health quality metric performance on a quantile basis within and/or between hospitals and provide incentive payments for improving the achievement of the lower-performing quantiles.
  - 2. For example, the Commonwealth may stratify health quality metric performance based on geographic or community-level markers of identified social risks and provide incentive payments for improving the achievement of metric performance among those members who reside in or are associated with these geographies/communities.
  - 3. For example, the Commonwealth may stratify health quality metric performance by demographic factors. However, if it chooses to do so, the Commonwealth must do so using a combination of multiple demographic and clinical factors and provide incentive payments for reducing the disparity between achievement of low performing and high performing groups among these stratifications. Such an incentive design as detailed in the Hospital Quality and Equity Implementation Plan must be calculated to reward performance on reducing disparities through increasing metric performance for lower-performing groups, and not where the disparity shrinks because of lower performance for previously higher-performing groups.
- c. For up to the first 3 performance years, performance will be based on expectations described in STCs 14.4(b)(i) and 14.4(b)(ii). For at least the last two performance years, performance will also be based on expectations described in STC 14.4(b)(iii), thus allowing adequate time to mitigate the lack of available and complete stratified data within the Commonwealth that would support the determination of benchmarks or baselines for tracking performance improvement on these dimensions at the time of initial initiative approval.

The measures and additional information on performance expectations and incentive payments will be further specified in the Hospital Quality and Equity Initiative Implementation Plan.

#### **14.5. Capacity and Collaboration Domain Goals.**

- a. MassHealth and its participating hospitals will be incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain

may relate to provider cultural competence and achievement of externally validated equity standards. The measures will ultimately be reviewed and approved by CMS, and the approved measures incorporated into the Hospital Quality and Equity Initiative Implementation Plan.

- b. MassHealth and its participating hospitals will be expected to meet a target of 80 percent of hospitals achieving rigorous standards regarding service capacity, access, and delivery of culturally and linguistically appropriate care by the end of PY 3 (DY 30), as established by a national quality or accreditation organization.

#### **14.6. Performance Assessment Methodology.**

- a. MassHealth will implement a performance assessment methodology that should encourage all participating hospitals to improve, including high-performing hospitals where there may be reduced opportunity for improvement as compared to other participating hospitals. This methodology should be consistent across measures and detailed in the Hospital Quality and Equity Initiative Implementation Plan.
  - i. For metrics described in STC 14.3 and 14.5, MassHealth must set performance targets (or benchmarks) and reward participating hospitals for improvement and/or achievement on the established benchmarks based on aggregate performance.
  - ii. For metrics described in STC 14.4, MassHealth must set performance targets (or benchmarks) and reward hospitals for improvement and/or achievement for the established benchmarks based on aggregate performance and stratified performance as described in STC 14.4(b)(iii), including by reducing observed performance disparities through improvement (and not through reduced performance for certain groups or quantiles).
- b. If a measure benchmark cannot be established by July 1, 2025 using Massachusetts-derived data, the impacted measure must be replaced by the Commonwealth, choosing a CMS-approved measure that is already widely used within Massachusetts (or for which reliable data to establish a valid benchmark are readily available). The Commonwealth will then establish a benchmark, using the alternative data, using the same methodology included in the approved Hospital Quality and Equity Initiative Implementation Plan unless modifications are required to accommodate differences between the intended data and the alternative data that will be used.
- c. The Commonwealth may use imputed data prior to full data collection to support disparities assessment only; payment to participating hospitals for completeness of demographic and health-related social needs data cannot be based on imputed data for either the benchmark or the performance period data, nor may imputed data be used in the calculation of stratified metrics that may form the basis for incentivize payment.

#### **14.7. Expenditure Authority Allocation Across Domains.**

- a. The expenditure authority (total computable) for the private acute hospitals in the Hospital Quality and Equity Initiative will be allocated by domains according to the following, across all performance years:

<b>Table 14: Expenditure Authority Annual Allocation by Domain</b>			
	<b>Domain 1: Demographic and Health-Related Social Needs Data Collection</b>	<b>Domain 2: Equitable Quality and Access</b>	<b>Domain 3: Capacity and Collaboration</b>
% of Annual Limit	25 percent	50 percent	25 percent
Annual Amount (\$)	\$100M	\$200M	\$100M

- b. Within each domain, individual subdomains and measures may be weighted evenly or differently, reflecting agreed upon MassHealth and CMS priorities, or the anticipated difficulty in implementing interventions that are expected to lead to improvements in the measures. Such weighting will be specified within the Hospital Quality and Equity Initiative Implementation Plan, subject to CMS approval.
- c. The Commonwealth may vary the incentive payment amount each participating hospital is eligible to earn, with safety net hospitals as identified by the Commonwealth eligible to earn a relatively larger incentive amount than non-safety net hospitals.

**14.8. Hospital Quality and Equity Initiative Implementation Plan.** The Commonwealth must submit a proposed Hospital Quality and Equity Initiative Implementation Plan describing activities to occur during PY 1 (DY 27 and DY 28) for CMS approval. FFP will be available retroactively to the beginning of the demonstration approval period for approved elements of the Hospital Quality and Equity Initiative Implementation Plan, should the state make qualifying expenditures prior to the Plan's approval. The Commonwealth is at risk for all expenditures until the Hospital Quality and Equity Initiative Implementation Plan is approved. Six months prior to the beginning of PY 2, the Commonwealth shall submit an addendum to the Implementation Plan to address the remaining performance years occurring in DY 29 through DY 32 for CMS review and approval. No FFP is available starting DY 29 until the addendum is approved by CMS. The Commonwealth may submit additional annual addenda for CMS review and approval in PY 2, PY 3, and PY 4 to reflect new data collected and reported under this initiative delineating new and emerging needs and learnings identified from the data, and other programmatic changes or stakeholder input. The Hospital Quality and Equity Initiative Implementation Plan will be appended to these STC as Attachment J. The Hospital Quality and Equity Initiative Implementation Plan must include the following information:

- a. Description of the statewide approach to advance healthcare quality and equity, including the relationship between state accountability metrics and the interventions at the health system level. For example, how the state will use metrics and health

outcomes data to inform future interventions toward improving overall quality of care, which in turn may also address equity goals.

- b. The Commonwealth will also discuss how its analysis (including Needs Assessment), which will identify areas for improvement across Domains, led to the selection of the measures and interventions within the Hospital Quality and Equity Implementation Plan. The analysis and/or Needs Assessment may be updated in subsequent years through PY 4 to reflect baseline health disparity data collected during the initial years of the Hospital Quality and Equity Initiative. The Commonwealth must submit these updates in the monitoring reports described in STC 16.5.
- c. Summarized approach of how the participating hospitals are expected to achieve the performance goals outlined, which will have been developed in collaboration with the health systems/providers.
- d. Conceptual framework that provides an overview of the initiatives, clinical strategies, staffing/HR changes, operational changes, systems changes, and other actions that will be undertaken by the hospitals using Hospital Quality and Equity Initiative payments.
- e. An overview of the Commonwealth's intended approach to a corrective action plan process in the event that providers are not on track to meet the expectations or objectives of the program, such as if providers are not on track to achieve defined performance targets in relation to metrics identified in the Hospital Quality and Equity Implementation Plan.
- f. Selected measures and their technical specifications for the Hospital Quality and Equity Initiative. The Commonwealth must have written permission from measure stewards to use their measures, as applicable. Validated and tested measures from nationally recognized measure stewards will be considered for use in this program; if such measures are not available to address program goals, additional measures may be selected or developed, subject to CMS approval. In the event that a measure is retired by a measure steward for any reason, the Commonwealth must replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within Massachusetts (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the findings from analysis and/or Needs Assessment. Measure technical specifications must be submitted for CMS review and approval as a separate document from the Implementation Plan. Following CMS approval, the Commonwealth must publish the approved technical specifications for transparency. Updates to approved technical specifications shall not require CMS approval insofar as the updates do not alter the intention of measures, but must be documented in Monitoring Reports and the technical specifications documents, as appropriate.
- g. Information about how the Commonwealth and its hospitals will identify beneficiaries with unmet HRSN needs or at risk of experiencing unmet HRSN, as

well as a description of the beneficiary eligibility for HRSN services criteria, implementation settings, any screening tools selected, and rescreening approach and frequency, as applicable.

- h. Information about how beneficiaries will be linked to services to address unmet health-related social needs, whether through social needs case management or alternative approaches, as applicable. The implementation plan should also describe how the Commonwealth will ensure that screening and services related to the demonstration are provided to beneficiaries in ways that are culturally appropriate and/or trauma informed.

14.9. **State and Hospital Risk for Health Quality and Equity.** Funding for the Hospital Quality and Equity Initiative will be at risk for each performance year, according to the following framework:

- a. Statewide accountability is applied prior to calculations of hospital accountability, so any reductions from statewide accountability apply to the global amount of funding from which hospital payments may be made, subject to the hospital accountability calculations described in STC 14.9(b), below.
  - i. The components of statewide accountability calculations include the following:
    - 1. Achievement of and/or improvement towards performance goals on the following measures across both Cambridge Health Alliance and participating hospitals in the Hospital Quality and Equity Initiative:
      - a. A selection of measures established for hospitals as described in STC 14.3, 14.4, and 14.5.
      - b. A selection of metrics agreed upon by CMS and the Commonwealth from the draft CMS Health Equity Measure Slate for DY 27 and DY 28, and the final CMS Health Equity Measure Slate for remaining performance years, upon its release; at least three of these agreed-upon metrics may be included in measures established for hospitals as described in 14.9(a)(i)(1)(a).
    - 2. Maternal Morbidity Measure (to be specified by CMS).
  - ii. Each statewide accountability component will be assigned a weight for each performance year in the Implementation Plan, such that the sum of the component weights is 100 percent each year. State performance in each component will be multiplied by the associated weight, and then summed together to create an aggregate score, which will be the State's Accountability Score. The state will report its Accountability Score to CMS once it is available, with supporting documentation showing the calculation of the score, and the score will then be used by the State and CMS to determine

whether the Commonwealth's Hospital Quality and Equity Initiative expenditure authority will be reduced for the relevant demonstration year. The maximum amount of funding at risk for statewide accountability is described in the table immediately below, and the actual amount of any reduction for a fiscal year will be determined according to a methodology agreed upon by the state and CMS in the Hospital Quality and Equity Initiative Implementation Plan.

<b>Table 15: Funding At-Risk by Demonstration Year</b>					
	<b>DY 27-28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>
Funding at risk for statewide achievement	5 percent	15 percent	20 percent	25 percent	25 percent
At-risk assigned by Performance years	PY 1	PY 2	PY 3	PY 4	PY 5

- b. Participating hospital performance is assessed individually by hospital and by domain and measure to determine whether the hospital has met the established targets for incentive payments. Each participating hospital must receive a domain-specific score, which are then weighted according to the methodology that is defined in the Implementation Plan. The aggregate score will be used to calculate the participating hospital's earned incentive payment.
  - c. Unearned payments to participating hospitals and expenditure limit reductions for the Commonwealth are forfeited and cannot be earned back in subsequent demonstration years. However, an earned incentive payment based on one performance year may be paid in a subsequent performance year against the expenditure limit for the performance year on which the incentive payment is based, as necessary pursuant to following operational processes to determine the final earned incentive payment amount.
- 14.10. **CMS Health Equity Measure Slate and Statewide Accountability.** MassHealth will incorporate into demonstration monitoring a selection of metrics agreed upon by CMS and the Commonwealth from the draft CMS Health Equity Measure Slate for DY 27/DY 28 and the final CMS's Health Equity Measure Slate upon its release, anticipated within 2023. The Health Equity Measure Slate will reflect CMS priorities and align with other CMS initiatives. MassHealth will be required to include reporting on applicable measures included within the CMS Health Equity Measure Slate, along with the reporting otherwise discussed within these STCs. The Commonwealth and CMS will agree on at least seven of these measures to be introduced as part of statewide accountability calculations; the measures chosen should be chosen from across each priority area category as provided in STC 14.4(a). Measures from the CMS Health Equity Measure Slate will not be required to be implemented as part of hospital accountability (i.e., three domains described in STCs 14.2-14.5).

- 14.11. **Limitations on Interventions.** The Commonwealth must ensure that the Commonwealth and its participating hospitals implement clinically appropriate interventions that are broadly accessible irrespective of race, ethnicity, national origin, religion, sex, or gender; and the Commonwealth shall ensure interventions are delivered in a culturally and linguistically competent manner. Interventions may be based upon health status and health needs, geography, and other factors not listed in the previous sentence only as relevant to the specific measure (e.g., current or past pregnancy status for maternal health measures). The Commonwealth must ensure compliance with Federal anti-discrimination statutes consistent with STC 3.1.
- 14.12. **State Oversight of Programs.** The Commonwealth must demonstrate ongoing performance oversight of health systems and participating hospitals receiving the Hospital Quality and Equity Initiative payments, including performance monitoring, a corrective action plan process, and a process for ensuring compliance with all applicable requirements, including those specified in STC 14.11. The Commonwealth is required to report findings from its performance assessments and any corrective action plans to CMS in its Quarterly and Annual Monitoring Reports, per STC 16.5.
- 14.13. **Claiming processes for Hospital Quality and Equity Initiative.** The Commonwealth is required to report expenditures for the program on the CMS-64 as prescribed within these STCs and follow applicable timely filing rules.
- a. The Commonwealth will incur administrative costs related to implementing and overseeing the Hospital Quality and Equity Initiative for the entirety of the demonstration period, but also related administrative closeout costs that may be claimed for up to two years following the conclusion of Performance Year 5.
  - b. The Commonwealth may only distribute incentive payments associated with Performance Years 1-5. Nothing in this STC restricts the Commonwealth from seeking an extension of the Hospital Quality and Equity Initiative expenditure authority.
- 14.14. **Independent Assessor for the Hospital Quality and Equity Initiative.**
- a. The state will identify independent entities with expertise in delivery system improvement to assist with Hospital Quality and Equity Initiative administration, oversight, and monitoring as may be appropriate, including the identification and engagement of an independent assessor. The Commonwealth must ensure that the independent assessor, in collaboration with other entities identified by the state as needed, will review proposals, progress reports and other related documents, to ensure compliance with the approved STCs, the Hospital Quality and Equity Initiative Implementation Plan, and any applicable Protocols. The Commonwealth must ensure that the independent assessor makes recommendations to the Commonwealth for program improvement. The independent assessor (or another independent entity identified by the Commonwealth) will also assist the Commonwealth with compiling data for progress reports, other ongoing reviews of



the Hospital Quality and Equity Initiative Implementation Plan, and any applicable protocols, and assist with continuous quality improvement activities.

- b. Spending on the independent entities and other administrative costs associated with the Hospital Quality and Equity Initiative fund is classified as a state administrative activity. The Commonwealth must ensure that all administrative expenditures for the independent entities are proper and efficient for the administration of the program.
- 14.15. **Provider Rate Increase Expectations.** As a condition of the Hospital Quality and Equity Initiative expenditure authority, Massachusetts must comply with the provider rate increase requirements in Section 21 of the STCs.
- 14.16. **Cambridge Health Alliance Hospital Quality and Equity Initiative Design and Goals.** CMS will authorize up to \$90 million (total computable) a year (except DY 27) for Cambridge Health Alliance (CHA) to implement a program that addresses health quality and equity for its patients, subject to the limitations outlined in STC 14.11 incorporating responsibility for both Medicaid beneficiaries and the uninsured. See table 16 in STC 14.17 for the annual expenditure authority limits and allocations for hospital performance (described in STC 14.18(a)) and ambulatory performance (described in STC 14.18(b)).
- 14.17. **Cambridge Health Alliance Hospital Quality and Equity Initiative Measurement.**
  - a. 70 percent of the incentive payment for CHA is allocated to CHA's performance on the Hospital Quality and Equity Initiative domains, which will be described within the Hospital Quality and Equity Initiative Implementation Plan. CHA is held to an aligned improvement methodology, measure selection, and benchmarking methodology for Medicaid beneficiaries as established in STC 14.6 for private acute hospitals. However, in addition to the Medicaid population, CHA will also be held responsible for the served uninsured population within its service area, which will be measured separately. Recognizing adaptation necessary for an uninsured population, the specific applicable domain elements, weighting, measurement, and performance assessment methodology, and attribution methodology for the uninsured population will be described within the CHA addendum to the Hospital Quality and Equity Initiative Implementation Plan.
  - b. 30 percent of the incentive payment for CHA is allocated to CHA's reporting and/or performance on ambulatory quality measures for the served uninsured population (e.g., controlling high blood pressure, HbA1c control) and payment may be based on both overall improvement and disparities reduction on those measures. Details of the methodology and measures will be described within the CHA addendum to the Hospital Quality and Equity Initiative Implementation Plan. In general, Massachusetts will calculate a total performance score based on CHA's performance on the approved measures. The total performance score will be used to determine the earned incentive payment.

- c. To determine the total earned incentive payment, the Commonwealth will sum the payment earned from CHA's performance described in STC 14.17(a) with payment earned in STC 14.17(b).

<b>Table 16: CHA Expenditure Authority Allotments (total computable)</b>						
	<b>DY 27</b>	<b>DY 28</b>	<b>DY 29</b>	<b>DY 30</b>	<b>DY 31</b>	<b>DY 32</b>
Hospital performance	\$15.75M	\$63M	\$63M	\$63M	\$63M	\$63M
Ambulatory performance	\$6.75M	\$27M	\$27M	\$27M	\$27M	\$27M
Total Annual Limit	\$22.5M	\$90M	\$90M	\$90M	\$90M	\$90M

- 14.18. **CHA Hospital Quality and Equity Initiative Implementation Plan.** The implementation plan for CHA's Hospital Quality and Equity Initiative will be an addendum to the Hospital Quality and Equity Initiative Implementation Plan as defined in STC 14.8 and must address the same content expectations specified in STC 14.8 related to 14.17(a) for the hospital-based Medicaid population, with adaptations necessary for the inclusion of the uninsured individuals served by CHA. The parameters for 14.17(b) will be included in the CHA addendum to the Hospital Quality and Equity Initiative Implementation Plan. The addendum describing PY 1 (DY 27 – DY 28) of the initiative must be submitted to CMS by January 30, 2023. Descriptions of activities occurring in PYs 2 through 5 (DY 29 – 32) must be included in the Implementation Plan addendum due no later than six months prior to PY 2, as defined in STC 14.8. To the extent MassHealth intends to make any changes to the CHA program's operation, it must submit the proposed change to the Hospital Quality and Equity Initiative Implementation Plan to CMS and receive approval prior to implementation of any changes. Updates to approved technical specifications shall not require CMS approval insofar as the updates do not alter the intention of measures, but must be documented in Monitoring Reports and the technical specifications documents, as appropriate. FFP cannot be claimed until the protocol is approved by CMS, but FFP may be claimed retroactively to the date of the initiative's approval, for approved elements of the CHA addendum to the Hospital Quality and Equity Initiative Implementation Plan.
- 14.19. **Statewide Accountability and Cambridge Health Alliance.** Cambridge Health Alliance's performance for Medicaid beneficiaries on the Hospital Quality and Equity Initiative will be an input into statewide accountability calculation, as described in STC 14.9. In the event that statewide accountability calculations lead to a reduction in expenditure authority for the Hospital Quality and Equity Initiative for a performance year, a proportionate reduction will be made to the CHA-specific program's expenditure authority.
- 14.20. **Budget Neutrality Treatment for Hospital Quality and Equity Initiative.** The expenditure authority for the Hospital Quality and Equity Initiative must be supported out of budget neutrality savings.

- 14.21. **Federal Matching Rate for Hospital Quality and Equity Initiative.** All expenditures for the Hospital Quality and Equity Initiative must be claimed as administrative on the applicable CMS 64.10 waiver form(s).
- 14.22. **Exclusion from Uncompensated Care Calculations.** Incentive payments under this authority shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the cost limit protocol approved under the demonstration authority, or the uncompensated care protocol.
- 14.23. **Hospital Quality and Equity Initiative Advisory Committee.** The Commonwealth will develop and convene a committee of stakeholders (Committee) who will be responsible for supporting the clinical performance improvement cycle of Hospital Quality and Equity Initiative activities. The Committee will serve as an advisory group offering expertise in health care quality measurement, equity measurement, quality and equity improvement, and clinical, demographic, and health-related social needs data used in performance improvement initiatives, quality, and best practices. Final decision-making authority over the demonstration will be retained by the Commonwealth (and CMS, as applicable), although the Commonwealth will consider all Committee recommendations.

## 15. HEALTH-RELATED SOCIAL NEEDS

Over the life of the MassHealth demonstration, the Commonwealth has taken steps to offer programs and services (e.g., Flexible Services and the Specialized Community Support Programs) that address health-related social needs (HRSN) for individuals meeting certain clinical and risk-based needs criteria. This section of the STCs establishes a framework for ongoing HRSN services and new services authorized through expenditure authority in order for the Commonwealth and CMS to better evaluate the effects of HRSN on the Medicaid population.

- 15.1. **HRSN Services Glide Path.** Given that MassHealth currently operates the Flexible Services Program, which is being modified through this framework, CMS will permit the Commonwealth until the beginning of DY 30 to come into compliance with the terms of this section within STC 15.7 through STC 15.9, and 15.13(b) and (c) for HRSN Flexible Services. Expectations for CSP-JI are addressed by STC 15.1(d) below. No other flexibility is provided.
- a. **HRSN Flexible Service Transition into Managed Care Delivery Systems.** By no later than January 1, 2025, Massachusetts will include coverage for HRSN Flexible Services into managed care delivery systems and comply with all Federal requirements, including those outlined in 42 CFR 438, and those outlined within Section 15 of the STCs. In order to demonstrate the Commonwealth is prepared to implement HRSN flexible services in managed care delivery systems, Massachusetts must complete key action steps within CMS's required timelines outlined below. In no event, shall this time-limited expenditure authority for this glide path extend beyond December 31, 2024. CMS reserves the right to ask for additional supporting documentation related to managed care implementation.

- i. If the Commonwealth faces unforeseen circumstances in meeting a required timeline for a key action step, it may formally request an extension to one of the required timelines specified in STC 15.1(a)(ii)-(vii). below, subject to CMS review and approval. The Commonwealth's extension request must include the required components outlined below and be submitted to CMS no later than 60 days prior to the required timeline associated with a key action step. Additionally, with an extension request, the Commonwealth must: (1) provide a description of the unforeseen circumstance impacting the Commonwealth's ability to meet a key action step within the required timeline; (2) propose a new timeline for meeting the required action step, including a description of why this requested new timeline is reasonable and appropriate; and (3) submit a Corrective Action Plan detailing the activities the Commonwealth will undertake to ensure no further delays in completing key action steps within the required timelines. In no event, shall the expenditure authority for this glidepath extend beyond December 31, 2024. CMS reserves the right to ask for additional supporting documentation or request a revised timeline related to the Commonwealth's extension request. An approved extension becomes a component of the 1115 and CMS will publish the extension, including all components outlined above, as an Attachment to the 1115.
- ii. By July 1, 2023, the Commonwealth must submit to CMS for review and approval a complete implementation plan outlining key action items and required timelines to implement HRSN flexible services into managed care delivery systems, including but not limited to the following key topics: (1) beneficiary rights and protections; (2) operations, data and system management; (3) payment/capitation rate development; (4) provider enrollment, service delivery and network adequacy.
- iii. By April 1, 2024, the Commonwealth must notify CMS if it intends to utilize a state directed payment(s) to direct the expenditures of its risk-based managed care plans related to HRSN flexible services, such as by requiring a minimum fee schedule or other payment arrangement, beginning January 1, 2025.
- iv. By July 1, 2024, the Commonwealth must submit a complete preprint(s) for the calendar year 2025 rating period if CMS determines that prior approval by CMS is required for any state directed payment(s), in accordance with 42 CFR 438.6(c).
- v. By August 1, 2024, the Commonwealth must submit draft managed care plan contract actions that incorporate HRSN flexible services in compliance with Federal requirements, including but not limited to, those outlined the framework described in the STCs and 42 CFR 438.
- vi. By October 1, 2024, the Commonwealth must submit calendar year 2025 rate certifications for all Medicaid managed care programs that incorporate HRSN flexible services into the risk-based capitation rates for MCOs and PIHPs that

provide HRSN flexible services. The rate certifications must include all necessary documentation outlined in the Medicaid Managed Care Rate Development Guide. The Primary Care ACOs may provide payment to providers for HRSN services consistent with the fee-for-service rates reviewed and approved by CMS.

vii. By October 1, 2024, the Commonwealth must submit the related executed managed care plan contract actions that incorporate HRSN flexible services in compliance with Federal requirements, including but not limited to, those outlined the framework described in the STCs and 42 CFR 438.

viii. By October 31, 2024, the Commonwealth must submit documentation of its completed readiness review consistent with the requirements outlined in 42 CFR 438.66(d).

b. **Flexible Services Transition to HRSN Fee-For-Service Framework.** For fee-for-service delivery systems, the Commonwealth must submit HRSN Flexible Service rates for CMS review and approval, following the expectations described in the HRSN Implementation Plan section below, by July 1, 2024. Following December 31, 2024, the Commonwealth must comply with all of the applicable requirements identified within Section 15 of the STCs.

c. The Commonwealth may submit an amendment at a future date in order to request any necessary changes to authorities or these STC to reflect its intended operational design for the program, but must comport with this framework and applicable regulations and statute.

d. **CSP HRSN Services Transition.** CSP for individuals with justice involvement (CSP-JI) Services will meet the requirements of this STC 15 as of April 1, 2023. Prior to April 1, 2023, CSP-JI will operate under the BH Diversionary Services construct, per STC 5.11.

15.2. **Health- Related Social Needs (HRSN) Services.** The Commonwealth may claim FFP for expenditures for certain evidence-based and allowable HRSN services identified in Attachment P and this STC, subject to the restrictions described below, including Section 21 of these STCs. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX or Title XXI, but consistent with Medicaid demonstration objectives that enable the Commonwealth to continue to increase the efficiency and quality of care. The Commonwealth is required to align clinical and health-related social needs criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the Commonwealth or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the Commonwealth be permitted to condition Medicaid coverage, or coverage of any

benefit or service, on receipt of HRSN services. Additional detail on covered services must be submitted to CMS for approval, outlining the name and description of each proposed HRSN service, the criteria for defining a medically appropriate population for each service, and the process by which that criteria will be applied, including care plan requirements or other documented processes as outlined in STC 15.6 and Attachment P.

**15.3. Allowable HRSN services.** The Commonwealth may cover the following HRSN services:

- a. Housing supports, including:
  - i. Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention.
  - ii. Housing transition navigation services.
  - iii. One-time transition and moving costs (e.g., security deposit, first-month's rent, utilities activation fees and payments in arrears, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture).
  - iv. Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification.
  - v. Medically necessary air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units as needed for medical treatment.
  - vi. Medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.
- b. Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees. This category includes the services authorized in the Community Support Program for Justice Involved individuals (CSP-JI).
- c. Nutrition Supports
  - i. Nutrition counseling and education, including on healthy meal preparation.
  - ii. Up to 3 meals a day delivered in the home, or private residence, for up to 6 months. Additional meal support is permitted when provided to the household of a child identified as high risk or pregnant individual, as defined in the risk and needs-based criteria, and in accordance with the Flexible Service Program requirements.
  - iii. Medically-tailored or nutritionally-appropriate food prescriptions (e.g., fruit and vegetable prescriptions, protein box), delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months.

- iv. Cooking supplies that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs (e.g., pots and pans, utensils, refrigerator).
  - d. Transportation to HRSN services for tenancy supports as described in 15.3(a) above and nutrition supports as described in 15.3(c) above.
- 15.4. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:
- a. Construction costs (bricks and mortar) or capital investments.
  - b. Room and board outside of specifically enumerated care or housing transitions.
  - c. Research grants and expenditures not related to monitoring and evaluation.
  - d. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting.
  - e. Services provided to individuals who are not lawfully present in the United States or are undocumented.
  - f. Expenditures that supplant services and activities funded by other state and federal governmental entities.
  - g. School-based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education and/or state or the local education agency.
  - h. Any other projects or activities not specifically approved by CMS as qualifying for coverage as a HRSN item or service under this demonstration.
- 15.5. **Covered Populations.** Expenditures for HRSN services may be made for the targeted populations specified below. To receive HRSN services, individuals in the target populations must have a documented medical need for the services and the services must be determined medically appropriate, as described in the HRSN Services STC 15.2, for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's HRSN service plan or medical record. Additional detail on targeted populations, including the clinical and other health-related social needs criteria, is outlined in Attachment P.
- a. **Flexible Services Program.** The Flexible Services Program targets MassHealth ACO-enrolled members ages 0 to 64, including individuals up to 12 months post-partum and their child(ren), who meet at least one of the health needs-based criteria and at least one risk factor defined by the Commonwealth in Attachment P. The Flexible Services program addresses the health-related social needs of

eligible individuals in the areas of housing and nutrition by providing access to tenancy preservation and nutrition sustaining supports.

- b. **Specialized Community Support Programs (Specialized CSPs).** MassHealth members, except MassHealth Limited members, who meet certain criteria related to behavioral health needs are eligible to receive specialized CSP services. Specialized CSP services are outreach and supportive services to enable beneficiaries to use clinical treatment services and other supports, as described below. The Specialized CSP provider does not provide clinical treatment services. Specialized CSPs may also provide support for transition between service settings, including connecting with the member just prior to discharge from an inpatient or 24-hour diversionary setting and supporting them through the transition to accessing outpatient and community-based services and supports. Services will vary with respect to hours, type and intensity of services depending on the changing needs of the beneficiary. The following Specialized CSPs will target populations in need of specialized supports.
  - i. **CSP for Homeless Individuals (HI).** CSP for Homeless Individuals (HI) is a more intensive form of CSP for members who are experiencing homelessness. Specialized services include assistance from specialized professionals who assist members in searching for housing opportunities, transitioning into community based housing, sustaining tenancy, and meeting their health needs.
  - ii. **CSP for Individuals with Justice Involvement (JI).** CSP for Individuals with Justice Involvement targets beneficiaries with justice involvement living in the community in need of specialized services to improve and maintain health while transitioning back to the community and to promote successful community tenure. Individuals with justice involvement living in the community are defined as covered individuals released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.
  - iii. **CSP Tenancy Preservation Program (TPP).** CSP-TPP is a specialized form of CSP that works directly with members with behavioral health needs who are facing eviction as a result of behavior related to their condition (rather than strictly non-payment of rent), in order to preserve tenancy.

- 15.6. **Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications.** The Commonwealth must complete and submit to CMS for approval a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services, in accordance with STC 15.1. This Protocol must include a list of the services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including service plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, and provider qualification criteria for each service. The Commonwealth must submit this Protocol for Assessment of Beneficiary Eligibility and



Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 calendar days of the approval of the 1115 demonstration extension. The Commonwealth must resubmit an updated Protocol, as required by CMS feedback on the initial submission. The Commonwealth may not claim FFP for HRSN service provision or HRSN infrastructure expenditures until CMS approves the Protocol, except as otherwise provided herein. Once approved, the Commonwealth can claim FFP for HRSN services and HRSN infrastructure retrospectively to the beginning of the extension approval date. Once approved, the Protocol will be appended to the STCs as Attachment P.

**15.7. Service Delivery.** Consistent with the managed care contract and guidance:

a. Terms applicable to all HRSN Services.

- i. Any applicable HRSN 1115 services that are delivered by managed care plans must be included in the managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and (r).
- ii. HRSN 1115 services may be paid on a fee-for-service basis when provided by the Commonwealth. HRSN 1115 services, when provided by a managed care plan, must be paid as outlined below. The Commonwealth must also comply with STC 15 for all HRSN services.
- iii. When HRSN (i.e., HRSN services defined in STC 15.3 for the covered populations outlined in STC 15.5) is included in risk-based capitation rates, HRSN services should be reported in the MLR reporting as incurred claims. Managed care plans should not report HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates.
  1. The Commonwealth must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, in accordance with STC 15.1. The Commonwealth may submit this process to CMS at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov). This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The Commonwealth's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

b. Terms applicable to Specialized CSP HRSN Services

- i. Specialized CSP HRSN services will be available through the fee-for-service and managed care delivery systems.
- ii. Specialized CSP HRSN services, pursuant to STC 15, when provided by MassHealth MCOs, BH PIHP, and Accountable Care Partnership Plans, must be included within the risk-based capitation rates, and must be submitted to CMS for review and approval in accordance with 42 CFR 438.4(b) and 438.7(a).

c. Terms applicable to Flexible Services HRSN Services

- i. Flexible Services HRSN Services will only be available to enrollees of Primary Care ACOs and Accountable Care Partnership Plans.
- ii. Primary Care ACOs, and Accountable Care Partnership Plans provide HRSN Flexible Services authorized under this demonstration through contracted network providers, as further described in STC 15.7.
- iii. The Commonwealth may allow Primary Care ACOs and Accountable Care Partnership Plans to offer the Flexible Services HRSN services statewide or in some or all geographic areas in which the plan operates.
- iv. The Commonwealth must require that each Primary Care ACOs and Accountable Care Partnership Plans report to the state Medicaid agency, the geographic areas in which it intends to offer the Flexible services HRSN services and any sub-area limitations on the availability of the service. Primary Care ACOs and Accountable Care Partnership Plans must receive state approval and provide public notice of any such limitations on each Flexible service including specifying such limitations in the enrollee handbook.
- v. HRSN Flexible Services, pursuant to STC 15.4(a), will be paid as follows, as of January 1, 2025:
  1. The Primary Care ACOs (PCCM entities) may provide payment to providers for Flexible Services, consistent with the fee-for-service rates reviewed and approved by CMS.
  2. For Accountable Care Partnership Plans, it is permissible for Flexible Services HRSN Services to be provided as a non-risk payment. For a non-risk payment, the MCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR § 447.362 and may be reimbursed by the Commonwealth at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR § 447.362 is the fee-for-service authorized in this demonstration for Flexible Services paid on a fee-for-service basis by MassHealth. If the Commonwealth chooses instead to incorporate the Flexible Services HRSN Services into the risk-based capitation rates it must comply with all applicable Federal requirements, including but not limited to 42 CFR §§ 438.4, 438.5 and 438.7.
- vi. MassHealth may offer Primary Care ACOs and Accountable Care Partnership Plans the option to newly offer Flexible Services HRSN services or change their election from time to time and may make or change such election pursuant to the terms of their contract with the Commonwealth. Any change to the coverage of Flexible Services HRSN services requires an amendment to

the Commonwealth's contracts with the Primary Care ACOs and Accountable Partnership Plans that requires CMS review and approval in accordance with 42 CFR 438.3(a) and (r). Additionally, when Flexible Services HRSN services are included in risk-based capitation rates for the Accountable Care Partnership Plans, the Commonwealth's actuary must evaluate if a rate amendment is necessary to ensure actuarially sound capitation rates in accordance with 42 CFR 438.4. The Commonwealth or managed care plan must also provide adequate notice to beneficiaries.

- vii. MassHealth may permit Primary Care ACOs and Accountable Care Partnership Plans to discontinue offering Flexible Services HRSN services with notice to the state Medicaid agency, and beneficiaries, at the Commonwealth's discretion. When a managed care plan ceases to offer Flexible Services HRSN service to its enrollees, the Commonwealth or the plan, as directed by the Commonwealth, must develop a transition of care policy to ensure enrollee protections as well as minimal disruption of care and adequate access to state plan services and settings. The Commonwealth must also modify the corresponding managed care contracts and submit the modified contracts to CMS as required in 42 CFR 438.3(a). Additionally, the Commonwealth must adjust payment as needed to either remove the non-risk payment if the HRSN is reimbursed in that manner, or if the HRSN is included within the risk-based capitation rate it should be revised, as needed, to remove utilization and cost of the HRSN from capitation rates as required in § 438.7(a) and § 438.7(c)(2).

#### **15.8. Contracted Providers.**

- a. Specialized CSP HRSN Services, applicable as of April 1, 2023
  - i. MassHealth, MassHealth MCOs, BH PIHP, and Accountable Care Partnership Plans will contract with specialized CSP service providers ("Contracted Providers") to deliver the specialized CSP HRSN services authorized under the demonstration.
  - ii. MassHealth, MassHealth MCOs, BH PIHP and Accountable Care Partnership Plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the specialized CSP services being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable, based on the services being furnished or activities being performed by the staff.
- b. Flexible Services HRSN Services, applicable as of January 1, 2025
  - i. MassHealth, Primary Care ACOs, and/or Accountable Care Partnership Plans may contract with HRSN service providers ("Contracted Providers") to

deliver the Flexible Services HRSN services authorized under the demonstration.

- ii. MassHealth, Primary Care ACOs, and/or Accountable Care Partnership Plans should establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the Flexible Services HRSN services being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable, based on the services furnished or activities being performed by the staff.
- iii. Any state direction on the payment arrangement for Flexible Services HRSN that constitutes a state directed payment must satisfy the requirements in 42 CFR 438.6(c).

15.9. **Provider Network Capacity.** As of April 1, 2023, the Commonwealth must require MassHealth MCOs, BH PIHP and/or Accountable Care Partnership Plans to ensure the Specialized CSP HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the specialized CSP HRSN services, in accordance with the MassHealth MCOs, BH PIHP and/or Accountable Care Partnership Plans contracts and other state Medicaid agency guidance.

As of January 1, 2025, the Commonwealth must require Primary Care ACOs and Accountable Care Partnership Plans to ensure the Flexible Services HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the Flexible Services HRSN services, in accordance with the Primary Care ACOs' and Accountable Care Partnership Plans' contracts and other state Medicaid agency guidance.

The Commonwealth must provide comparable protections and network adequacy as described within this STC to beneficiaries provided HRSN within fee-for-service delivery systems as of January 1, 2025.

15.10. **Compliance with Federal Requirements.** The Commonwealth shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

15.11. **Person Centered Plan.** As of January 1, 2025, the Commonwealth shall ensure there is a service plan for each individual receiving HRSN services that is person-centered, identifies the member's needs and individualized strategies and interventions for meeting those needs, and is developed in consultation with the member and member's chosen support network, as appropriate. The service plan is reviewed, and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

- 15.12. **Conflict of Interest.** The Commonwealth shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The Commonwealth also agrees that appropriate separation of service planning and service provision functions are incorporated into the Commonwealth's conflict of interest policies.
- 15.13. **Medicaid Beneficiary Protections.** As part of the Commonwealth's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the Commonwealth must provide documentation including, but not limited to:
- a. Beneficiary and plan protections, including but not limited to:
    - i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.
    - ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.
    - iii. Medicaid beneficiaries who are offered or utilize an HRSN retain all rights and protections afforded under part 438.
    - iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested those services, or have received these services in the past.
    - v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.
  - b. Managed care plans must timely submit any related data requested by the Commonwealth or CMS, including, but not limited to:
    - i. Data to evaluate the utilization and effectiveness of the HRSN services.
    - ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and/or supplemental reporting on health outcomes and any disparities. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.
    - iii. Any data necessary to monitor appeals and grievances for beneficiaries.
    - iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.
    - v. Any data determined necessary by the Commonwealth or CMS to monitor and oversee the HRSN initiatives.

- c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:
    - i. The managed care plans must submit timely and accurate encounter data to the Commonwealth for beneficiaries eligible for HRSN services. The Commonwealth must seek CMS approval on what is considered appropriate and reasonable timeframe for plan submission of encounter data. When possible, this encounter data must include data necessary for the Commonwealth to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the Commonwealth.
    - ii. Any additional information requested by CMS, the Commonwealth or a legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the Commonwealth, CMS, or a legally authorized independent entity.
    - iii. The Commonwealth must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on its progress in building and sustaining its partnership with existing housing and nutrition agencies to utilize their expertise and existing housing and nutrition resources and avoiding duplication of efforts.
    - iv. Any additional information determined reasonable, appropriate and necessary by CMS.
- 15.14. **Maintenance of Effort (MOE).** The Commonwealth must maintain level state funding for social services related to housing transitions supports and nutrition supports for the duration of the demonstration. In accordance with STC 15.1, within 90 days of demonstration approval, the Commonwealth will submit a preliminary plan to CMS as part of the HRSN Implementation Plan that outlines how it will determine baseline spending on these services throughout the Commonwealth. The Commonwealth will submit a final version of this plan as part of its complete HRSN Implementation Plan, due by July 1, 2023. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 16.6, including any justifications necessary to describe the findings.
- 15.15. **Partnerships with State and Local Entities.** The Commonwealth must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care program, local housing authorities, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The Commonwealth will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and other

supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly and Annual Monitoring described in STC 16.6, the Commonwealth will provide the status of the Commonwealth's fulfillment of its plan and progress relative to timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the Commonwealth's plan is fully implemented then the Commonwealth may conclude its status updates in the Monitoring Reports.

- 15.16. **HRSN Implementation Plan.** The Commonwealth is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The Implementation Plan can be updated as initiatives are changed or added. CMS will provide a template to support this reporting that the Commonwealth will be required to use to help structure the information provided and prompt the Commonwealth for information CMS would find helpful in approving the Implementation Plan. The Commonwealth must submit a partial Implementation Plan within 90 calendar days after approval of this demonstration, in accordance with STC 15.1. A complete Implementation Plan is due on July 1, 2023, per the terms in this STC and STC 15.1. The Commonwealth must submit further clarifications or revisions to information submitted in the Implementation Plan if required by CMS feedback within 60 calendar days after receipt of CMS's comments. Once approved, the Implementation Plan will be appended as Attachment T, and, once appended, may be altered only with CMS approval.

At a minimum, the Implementation Plan must provide a description of the Commonwealth's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

The Implementation Plan must include information on, but not limited to, the following:

- a. To the extent the information is not already provided in the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications (per STC 9.6), the Implementation Plan must add any outstanding details or updates on:
  - i. Process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.
  - ii. Process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.

1. Plan to identify specific diagnosis or procedure codes (e.g., ICD-10, CPT, HCPCS codes) that the Commonwealth will use to operationalize the criteria;
  2. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and other stakeholders;
- b. Process for developing care plans based on assessment of need:
- i. Plan to initiate care plans and referrals (with feedback to the referring provider or entity that the referral has been completed and information about any referred services furnished) to social services and community providers based on outcomes of the screening.
  - ii. Information about (1) how and on what timeline beneficiaries will be linked to services to address unmet social needs, and (2) how and when beneficiaries will receive follow up with a care plan, through social needs case management or alternative approaches, as applicable, the timeframe in which beneficiaries will be linked to services, the approach to follow-up, who will conduct the linkage and follow-up, and the approach to developing care plans, if applicable.
  - iii. Description of how the Commonwealth will ensure that screening and services related to the demonstration are provided to beneficiaries in ways that are culturally appropriate and/or trauma informed.
- c. Medicaid services to which beneficiaries could be referred.
- d. Plans for technical assistance, quality improvement, and sustainability planning.
- e. Plan for establishing and/or improving data sharing and partnerships with an array of health and social system stakeholders to the extent those entities are vital to provide needed data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.
- f. Information about key partnerships, capacity building for community partners, and how the Commonwealth will solicit and incorporate input from impacted groups, such as community partners, health care delivery system partners, and beneficiaries.
- g. Information technology infrastructure to support data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision. A plan for tracking and improving upon the share of Medicaid beneficiaries who are eligible and enrolled in SNAP and WIC, relative to the number eligible.



- h. Implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout that can facilitate robust evaluation designs if these implementation strategies are culturally appropriate.
- i. Information as required per STC 15.14 (MOE).
- j. Documentation of existing partnerships with state and local entities (e.g., Department of Housing and Urban Development, Continuum of Care program, local housing authority, SNAP state agency) and plan to ensure that pathways to non-Medicaid funding sources of housing and other supports are available upon the conclusion of temporary Medicaid reimbursement.
- k. Information as required per STC 15.15 (Partnerships with State and Local Entities).
- l. All rate/payment methodologies for authorized HRSN services outlined in the STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to fee-for-service payment as well as non-risk payments, capitation rates and PCCM entity payment in managed care delivery systems, as part of the Implementation Plan at least 60 days prior to implementation. The Commonwealth must submit all documentation requested by CMS, including but not limited to: the payment rate methodology as well as other documentation and supporting information (e.g., Commonwealth responses to Medicaid non-federal share financing questions). The Commonwealth must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting fee-for-service payment rates.
- m. Alignment with other state initiatives.

Failure to submit a HRSN Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the HRSN services initiative under this demonstration.

#### **15.17. HRSN Infrastructure Investments: Social Service Organization (SSO) Integration Fund**

- a. Up to \$8 million (total computable) in expenditure authority will be made available for the first 4 years of the demonstration, in order for the Commonwealth to support the development and implementation of HRSN services. Funding will be available for the following activities, subject to the exclusions in STC 15.4:
  - i. Technology – e.g., electronic referral systems, shared data platforms, EHR adaptations or data bridges, screening and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems.

- ii. Developing business or operational practices to support delivery of Flexible Services – e.g., developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.
  - iii. Workforce development – e.g., cultural competency training, trauma-informed training, Community Health Worker (CHW) certification, training staff on new policies and procedures.
  - iv. Outreach and education – e.g., design and production of outreach and education materials, translation, obtaining community input.
- b. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The Commonwealth must ensure there is no duplication of funds. HRSN infrastructure funding must be claimed at the applicable administrative match rate.
  - c. To the extent the Commonwealth requests any additional Social Service Organization Infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS’s consideration.
  - d. The Commonwealth may not claim any FFP for Social Service Organization Infrastructure funding until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications is approved. Once approved, the Commonwealth can claim FFP for HRSN Social Service Organization Infrastructure funding retrospectively to the beginning of the extension approval date.
- 15.18. **Provider Rate Increase Expectations.** As a condition of the HRSN and Hospital Quality and Equity Initiative expenditure authority, Massachusetts must comply with the provider rate increase requirements in Section 21 of the STCs.

## 16. MONITORING AND REPORTING REQUIREMENTS

- 16.1. **Submission of Post-approval Deliverables.** The Commonwealth shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs (“deliverables”). The Commonwealth shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.
- 16.2. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to be not consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The Commonwealth does not relinquish its rights provided under

42 CFR part 430 subpart C to challenge any CMS finding that the Commonwealth materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due, if the Commonwealth has not submitted a written request to CMS for approval of an extension as described in subsection (b) below, or 2) 30 calendar days after CMS has notified the Commonwealth in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the Commonwealth providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the Commonwealth may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps that the Commonwealth has taken to address such issue, and the Commonwealth's anticipated date of submission. Should CMS agree in writing to the Commonwealth's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the Commonwealth fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the Commonwealth.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the Commonwealth submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outline in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

- 16.3. **Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate section 1115 demonstration reporting and analytics functions, the Commonwealth shall work with CMS to:

- a. revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.
- b. ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the Commonwealth; and
- c. submit all deliverables to the appropriate system as directed by CMS.

16.4. **Monitoring Protocol for Other Policies.** The Commonwealth must submit to CMS, no later than 150 days after approval of the demonstration, a Monitoring Protocol addressing components of the demonstration not covered by the SUD and SMI/SED Monitoring Protocols (e.g., hospital health equity framework, workforce development initiatives, continuous eligibility, premiums, and waivers of retroactive eligibility). The Commonwealth must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol for Other Policies will be incorporated in the STCs as Attachment K. In addition, the Commonwealth must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol will affirm the Commonwealth's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the Commonwealth will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 16.5(b)), the Commonwealth is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the Commonwealth's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the Commonwealth's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the Commonwealth's HRSN initiatives authorized through this demonstration, the Monitoring Protocol requires specifying selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines. CMS underscores the importance of the Commonwealth's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in

Medicaid/CHIP (e.g., the National Quality Forum (NQF) “disparities-sensitive” measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers. The Monitoring Protocol must also outline the Commonwealth’s planned approaches and parameters to track performance relative to the goals and milestones, as provided in the Implementation Plan, for the HRSN infrastructure investments.

Furthermore, for HRSN initiatives, the Commonwealth must describe in the Monitoring Protocol its plans and methods to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics, as applicable. These sources may include, but are not limited to (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or housing assistance), (3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable), and (4) social needs screening results from electronic health records, health plans, or other partner agencies as applicable. Across data sources, the Commonwealth must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

For the qualitative elements (e.g., operational updates as described in STC 16.5(a) below), CMS will provide the Commonwealth with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the Commonwealth’s Quarterly and Annual Monitoring Reports.

**16.5. Quarterly and Annual Monitoring Reports.** The Commonwealth must submit three Quarterly Reports and one Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 days following the end of each demonstration quarter. The Annual Report (including the fourth quarter information) is due no later than 90 days following the end of the DY. The Commonwealth must submit a revised Monitoring Report within 60 days after receipt of CMS’s comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

- a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The Commonwealth must also share findings and updates on other demonstration components, including (but not limited to): primary care payment oversight activities (e.g., auditing of PCPs); the volume and nature of beneficiary support system contacts and the resolution of such contacts; findings from ACO and CP quarterly operation reports; HRSN infrastructure investments, and findings from performance

assessments and corrective action plans related to oversight of health systems and providers receiving health equity incentive funding. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

- b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the Commonwealth is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration’s program and policy implementation and infrastructure investments, and must cover all key policies under this demonstration. Metrics in the Commonwealth’s Monitoring Reports must cover key policies under this demonstration, including but not limited to SUD, SMI/SED, the hospital health quality framework, continuous eligibility, workforce development initiatives, HRSN demonstration component, premiums, and waivers of retroactive eligibility. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries’ outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

The Commonwealth’s metrics reporting must cover categories to include, but not limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, enrollment by premium payment status, unpaid medical bills at time of application, and quality of care and health outcomes. The Commonwealth must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration’s policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration component—to the extent feasible—to identify existing inequities and track progress towards reducing inequities. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration’s initiatives help improve outcomes for the Commonwealth’s Medicaid population, including the narrowing of any identified disparities.

In addition to the SUD and SMI/SED metrics, for each of the demonstration components listed below, the Commonwealth should report metrics related (but not limited) to:

- i. For the Hospital Quality and Equity Initiative, in coordination with CMS and in alignment with a critical set of health equity measures CMS is finalizing,

the Commonwealth's reporting of quality of care and health outcomes metrics must represent a critical set of health equity-focused measures from CMS's upcoming guidance on Health Equity Measure Slate.

- ii. For the workforce initiatives component, the Commonwealth must monitor, for example, the numbers of students (primary care and behavioral health) and family nurse practitioners supported through the loan repayment and residency grant programs under the demonstration, provider tenure, the demographic makeup of providers.
- iii. For the HRSN initiatives, in addition to reporting on the metrics described above, the Commonwealth must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the Commonwealth or partner entities assisting in the administration of the demonstration and social services organizations. Specifically, in the context of the HRSN initiatives, the Commonwealth's enrollment and renewal metrics must capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible.

In addition, if the Commonwealth, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the Commonwealth must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics.

- iv. In addition to the enrollment and renewal metrics that support tracking Medicaid churn, systematic monitoring of the continuous eligibility policy must—at a minimum—capture data on utilization of preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.
- v. To monitor premiums and premium assistance policies, the Commonwealth must report metrics including (but not limited to) the number of beneficiaries subject to these policies, enrollment continuity and disenrollment rates, and third-party payment. Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.
- vi. For the waiver of retroactive eligibility, the Commonwealth must report the number of beneficiaries who indicated they had unpaid medical bills at the

time of application, and information about beneficiaries who experienced a gap in coverage.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

- c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The Commonwealth must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the Commonwealth must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.
- d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. The Commonwealth shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

**16.6. Monitoring Calls.** CMS will convene periodic conference calls with the Commonwealth.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, the status of investment submissions, and progress on evaluation activities.
- b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The Commonwealth and CMS will jointly develop the agenda for the calls.

**16.7. Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the Commonwealth to submit a correction action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change,



inconsistent with state targets and goals, as applicable, and the Commonwealth has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

- 16.8. **Post-Award Forum.** Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

## 17. EVALUATION OF THE DEMONSTRATION

- 17.1. **Independent Evaluator.** The Commonwealth must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the Commonwealth may request, and CMS may agree to changes in the methodology in appropriate circumstances.
- 17.2. **Cooperation with Federal Evaluators and Learning Collaboration.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration, the Commonwealth shall cooperate fully and timely with CMS and its contractors' evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The Commonwealth shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required of the Commonwealth under 42 CFR 431.420(f) to support federal evaluation. This may also include the Commonwealth's participation—including representation from the Commonwealth's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The Commonwealth may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 16.2.

17.3. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

17.4. **Draft Evaluation Design.** The Commonwealth must submit, for CMS comment and approval, a draft Evaluation Design for this demonstration approval period no later than 180 calendar days after the approval date of the demonstration. The Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to): (1) Attachment A (Preparing the Evaluation Design) of these STCs, and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the Commonwealth is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The Commonwealth is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 17.7 and 17.8.

For any amendment to the demonstration, the Commonwealth will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the Commonwealth may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the Commonwealth's Interim (as applicable) and Summative Evaluation Reports, described below.

17.5. **Evaluation Design Approval and Updates.** The Commonwealth must submit a revised Evaluation Design within 60 days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment S of these STCs. Per 42 CFR 431.424(c), the Commonwealth will publish the approved Evaluation Design to its Medicaid website within 30 days of CMS approval. Once CMS

approves the Evaluation Design, if the Commonwealth wishes to make changes, the Commonwealth must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the Commonwealth may include updates to the Evaluation Design in Monitoring Reports.

- 17.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the Commonwealth intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the Commonwealth undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components including premiums and the waiver of retroactive eligibility, beneficiary experiences with access to and quality of care, as well as changes in incidence of beneficiary medical debt. The Commonwealth is also strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the Commonwealth's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. To the extent feasible, the Commonwealth must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

As part of its evaluation efforts, the Commonwealth must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The Commonwealth must analyze the budgetary effects of the HRSN services, and the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the Commonwealth must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the Commonwealth's Medicaid program.

The Commonwealth must develop evaluation questions and hypotheses related to each demonstration component. Examples include, but are not limited to:

- a. **SUD Treatments.** Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include (but are not limited to): initiation and engagement with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.
- b. **SMI Services.** Hypotheses for the SMI program must include an assessment of the objectives of the SMI component of this 1115 demonstration. Examples include (but are not limited to): utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination.
- c. **Hospital Quality and Equity Initiative.** The Commonwealth's evaluation efforts must also include developing thoughtful hypotheses and research questions to assess the effectiveness of the Hospital Quality and Equity Initiative in ensuring provision of consistent high-quality care to all beneficiaries, and must provide evidence of the Commonwealth's efforts to collect stratified data for selected performance measures. The evaluation of the Initiative must also include robust analyses that help demonstrate whether the Commonwealth is succeeding in improving the quality and completeness of reporting on stratified data elements.
- d. **Workforce Development.** The Commonwealth must evaluate whether the targeted loan repayment and residency grant programs, and any other authorized workforce initiatives under the demonstration, improve access to covered services for Medicaid beneficiaries. To that end, the Commonwealth must investigate—to the extent feasible—the effects of the workforce initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention, especially in the concentration areas such as primary care, behavioral health and family practice. Because these initiatives may affect a small number of providers, the Commonwealth is strongly encouraged to use a mixed-

methods approach that would incorporate qualitative data sources, including interviews and/or focus groups with participating providers, and beneficiary experience surveys.

- e. **HRSN.** Evaluation hypotheses for the HRSN initiatives in the demonstration must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include an analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. In alignment with the demonstration's objectives to improve outcomes for the Commonwealth's overall beneficiary populations eligible for the HRSN initiatives, the Commonwealth must also include research questions and hypotheses focused on understanding the impact of HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing, nutrition and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. It is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

- f. **Continuous Eligibility.** For the continuous eligibility policy, the Commonwealth must evaluate the impact of the program on all relevant populations appropriately tailored for the specific time span of eligibility. For example, the Commonwealth must evaluate how the continuous eligibility policy affects coverage, enrollment, and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled and re-enroll within 12 months), as well as population-specific appropriate measures of service utilization and health outcomes. The Commonwealth must also evaluate the effectiveness of the continuous eligibility authority. For example, for the Commonwealth's populations of focus under the demonstration's continuous eligibility policy, to the extent feasible, the Commonwealth may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the Commonwealth's

administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the Commonwealth may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

- g. **Premiums and Premium Assistance.** The Commonwealth must include hypotheses including (but not limited to): beneficiary access to and utilization of preventive, primary, specialist, and emergency services; enrollment continuity, number and frequency of coverage gaps, and disenrollment rates; and beneficiary experiences with care.
- h. **Waiver of Retroactive Eligibility.** Hypotheses for the waiver of retroactive eligibility must include an assessment of the outcomes of the retroactive eligibility component of this section 1115 demonstration. Examples include (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, health status, and beneficiary medical debt, which can be assessed through a beneficiary survey or using data obtained from credit bureaus.
- i. **Delivery System Reform.** The following are among the hypotheses to be considered in development of the Evaluation Design and will be included in the design as appropriate:
  - i. the formation of new partnerships and collaborations within the delivery system;
  - ii. the increased acceptance of TCOC risk-based payments among MassHealth providers;
  - iii. improvements in the member experience of care, particularly through increased member engagement in the primary care setting or closer coordination among providers; more robust EHR and other infrastructure capabilities and interconnectivity among providers; increased coordination across silos of care (e.g., physical health, behavioral health, LTSS, social supports);
  - iv. maintenance or improvement of clinical quality; and
  - v. the enhancement of safety net providers' capacity to serve Medicaid and uninsured patients in the Commonwealth.

17.7. **Interim Evaluation Report.** The Commonwealth must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report should be posted to the Commonwealth's website with the application for public comment.

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

- b. For demonstration authority or any components within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the Commonwealth.
- c. If the Commonwealth is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or 1 year prior to the end of the demonstration, whichever is sooner. If the Commonwealth is not requesting an extension for a demonstration, an Interim Evaluation report is due 1 year prior to the end of the demonstration.
- d. The Commonwealth must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the Commonwealth must post the final Interim Evaluation Report to the Commonwealth's Medicaid website within 30 calendar days.
- e. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

17.8. **Summative Evaluation Report.** The Commonwealth must submit a draft Summative Evaluation Report for the demonstration's approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. The Commonwealth must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the Commonwealth's Medicaid website within 30 calendar days of approval by CMS.

17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the Commonwealth to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

- 17.10. **State Presentations for CMS.** CMS reserves the right to request that the Commonwealth present and participate in a discussion with CMS on the Evaluation Design, Interim Evaluation Report, and/or Summative Evaluation report. Presentations may be conducted remotely.
- 17.11. **Close Out Report.** Within 120 calendar days after the expiration of the demonstration, the Commonwealth must submit a draft Close Out Report to CMS for comments.
- a. The Close Out Report must comply with the most current Guidance from CMS.
  - b. In consultation with CMS, and per guidance from CMS, the Commonwealth will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close Out Report. Depending on the timeline of the phase-out during the demonstration approval period, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 15.6 and 15.7, respectively.
  - c. The Commonwealth will present to and participate in a discussion with CMS on the Close Out Report.
  - d. The Commonwealth must take into consideration CMS's comments for incorporation into the final Close Out Report.
  - e. A revised Close Out Report is due to CMS no later than 30 days after receipt of CMS's comments, if any.
  - f. A delay in submitting the draft or final versions of the Close Out Report could subject the Commonwealth to penalties described above.
- 17.12. **Public Access.** The Commonwealth shall post the final documents (e.g., Implementation Plans, Monitoring Protocols, monitoring reports, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the Commonwealth's Medicaid website within 30 days of approval by CMS.
- 17.13. **Additional Presentations and Publications.** For a period of 12 months following the CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings including in related publications (including, for example, journal articles), by the Commonwealth, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.



## 18. GENERAL FINANCIAL REQUIREMENTS

- 18.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.
- 18.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The Commonwealth will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The Commonwealth will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the Commonwealth's estimate, as approved by CMS. Within 30 days after the end of each quarter, the Commonwealth shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the Commonwealth, and include the reconciling adjustment in the finalization of the grant award to the Commonwealth.
- 18.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The Commonwealth further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.
- a. If requested, the Commonwealth must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
  - b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the Commonwealth must address CMS's concerns within the time frames allotted by CMS.

- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

**18.4. State Certification of Funding Conditions.** As a condition of demonstration approval, the Commonwealth certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the Commonwealth must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
- b. To the extent the Commonwealth utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the Commonwealth must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the Commonwealth identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).
- c. The Commonwealth may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the Commonwealth. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the Commonwealth any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the Commonwealth's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

**18.5. Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the Commonwealth attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

**18.6. Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the Commonwealth attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).
- c. If the health care-related tax is either not broad-based or not uniform, the Commonwealth has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).
- e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

**18.7. State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the Commonwealth must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 16.2. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the Commonwealth, or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;

- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the Commonwealth will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

18.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 19:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

18.9. **Program Integrity.** The Commonwealth must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The Commonwealth must also ensure that the Commonwealth and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

18.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Base Families	Main	X		X	Eligible non-disabled individuals enrolled in MassHealth Standard (including those enrolled in Temporary Assistance for Needy Families), as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only).
Base Disabled	Main	X		X	Eligible individuals with disabilities enrolled in MassHealth Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only).
1902(r)(2) Children	Main	X		X	Medicaid expansion children and pregnant individuals who are enrolled in MassHealth Standard, as well as eligible children and pregnant individuals enrolled in MassHealth Limited (emergency services only).
1902(r)(2) Disabled	Main	X		X	Eligible individuals with disabilities enrolled in MassHealth Standard with income between 114.1 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency services only).
BCCDP	Main	X		X	Individuals eligible under the Breast and Cervical Cancer Demonstration Program who are enrolled in MassHealth Standard.

Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
CommonHealth	Hypo 1	X		X	Higher income working adults and children with disabilities enrolled in CommonHealth.
e-Family Assistance	Main			X	Eligible children receiving premium assistance or direct coverage through 300 percent of the FPL enrolled in Family Assistance.
e-HIV/FA	Main			X	Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance.
SNCP-DSRIP	Main			X	Expenditures for Delivery System Reform Payments (DSRIP). This should be inclusive of SNCP-DSRIP-ACO, SNCP-DSRIP-CP, SNCP-DSRIP-SWI, SNCP-DSRIP-Operations.
SNCP-PHTII	Main			X	Expenditures authorized under the Public Hospital Transformation and Incentives Initiative
SNCP-DSH-HSNTF	Main			X	Expenditures authorized under the Health Safety Net program as referenced on Attachment E item 4.
SNCP-DSH-IMD	Main			X	Expenditures authorized under the SNCP for IMD services, as referenced on Attachment E item 5, excluding expenditures reported under STC 13.2(f)
SNCP-DSH-CPE	Main			X	Expenditures for State owned non-acute hospitals operated by the Department of Public Health and the Department of Mental Health, as referenced on Attachment E items 6 and 7.

Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
SNCP-UCC	Main			X	Expenditures authorized under the Uncompensated Care Pool.
SNCP-OTHER	Main			X	All other expenditures authorized under the SNCP, including Public Services Hospital Safety Net Care Payments as referenced on Attachment E item 1
SNCP - Safety Net Provider Payments	Main			X	Expenditures for Safety Net Provider Payments, as referenced on Attachment E item 8
New Adult Group	Hypo 2	X		X	Report for all expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.
Marketplace Subsidies	Hypo 3	X		X	Expenditures for premium and cost sharing subsidies and Connector gap coverage under the demonstration.
Provisional Eligibility	Main			X	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority consistent with STC 4.7.
EAEDC	Main			X	Expenditures for health care related costs for individuals receiving Emergency Aid to Elders, Disabled and Children.
End of Month Coverage	Main			X	Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.
FFCY	Hypo 4	X		X	Expenditures for those individuals enrolled as “Out-of-state Former Foster Care Youth,” who are youth under age 26 who were in foster care under the

Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
					responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18 (or a higher age at which the state's or Tribe's foster care assistance ends), and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.
SUD	Hypo 5	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table 6 of Section 6.
SMI IMD Services	Hypo 6	X		X	Expenditures for costs of medical assistance provided to Base Disabled, Base Families, CommonHealth, eHIV/FA, 1902(r)(2) Disabled, 1902(r)(2) BCCDP, and New Adult Group individuals while they are a patient in an IMD for SMI treatment that could be covered, were it not for the IMD prohibition under the state plan as described in Expenditure Authority #15.
Medicare Savings Program (MSP) Expansion	Main			X	All expenditures for MSP benefits as described in Expenditure Authority #17 for MassHealth members eligible for Medicare cost sharing assistance through the Commonwealth's MSP income limit expansion, without applying an asset test (i.e., MassHealth income limit between 133 percent FPL and 165 percent FPL).



Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Diversionsary BH	Main			X	All expenditures for Diversionsary BH Services
LTSS CP Enhanced Care Coordination	Main			X	Report all expenditures for payments directly to LTSS CPs to support LTSS CPs care coordination responsibilities.
Hospital Quality and Equity Initiative	Main			X	All expenditures authorized through the Hospital Quality and Equity Initiative.
Workforce Initiative	Main			X	All expenditures for student loan repayment and residency programs.
HRSN Services	Capped Hypo		X	X	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	Capped Hypo		X	X	All infrastructure expenditures for certain HRSN initiatives.
Flexible Services: Transportation	Main			X	All expenditures for the transportation benefit under the Flexible Services Program.
Flexible Services: Cooking Supplies	Main			X	Report all expenditures for the cooking supplies under the Flexible Services Program.
CE Formerly Incarcerated/ Base Families	Hypo 7	X		X	All expenditures for Formerly Incarcerated individuals who are defined as Base Families during the Continuous Eligibility period.
CE Formerly Incarcerated/ Base Disabled	Hypo 7	X		X	All expenditures for Formerly Incarcerated individuals who are defined as Base Disabled during the Continuous Eligibility period.
CE Homeless/Base Families	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as Base Families during the Continuous Eligibility period.

Table 17: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
CE Homeless/Base Disabled	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as Base Disabled during the Continuous Eligibility period.
CE Homeless/ 1902(r)2 Children	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as 1902(r)2 Children during the Continuous Eligibility period.
CE Homeless/ 1902(r)2 Disabled	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as 1902(r)2 Disabled during the Continuous Eligibility period.
CE Homeless/ 1902(r)2 BCCDP	Hypo 7	X		X	All expenditures for Homeless individuals who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

- 18.11. **Reporting Expenditures and Member Months.** The Commonwealth must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00030/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the Commonwealth also must report member months of eligibility for specified MEGs.
- a. **Cost Settlements.** The Commonwealth will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
  - b. **Premiums and Cost Sharing Collected by the State.** The Commonwealth will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the Commonwealth's compliance with the budget neutrality limits.
  - c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the Commonwealth must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The Commonwealth must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must

be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

- d. **Administrative Costs.** The Commonwealth will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 19, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
  - e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 16, the Commonwealth must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The Commonwealth must submit a statement accompanying the annual report certifying the accuracy of this information.
  - f. **Budget Neutrality Specifications Manual.** The Commonwealth will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the Commonwealth will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the Commonwealth compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.
- 18.12. **Reporting Expenditures under the Demonstration for Groups that are Eligible First under the Separate Title XXI Program.** The Commonwealth is entitled to claim title XXI funds for expenditures for certain children that are also eligible under this title XIX demonstration included within the Base Families MEG, the 1902(r)(2) Children EG, the CommonHealth MEG and the Family Assistance EG. These groups are included in the Commonwealth’s title XXI state plan and therefore can be funded through the separate title XXI program up to the amount of its title XXI allotment (including any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual. If the title XXI allotment has been exhausted, including any reallocations or redistributions, these children are then eligible under this title XIX demonstration and the following reporting requirements for these MEGs under the title XIX demonstration apply:

- a. **Base Families XXI RO, 1902(r)(2) RO, CommonHealth XXI, and Fam Assist XXI Exhaustion of Title XXI Funds.** If the Commonwealth has exhausted title XXI funds, expenditures for these optional targeted low-income children may be claimed as title XIX expenditures as approved in the Medicaid state plan. The Commonwealth shall report expenditures for these children as waiver expenditures on the forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 18.11 (Reporting Expenditures and Member Months).
- b. **Exhaustion of Title XXI Funds Notification.** The Commonwealth must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures.
- c. If the Commonwealth chooses to claim expenditures for Base Families XXI RO, 1902(r)(2) RO, and CommonHealth XXI groups under title XIX, the expenditures and caseload attributable to these MEGs will:
  - i. Count toward the budget neutrality expenditure limit calculated under section 19, STC 19.3 (Calculation of the Budget Neutrality Limits and How They are Applied); and
  - ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 19.3, so that the Commonwealth is not at risk for caseload while claiming title XIX federal matching funds when title XXI funds are exhausted.
- d. If the Commonwealth chooses to claim expenditures for Fam Assist XXI under title XIX, the expenditures and caseload attributable to this MEG will be considered expenditures subject to the budget neutrality agreement as defined in STC 19.3. The Commonwealth is at risk for both caseload and expenditures while claiming Title XIX federal matching funds for this population when title XXI funds are exhausted.

**Table 18: MEG Detail for Expenditure and Member Month Reporting**

<b>MEG (Waiver Name)</b>	<b>Detailed Description</b>	<b>Exclusions</b>	<b>CMS-64.9 or 64.10 Line(s) To Use</b>	<b>How Expend. Are Assigned to DY</b>	<b>MAP or ADM</b>	<b>Report Member Months (Y/N)</b>	<b>MEG Start Date</b>	<b>MEG End Date</b>
<b>Base Families</b>	Report all medical assistance expenditures for eligible non-disabled individuals enrolled in MassHealth Standard (including those receiving Temporary Assistance for Needy Families) and eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>Base Disabled</b>	Report all medical assistance expenditures for eligible individuals with disabilities enrolled in MassHealth Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27

<b>1902(r)(2) Children</b>	Report all medical assistance expenditures for Medicaid expansion children and pregnant individuals who are enrolled in MassHealth Standard, as well as eligible children and pregnant individuals enrolled in MassHealth Limited (emergency services only).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>1902(r)(2) Disabled</b>	Report all medical assistance expenditures for eligible individuals with disabilities enrolled in MassHealth Standard with income between 114.1 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency services only).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>BCCDP</b>	Report all medical assistance expenditures for individuals eligible under the Breast and Cervical Cancer Demonstration Program who are enrolled in MassHealth Standard.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27

<b>CommonHealth</b>	Report all medical assistance expenditures for higher income working adults and children with disabilities enrolled in CommonHealth.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>e-Family Assistance</b>	Report all medical assistance expenditures for eligible children receiving premium assistance or direct coverage through 300 percent of the FPL enrolled in Family Assistance.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	7/1/97	12/31/27
<b>e-HIV/FA</b>	Report all medical assistance expenditures for Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>SNCP-DSRIP</b>	Report expenditures for Delivery System Reform Payments (DSRIP). This should be inclusive of SNCP-DSRIP-ACO, SNCP-DSRIP-CP, SNCP-		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	7/1/17	12/31/27



	DSRIP-SWI, SNCP-DSRIP-Operations.							
<b>SNCP-PHTII</b>	Report expenditures authorized under the Public Hospital Transformation and Incentives Initiative		Follow standard CMS-64.9 Category of Service Definition	Date of service/Date of payment	MAP	N	7/1/17	06/30/2024
<b>SNCP-DSH-HSNTF</b>	Report expenditures authorized under the Health Safety Net program as referenced on Attachment E item 4.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP-DSH-IMD</b>	Report expenditures authorized under the SNCP for IMD services, as referenced on Attachment E item 5, excluding expenditures reported under STC 13.2(f)		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP-DSH-CPE</b>	Report expenditures for State owned non-acute hospitals operated by the Department of Public Health and the Department of Mental Health, as referenced on Attachment E items 6 and 7.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27

<b>SNCP-UCC</b>	Report expenditures authorized under the Uncompensated Care Pool.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP-OTHER</b>	Report all other expenditures authorized under the SNCP, including Public Services Hospital Safety Net Care Payments, as referenced on Attachment E item 1.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	7/1/17	12/31/27
<b>SNCP - Safety Net Provider Payments</b>	Report expenditures authorized under the SNCP as referenced on Attachment E item 8.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	10/1/22	12/31/27
<b>New Adult Group</b>	Report for all expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27
<b>Marketplace Subsidies</b>	Report expenditures for premium and cost sharing subsidies and Connector gap coverage under the demonstration.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	10/1/22	12/31/27

<b>Provisional Eligibility</b>	Report expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority consistent with STC 4.7.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>EAEDC</b>	Report all medical assistance expenditures for health care related costs for individuals receiving Emergency Aid to Elders, Disabled and Children.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>End of Month Coverage</b>	Report all medical assistance expenditures for beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/17	12/31/27
<b>FFCY</b>	Report all medical assistance expenditures for those individuals enrolled as “Out-of-state Former Foster Care Youth,” who are youth under age 26 who were in foster care under the responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/97	12/31/27

	(or a higher age at which the state's or Tribe's foster care assistance ends), and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.							
<b>SUD</b>	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table 6 of Section 6.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>SMI IMD Services</b>	Report all medical assistance expenditures for costs of medical assistance provided to Base Disabled, Base Families, CommonHealth, eHIV/FA, 1902(r)(2) Disabled, 1902(r)(2) BCCDP, and New Adult Group individuals while they are a patient in an IMD for SMI treatment that could be covered, were it not for the IMD		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	8/11/22	12/31/27

	prohibition under the state plan as described in Expenditure Authority #15.							
<b>Medicare Savings Program (MSP) Expansion</b>	Report all medical assistance expenditures for MSP benefits as described in Expenditure Authority #17 for MassHealth members eligible for Medicare cost sharing assistance through the Commonwealth's MSP income limit expansion, without applying an asset test (i.e., MassHealth income limit between 133 percent FPL and 165 percent FPL).		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	8/11/22	12/31/27
<b>Diversiónary BH</b>	All expenditures for Diversiónary BH Services		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	10/1/22	12/31/27
<b>LTSS CP Enhanced Care Coordination</b>	Report all expenditures for payments directly to LTSS CPs to support LTSS CPs care coordination responsibilities.		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/22	12/31/27
<b>Hospital Quality and</b>	Report all expenditures for the Hospital		Follow standard	Date of payment	ADM	N	10/1/22	12/31/27

<b>Equity Initiative</b>	Quality and Equity Initiative.		CMS 64.10- Category of Service Definitions					
<b>Workforce Initiative</b>	Report all expenditures for student loan repayment and residency programs.		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/22	12/31/27
<b>HRSN Services</b>	Report all expenditures for approved HRSN initiatives.		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service/Date of payment	MAP/ADM	N	10/1/22	12/31/27
<b>HRSN Infrastructure</b>	Report all infrastructure expenditures for approved HRSN initiatives.		Follow standard CMS 64.10 Category of Service Definitions	Date of service/Date of payment	ADM	N	10/1/22	12/31/27
<b>Flexible Services: Transportation</b>	Report all expenditures for the transportation benefit under the Flexible Services Program.		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service/Date of payment	MAP/ADM	N	10/1/22	12/31/27
<b>Flexible Services: Cooking Supplies</b>	Report all expenditures for the cooking supplies benefit under the Flexible Services Program.		Follow standard CMS 64.10 Category of	Date of service/Date of payment	ADM	N	10/1/22	12/31/27

			Service Definitions					
<b>CE Formerly Incarcerated/ Base Families</b>	All expenditures for Formerly Incarcerated individuals who are defined as Base Families during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Formerly Incarcerated/ Base Disabled</b>	All expenditures for Formerly Incarcerated individuals who are defined as Base Disabled during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/Base Families</b>	All expenditures for Homeless individuals who are defined as Base Families during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/Base Disabled</b>	All expenditures for Homeless individuals who are defined as Base Disabled during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/ 1902(r)2 Children</b>	All expenditures for Homeless individuals who are defined as 1902(r)2 Children		Follow standard CMS-64.9 Category of	Date of service	MAP	Y	10/1/22	12/31/27

	during the Continuous Eligibility period.		Service Definitions					
<b>CE Homeless/ 1902(r)2 Disabled</b>	All expenditures for Homeless individuals who are defined as 1902(r)2 Disabled during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>CE Homeless/ 1902(r)2 BCCDP</b>	All expenditures for Homeless individuals who are defined as 1902(r)2 BCCDP during the Continuous Eligibility period.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/22	12/31/27
<b>ADM</b>	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/22	12/31/27

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group



- 18.13. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 19: Demonstration Years		
Demonstration Year 27	October 1, 2022 to December 31, 2022	3 months
Demonstration Year 28	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 29	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 30	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 31	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 32	January 1, 2027 to December 31, 2027	12 months

- 18.14. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the Commonwealth conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the Commonwealth’s regular Title XIX FMAP rate. Should state data indicate that there is an estimate more accurate than 2.6 percent by which to adjust claiming for individuals defined in 42 CFR 433.204(a)(1), CMS will work with the Commonwealth to update this percentage to the more accurate figure, as supported by the Commonwealth’s proposed methodology and data. CMS anticipates no increase in enrollment among individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) that are experiencing homelessness for the continuous eligibility period; therefore, no change in FMAP claiming is required for the homeless population.
- 18.15. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 18.14 above. The Commonwealth must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the Commonwealth’s regular Title XIX FMAP rate.
- 18.16. **Budget Neutrality Monitoring Tool.** The Commonwealth must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s actual expenditures to the budget

neutrality expenditure limits described in section 19. CMS will provide technical assistance, upon request.<sup>8</sup>

- 18.17. **Claiming Period.** The Commonwealth will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the Commonwealth will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 18.18. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
  - b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance

---

<sup>8</sup> Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

18.19. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 18.19.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
  - i. Provider rate increases that are anticipated to further strengthen access to care;
  - ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
  - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
  - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

- v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
  - vi. High cost innovative medical treatments that states are required to cover; or,
  - vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
- i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and
  - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

## 19. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 19.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.
- 19.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 17, Master MEG Chart and Table 18, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

- 19.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 19.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 20: Main Budget Neutrality Test										
MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Base Families	PC	Both	2019	4.80%	\$451.74	\$465.17	\$487.50	\$510.90	\$535.42	\$561.12
Base Disabled	PC	Both	2019	4.80%	\$1,315.34	\$1,354.45	\$1,419.47	\$1,487.60	\$1,559.01	\$1,633.84
1902(r)(2) Children	PC	Both	2019	4.80%	\$460.97	\$474.68	\$497.46	\$521.34	\$546.36	\$572.59
1902(r)(2) Disabled	PC	Both	2019	4.80%	\$586.71	\$604.16	\$633.16	\$663.55	\$695.40	\$728.78
BCCDP	PC	Both	2019	5.50%	\$2,125.26	\$2,197.58	\$2,318.45	\$2,445.96	\$2,580.49	\$2,722.42
e-Family Assistance	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
e-HIV/FA	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					

**Table 20: Main Budget Neutrality Test**

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SNCP-DSRIP	Agg	WW Only	2019	N/A	\$45,662,216	\$124,247,201	\$48,632,098	\$34,186,080	\$502,625	-
SNCP-PHTII	Agg	WW Only	2019	N/A	-	\$6,350,000	-	-	-	-
SNCP-DSH-HSNTF	Agg	WW Only	2019	N/A	\$56,705,632	\$236,000,000	\$236,000,000	\$236,000,000	\$236,000,000	\$236,000,000
SNCP-DSH-IMD	Agg	WW Only	2019	N/A	\$8,085,662	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000
SNCP-DSH-CPE	Agg	WW Only	2019	N/A	\$38,996,798	\$156,000,000	\$165,000,000	\$165,000,000	\$165,000,000	\$165,000,000
SNCP-UCC	Agg	WW Only	2019	N/A	-	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000
SNCP-OTHER	Agg	WW Only	2019	N/A	\$5,000,000	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000

Table 20: Main Budget Neutrality Test										
MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SNCP - Safety Net Provider Payments	Agg	WW Only	2019	N/A	\$74,750,000	\$316,025,039	\$329,380,000	\$299,000,000	\$299,000,000	\$299,000,000
Provisional Eligibility	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
EAEDC	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
End of Month Coverage	N/A	WW Only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
Medicare Savings Program (MSP) Expansion	N/A	WW only	2019	N/A	The Commonwealth must have savings to offset these expenditures.					
Diversionsary BH	N/A	WW only		N/A	The Commonwealth must have savings to offset these expenditures.					
LTSS CP Enhanced Care Coordination	Agg	WW only		N/A	-	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000



Table 20: Main Budget Neutrality Test										
MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Hospital Quality and Equity Initiative	Agg	WW only		N/A	\$102,500,000	\$410,000,000	\$490,000,000	\$490,000,000	\$490,000,000	\$490,000,000
Workforce Initiative	Agg	WW only		N/A	-	\$1,210,000	\$7,610,000	\$14,010,000	\$14,010,000	\$6,400,000
Flexible Services: Transportation	N/A	WW only		N/A	The Commonwealth must have savings to offset these expenditures.					
Flexible Services: Cooking Supplies	N/A	WW only		N/A	The Commonwealth must have savings to offset these expenditures.					
DSH Diversion^	Agg	WOW only		N/A	\$186,963,000	\$750,656,445	\$761,916,292	\$773,345,036	\$784,945,212	\$796,719,390

\*PC = Per Capita, Agg = Aggregate

^The annual DSH allotment is set by federal regulation. The figures in this table are only estimates.

19.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

19.6. **Hypothetical Budget Neutrality Test 1: CommonHealth** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 21: Hypothetical Budget Neutrality Test 1										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Common Health	PC	Both	2019	4.80%	\$510.23	\$525.40	\$550.62	\$577.05	\$604.75	\$633.78

19.7. **Hypothetical Budget Neutrality Test 2: New Adult Group** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are

designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

**Table 22: Hypothetical Budget Neutrality Test 2**

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
New Adult Group	PC	Both	2019	5.50%	\$694.88	\$718.53	\$758.05	\$799.74	\$843.72	\$890.13

- 19.8. **Hypothetical Budget Neutrality Test 3: Marketplace Subsidies.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

**Table 23: Hypothetical Budget Neutrality Test 3**

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
Marketplace Subsidies	PC	Both	2019	5.60%	\$170.96	\$176.88	\$186.79	\$197.25	\$208.29	\$219.96

19.9. **Hypothetical Budget Neutrality Test 4: FFCY.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 24: Hypothetical Budget Neutrality Test 4										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
FFCY	PC	Both	2021	5.50%	\$408.64	\$422.55	\$445.79	\$470.30	\$496.17	\$523.46

19.10. **Hypothetical Budget Neutrality Test 5: SUD.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 25: Hypothetical Budget Neutrality Test 5										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SUD	PC	Both	2019	5.60%	\$9,844.88	\$10,185.92	\$10,756.33	\$11,358.69	\$11,994.77	\$12,666.48

- 19.11. **Hypothetical Budget Neutrality Test 6: SMI IMD Services** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 26: Hypothetical Budget Neutrality Test 6										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
SMI IMD Services	PC	Both	2019	5.60%	\$4,167.70	\$4,312.08	\$4,553.55	\$4,808.55	\$5,077.83	\$5,362.19

- 19.12. **Hypothetical Budget Neutrality Test 7: Continuous Eligibility.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 27: Hypothetical Budget Neutrality Test 7										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
CE Formerly Incarcerated/ Base Families	PC	Both	2023	4.80%	-	\$465.17	\$487.50	\$510.90	\$535.42	\$561.12
CE Formerly Incarcerated/ Base Disabled	PC	Both	2023	4.80%	-	\$1,354.45	\$1,419.47	\$1,487.60	\$1,559.01	\$1,633.84
CE Homeless/ Base Families	PC	Both	2023	4.80%	-	\$465.17	\$487.50	\$510.90	\$535.42	\$561.12

Table 27: Hypothetical Budget Neutrality Test 7										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
CE Homeless/ Base Disabled	PC	Both	2023	4.80%	-	\$1,354.45	\$1,419.47	\$1,487.60	\$1,559.01	\$1,633.84
CE Homeless/ 1902(r)2 Children	PC	Both	2023	4.80%	-	\$474.68	\$497.46	\$521.34	\$546.36	\$572.59
CE Homeless/ 1902(r)2 Disabled	PC	Both	2023	4.80%	-	\$604.16	\$633.16	\$663.55	\$695.40	\$728.78
CE Homeless/ 1902(r)2 BCCDP	PC	Both	2023	5.50%	-	\$2,197.58	\$2,318.45	\$2,445.96	\$2,580.49	\$2,722.42

- 19.13. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 15), CMS considers these expenditures to be “capped hypothetical” expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state’s expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test’s expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state’s capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.
- 19.14. **Capped Hypothetical Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.



Table 28: Capped Hypothetical Budget Neutrality Test								
MEG	Agg	WOW Only, WW Only, or Both	DY 27	DY 28	DY 29	DY 30	DY 31	DY 32
HRSN Services	Agg	Both	-	\$71,903,277	\$124,899,764	\$163,699,764	\$163,699,764	\$163,699,764
HRSN Infrastructure	Agg	Both	-	-	\$8,000,000	-	-	-

- 19.15. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 19.16. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from October 1, 2022 to December 31, 2027. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (July 1, 2012 to June 30, 2022). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
- 19.17. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 19.16, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is \$18,699,799,972.

- 19.18. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 29: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	Cumulative Target Definition	Percentage
DY 27 through DY 28	Cumulative budget neutrality limit plus:	2.0 percent
DY 27 through DY 29	Cumulative budget neutrality limit plus:	1.5 percent
DY 27 through DY 30	Cumulative budget neutrality limit plus:	1.0 percent
DY 27 through DY 31	Cumulative budget neutrality limit plus:	0.5 percent
DY 27 through DY 32	Cumulative budget neutrality limit plus:	0.0 percent

## 20. MONITORING ALLOTMENT NEUTRALITY

- 20.1. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:
- Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS-64 reporting instructions as outlined in section 2115 of the State Medicaid Manual.
  - Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for the title XXI funded Medicaid expansion population (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and the title XXI funded separate CHIP population (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 and CMS-64.21U waiver forms for each title XXI demonstration population.
  - Premiums.** Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver and the CMS-64.21U Waiver forms (specifically lines 1A through 1D as applicable) for each title XXI demonstration

population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

- d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS-64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

20.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for the title XXI funded separate CHIP population and CMS-37 for the title XXI funded Medicaid expansion population. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

- a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the title XXI funded separate CHIP population and report demonstration expenditures for the title XXI funded Medicaid expansion population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS-64.21UP Waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

20.3. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

20.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 18.12 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or

reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

- 20.5. **Exhaustion of Title XXI Allotment for CHIP Populations.** If the state has exhausted title XXI funds, expenditures for the title XXI funded CHIP populations described in STC 18.12, and as approved within the CHIP state plan, may be claimed as title XIX expenditures. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the CHIP populations. The state shall report demonstration expenditures for these individuals on the Forms CMS-64.9W and/or CMS-64.9P W.

## **21. PROVIDER RATE INCREASE REQUIREMENTS**

- 21.1. The provider payment rate increase requirements described hereafter are a condition for both the Hospital Quality and Equity Initiative and HRSN expenditure authorities, as referenced in expenditure authorities #25 and #22, respectively.
- 21.2. As a condition of approval and ongoing provision of FFP for the Hospital Quality and Equity Initiative and HRSN expenditures over this demonstration period of performance, DY 27 through DY 32, the Commonwealth will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the Commonwealth's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of service is below 80 percent.
- 21.3. The Commonwealth may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC.
- 21.4. The Commonwealth will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section 21, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other Commonwealth and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the Commonwealth's definition of behavioral health care services.
- 21.5. No later than 90 days of the demonstration effective date, and if the Commonwealth makes fee for service payments, the Commonwealth must establish and report to CMS the Commonwealth's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

- a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the Commonwealth and the service category as noted in the following sources:

- i. for primary care and obstetric care services in Zuckerman, *et al.* 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); AND
- ii. for behavioral health services (the category called, ‘Psychotherapy’ in Clemans-Cope, *et al.* 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3)); OR

- b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

- i. Service codes must be representative of each service category as defined in STC 21.4;
- ii. Medicaid and Medicare data must be from the same year and not older than 2019.
- iii. The Commonwealth’s methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

- 21.6. To establish the Commonwealth’s ratio for each service category identified in STC 21.4 as it pertains to managed care plans’ provider payment rates in the Commonwealth, the Commonwealth must provide to CMS either:

- a. The average fee-for-service ratio as provided in STC 21.5(a), if the Commonwealth and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the Commonwealth pay providers based on state plan fee-for-service payment rate schedules); OR
- b. The data and methodology for any or all of the service categories as provided in STC 21.5(b) using Medicaid managed care provider payment rate and utilization data.

- 21.7. In determining the ratios required under STC 21.5 and 21.6, the Commonwealth may not incorporate fee-for-service supplemental payments that the Commonwealth made or plans

to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

- 21.8. If the Commonwealth is required to increase provider payment rates for managed care plans per STC 21.2 and 21.6, the Commonwealth must:
  - a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and
  - b. Ensure that the entirety of a two percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.
- 21.9. For the entirety of DY 30 through DY 32, the provider payment rate increase for each service in a service category for which the average ratio is less than 80 percent will be no lower than the highest rate in DY 28 for that service plus a two percentage point increase relative to the rate for the same or comparable Medicare service code rate in the same year, and such rate will be in effect on the first day of DY 30. A required payment rate increase shall apply to all services in a service category as defined under STC 21.3.
- 21.10. If the Commonwealth uses a managed care delivery system for any of the service categories defined in STC 21.3, for the beginning of the first rating period, as defined in 42 CFR 438.2(a), that starts in each demonstration year from DY 30 through DY 32, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 28 plus a two percentage point increase. The payment increase shall apply to all services in a service category as defined under STC 21.3.
- 21.11. If the Commonwealth has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the Commonwealth from implementing a required payment rate increase by the first day of DY 30 (or, as applicable, the first day of the first rating period that starts in DY 30), the Commonwealth will provide an alternative effective date and rationale for CMS review and approval.
- 21.12. Massachusetts will provide the information to document the payment rate ratio required under STC 21.5 and 21.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.
- 21.13. For demonstration years following the first year of provider payment rate increases, if any, Massachusetts will provide an annual attestation within the Commonwealth's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.
- 21.14. No later than 90 days following the demonstration effective date, the Commonwealth will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to

PMDA, along with a description of the Commonwealth's methodology and the Commonwealth's supporting data for establishing ratios for each of the three service categories in accordance with STC 21.5 and 21.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment V:

<b>Massachusetts Hospital Quality and Equity Initiative Related Provider Payment Increase Assessment – Attestation Table</b>		
The reported data and attestations pertain to Hospital Quality and Equity Initiative related provider payment increase requirements for the demonstration period of performance DY 27 through DY 32		
<b>Category of Service</b>	<b>Medicaid Fee-for-Service to Medicare Fee-for-service Ratio</b>	<b>Medicaid Managed Care to Medicare Fee-for-service Ratio</b>
Primary Care Services	<i>[insert percent, or N/A if state does not make Medicaid fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 21.5(a) or STC 21.5(b)]</i>	<i>[insert approach, either ratio derived under STC 21.6(a) or STC 21.6(b) and insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>
Obstetric Care Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 21.5(a) or STC 5(b)]</i>	<i>[insert approach, either ratio derived under STC 21.6(a) or STC 21.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>
Behavioral Health Care Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]</i>



	<i>[insert approach, either ratio derived under STC 21.5(a) or STC 21.5(b)]</i>	<i>[insert approach, either ratio derived under STC 21.6(a) or STC 21.6(b)]; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio</i>
<p>In accordance with STCs 21.1 through 21.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the Commonwealth's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on <i>[insert date]</i> and will not be lower than the highest rate for that service code in DY 28 plus a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least <i>[insert date]</i>.</p> <p>For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the Commonwealth agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the Commonwealth's definition.</p> <p>The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the Commonwealth's definition of the category, except the behavioral health codes do not have to include inpatient care services.</p> <p>For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 21.3 will be based on Medicaid managed care provider payment rate and utilization data.</p> <p><i>[Select the applicable effective date, must check either a. or b. below]</i></p> <p><input type="checkbox"/> a. The effective date of the rate increases is the first day of DY <i>[3, provide the actual year]</i> and will be at least sustained, if not higher, through DY <i>[5, provide the actual year]</i></p> <p><input type="checkbox"/> b. Massachusetts has a biennial legislative session that requires provider payment approval and the timing of that session precludes the Commonwealth from implementing the payment increase on the first day of DY <i>[3, provide the actual year]</i>. Massachusetts will effectuate the rate increases no later than the CMS approved date of <i>[insert date]</i>, and will sustain these rates, if not made higher, through DY <i>[5, provide the accrual year]</i>.</p>		

Massachusetts [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the Hospital Quality and Equity Initiative STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

Massachusetts [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the Hospital Quality and Equity Initiative STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 21.11 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than [*insert date*]

If the Commonwealth utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 21.10, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.

Massachusetts further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 21.

I, [*insert name of SMD or CFO(or equivalent position)*] [*insert title*], attest that the above information is complete and accurate.

[*Provide signature*\_\_\_\_\_] [*Provide date*\_\_\_\_\_]

[*Provide printed name of signator*\_\_\_\_\_]

## 22. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

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

Date – Specific	Deliverable	STC/Section Reference
180 calendar days from demonstration approval date	Draft Evaluation Design	STC 17.4
Within 60 days of receipt of CMS comments	Revised Evaluation Design	STC 17.5
One year prior to demonstration expiration or with extension application	Draft Interim Evaluation Report	STC 17.7
Within 60 days of receipt of CMS comments	Revised Interim Evaluation Report	STC 17.7
Within 18 months after the expiration of this demonstration period	Draft Summative Evaluation Report	STC 17.8
Within 60 days of receipt of CMS comments	Revised Summative Evaluation Report	STC 17.8
Within 120 days after the end of the demonstration	Draft Close Out Report	STC 17.11
Within 30 days after receipt of CMS comments	Revised Close Out Report	STC 17.11
90 calendar days after approval of this demonstration	Continuous Eligibility Implementation Plan	STC 4.13
90 calendar days after approval date of SMI/SED amendment to this Demonstration	SMI/SED Implementation Plan (including Health IT Plans and Financing Plan)	STC 7.15(a)
60 calendar days after receipt of CMS comments on SMI/SED Implementation Plans	Revised SMI/SED Implementation Plans (including Health IT Plans and Financing Plan)	STC 7.15(a)
150 calendar days after approval date of SMI/SED amendment to this Demonstration	SMI/SED Monitoring Protocol	STC 7.5
60 calendar days after receipt of CMS comments on SMI/SED Monitoring Protocol	Revised SMI/SED Monitoring Protocol	STC 7.5
No later than 60 calendar days after September 30, 2025	SMI/SED Mid-Point Assessment	STC 7.8

<b>Date – Specific</b>	<b>Deliverable</b>	<b>STC/Section Reference</b>
150 calendar days after approval of the demonstration	SUD Monitoring Protocol	STC 6.7
60 calendar days after receipt of CMS comments on SUD Monitoring Protocol	Revised SUD Monitoring Protocol	STC 6.7
No later than 60 calendar days after September 30, 2025	SUD Mid-Point Assessment	STC 6.8
No later than 60 days after demonstration effective date	SUD HIT Plan	STC 6.7
Prior to claiming UC FFP	UC Payment Protocol	STC 11.3
Prior to claiming FFP	Hospital Quality and Equity Implementation Plan	STC 14.8
By July 1, 2023	Assessment of beneficiary-reported demographic and health-related social needs data adequacy and completeness	STC 14.3(a)
No later than 90 days after demonstration effective date (prior to claiming FFP)	Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning and Provider Qualifications	STC 15.5
90 calendar days after demonstration effective date	HRSN Implementation Plan	STC 15.12
60 calendar days after receipt of CMS comments on HRSN Implementation Plan	Revised HRSN Implementation Plan	STC 15.12
No later than 90 days prior to the effective date	Primary Care Payment Protocol	STC 8.5
No later than 90 days after demonstration effective date	Provider Payment Rate Increase Assessment Attestation Table	STC 21.14
No later than 90 days of the demonstration effective date	Average Medicaid to Medicare fee-for-service provider rate ratio	STC 21.1
150 days after approval of the demonstration	Monitoring Protocol for Other Policies	STC 16.4
60 calendar days after receipt of CMS comments on Monitoring Protocol for Other Policies	Revised Monitoring Protocol for Other Policies	STC 16.4
<i>Annually</i>		
90 days after the end of each DY	Annual Monitoring Report (including Q4 monitoring information and budget neutrality)	STC 16.5
30 days of the receipt of CMS comments	Revised Annual Monitoring Report	STC 16.5

<b>Date – Specific</b>	<b>Deliverable</b>	<b>STC/Section Reference</b>
No later than 45 days after enactment of the state budget for each SFY	Updates to Charts A-B of Attachment E that reflect projected annual SNCP expenditures and identify the non-Federal share for each line item	STC 11.6
No later than 90 days after the end of each DY	Report of actual UC payments	STC 11.3
180 days after the close of the SFY (December 31)	Updates to Charts A-B of Attachment E that reflect actual SNCP payments and expenditures	STC 11.6
Updated at least annually	Update to Primary Care Payment Protocol	STC 8.5
<i>Quarterly</i>		
60 days following the end of the quarter	Quarterly Monitoring Reports, including metrics described in STC 16.5	STC 16.5
30 days following the end of the quarter	Quarterly Expenditure Reports	STC 16.5
60 days following the end of the quarter, except for Q4 which is submitted with Annual Report	Quarterly Budget Neutrality Report	STC 16.5