CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS & CONDITIONS

NUMBER: **11-W-00030/1**

TITLE: **MassHealth Medicaid Section 1115 Demonstration**

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts MassHealth section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (which is the single state agency that oversees the MassHealth program), (State/Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the Commonwealth's obligations to CMS during the life of the demonstration. The STCs are effective as of July 1, 2017, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the State's expenditures relating to dates of service during this demonstration extension, unless otherwise specified. The demonstration is set to expire on June 30, 2022.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

In this extension of the demonstration, the Commonwealth and CMS have 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 Program (DSRIP) to transition the Massachusetts delivery system into accountable care models. The Safety Net Care Pool (SNCP) has been redesigned to align SNCP 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.

During the new extension period approved for state fiscal year (SFY) 2018-2022, the goals of the demonstration are:

(1) Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care;
(2) Improve integration of physical, behavioral and long term services;
(3) Maintain near-universal coverage;
(4) Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals; and
(5) Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services; and,
(6) Increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state 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, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal 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 state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

    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 state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such a 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 subparagraph.

    b) If mandated changes in the federal law require state legislation, 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.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title 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 may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

    Pertaining to the new coverage of former foster care youth under this demonstration, as outlined in CMS' November 21, 2016 CMCS Informational Bulletin (CIB) to *Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the state shall submit a conforming amendment to the Medicaid State Plan withdrawing its current state plan authority effective as of the effective date of this section 1115 approval.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in 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 state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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, failure by the state to submit required reports and other deliverables in a timely fashion 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 15. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS.

   B. 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 extension 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 (EG)) the impact of the amendment;

   C. An up-to-date CHIP allotment neutrality worksheet, if necessary;

   D. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment, if necessary; and

   E. The state 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.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under section 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR section 431.412(c) or a phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a) **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) **Phase-out Plan Requirements:** The state 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 state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

Phase-out Procedures: The state must comply with all notice requirements found in 42 C.F.R. section 431.206, section 431.210, and § 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 C.F.R. section 431.220 and section 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 C.F.R. section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

c) **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to, normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

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 state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. The CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' 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 and

administrative costs of disenrolling participants.

13. **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.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 Code of Federal Regulations (CFR) section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state

15. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

16. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The State shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter. CMS expects the state to implement both an interim and long-term plan to collect, validate and report managed care encounter data, per required T-MSIS reporting and 1115 evaluation. The interim plan must be submitted to CMS by January 31, 2017. The long-term plan must be submitted to CMS no later than June 30, 2017. The system costs associated with this work are eligible for enhanced match. Failure to achieve this condition may result in a reduction in systems FFP for the costs associated with operations of the State's current data warehouse solution.

17. **Common Rule Exemption.** The state 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 program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for 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 46.101(b)(5).

IV. ELIGIBILITY AND ENROLLMENT

18. **Eligible Populations.** This demonstration affects mandatory and optional Medicaid state plan populations as well as populations eligible for benefits only through the demonstration. Table A at the end of section IV 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. Attachment A provides a complete overview of MassHealth coverage for children, including the separate title XXI CHIP program, which is incorporated by reference.

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.

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.

19. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance to STC 50 Table F.

20. **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 consider state veteran annuity 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. The Commonwealth may consider such payment as non-countable income for purposes of determining eligibility for MassHealth Standard, MassHealth CommonHealth, MassHealth CarePlus, MassHealth Family Assistance and MassHealth Limited benefits for individuals who would be eligible for such benefits but for the receipt of such state veteran annuity or the inclusion of such annuity in the household income, provided that such individuals described above are not otherwise eligible to receive comparable coverage on the state exchange. 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 such state veteran annuity or but for the inclusion of such annuity in the household income.

21. **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 up to 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 up to the age of 21.

c) Childless adults whose SNAP verified income is at or below 163 percent FPL.

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.

22. **TANF and EAEDC Recipients.** The Medicaid agency shall extend MassHealth eligibility to individuals receiving Temporary Assistance for Needy Families and 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 TANF/EAEDC benefits. Individuals in this demonstration population would not be described in the new adult group, because that is a group defined by an income determination. Therefore, the enhanced match for individuals in the new adult group is not available for this population. If an individual loses his/her TANF/EAEDC eligibility then he/she must apply for MassHealth benefits and receive an income eligibility determination in order to receive MassHealth benefits.

23. **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 Treatment Program under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan.

The hospital determined presumptive eligibility benefit for pregnant women and unborn children is a full MassHealth Standard benefit.

24. **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 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 enroll individuals for 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:

- Pregnant women with attested modified adjusted gross income (MAGI) at or below 200% of the federal poverty level (FPL)
- Adults 21 through 64 years of age who are HIV positive and have attested MAGI income at or below 200% FPL; and
- Individuals with breast and cervical cancer who are under 65 years of age and have attested MAGI income at or below 250% FPL
- 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 women 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 women 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 woman'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 F. 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.

25. **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 24. 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.

26. **Eligibility Exclusions.** Notwithstanding the criteria outlined in this section or in Table A, the following individuals are excluded from this demonstration. Payments or expenditures related to uncompensated care for such individuals as defined in STC 53, and for DSHP as described in STC 57, however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP). In addition, SUD services described in STC 40 provided to MassHealth eligible individuals age 65 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.

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
Participants in Program of All-Inclusive Care of the Elderly (PACE), except as otherwise described at STC 20(a)
Refugees served through the Refugee Resettlement Program

27. **Enrollment Caps.** The Commonwealth is authorized to impose enrollment caps on populations made eligible solely through the demonstration, except that enrollment caps may not be imposed for the demonstration expansion population groups listed as "Hypotheticals" in Table A. Setting and implementing specific caps are considered amendments to the demonstration and must be made consistent with section III, STC 7.

28. **Twelve Month Continuous Eligibility for Student Health Insurance Program Population.**

Individuals who are enrolled in a cost-effective Student Health Insurance Program will be continuously eligible for a period of up to 12 months while enrolled in the SHIP plan, until the end of the policy year date. The policy year will end on either July 31 or August 31 of each year. The Commonwealth will determine the individual's eligibility at the completion of each policy year to ensure that the individual remains eligible.

a) Exceptions. Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual's 12 month continuous eligibility period, the individual's Medicaid eligibility shall, after appropriate process, be terminated:
    i. The individual cannot be located for a period of more than one month, after good faith efforts by the state to do so.
    ii. The individual is no longer a Massachusetts resident.
    iii. The individual dies.
    iv. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required.
    v. The individual provided an incorrect or fraudulent Social Security Number.
b) Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual's 12 month continuous eligibility period, the individual's Medicaid eligibility shall be redetermined.
    i. The individual is no longer enrolled in a SHIP
    ii. The individual requests termination of SHIP enrollment.

Table A. MassHealth State Plan Base Populations[1] (See STC 91 for terminology)					
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%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted	**1902(r)(2)** **Children** **1902(r)(2) XXI** **RO**	Standard	

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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 until the age of 21 without regard to income or assets Former Foster Care Adolescents until the age of 26 without regard to income or assets (effective January 1, 2014)	• Title XIX	**Base Families**	Standard	

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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 Children Medicaid Expansion Children I	Age 6 - 17: 114.1% through 133% Age 18: 0 through 133%	Title XIX if insured at the time of application Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted	**Base Families** **Bas Fam XXI RO**	Standard	

[1] Massachusetts includes in the MassHealth demonstration almost all the mandatory and optional populations aged under 65 eligible under the state plan. All Standard and CommonHealth members who have access to qualifying private insurance may receive premium assistance plus wrap-around benefits. The Massachusetts state plan outlines all covered populations not specifically indicated here.

Table A. MassHealth State Plan Base Populations (continued)*					
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**
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted	**1902(r)(2) Children 1902(r)(2) XXI RO**	Standard	
Medicaid Expansion Children II (effective January 1, 2014)	Ages 19 and 20: 133.1 through 150%	Title XIX	**1902(r)(2) Children**	Standard	
CHIP Unborn Children	0 through 200%	Title XXI	**n/a**	Standard	
Pregnant women	0 through 185%	Title XIX	**Base Families**	Standard	
Parents and caretaker relatives ages 19 through 64 eligible under section 1931	0 through 133%	Title XIX	**Base Families**	Standard	

Table A. MassHealth State Plan Base Populations (continued)*					
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**
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	Must spend-down to medically needy income standard to become eligible as medically needy
Pregnant women	185.1 through 200%	Title XIX	**1902(r)(2) Children**	Standard	

Table A. MassHealth State Plan Base Populations (continued)*					
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**
"Non-qualified Aliens" or "Protected Aliens"	Otherwise eligible for Medicaid under the State Plan	Title XIX	**Base Families** **Base Disabled 1902(r)(2) Children** **1902(r)(2) Disabled** **New Adult Group (New Adult Group coverage began January 1, 2014)**	Limited	Member eligible for emergency services only 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	

Table A. MassHealth State Plan Base Populations (continued)*					
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**
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 • Require hospital or nursing facility level of care • Income < or = to $72.81, or deductible • $0 through $2,000 in assets	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

Table A. MassHealth State Plan Base Populations (continued)*					
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	• 0 through 300% SSI Federal Benefits Rate • $0 through $2,000 in assets	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 (effective January 1, 2014)	• Ages 19 and 20: 0 through 133% • Individuals with HIV or breast or cervical cancer: 0 through 133% • Individuals receiving services or on a waiting list to receive services through the Department of Mental Health: 0 through 133%	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

Table A. MassHealth Demonstration Expansion Populations *					
Groups with a Categorical Link Made Eligible through the Demonstration ("Hypotheticals")	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
Higher income children with disabilities	· < Age 1: 200.1 through 300% · Ages 1 - 18: 150.1 through 300%	• Title XIX if insured at the time of application • Title XXI via the separate XXI program if uninsured at the time of application (Funded through title XIX if title XXI is exhausted)	**CommonHealth** **CommonHealth** **XXI**	CommonHealth	The CommonHealth program existed prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI state plan and as authorized under this 1115 demonstration. Certain children derive eligibility from both the authority granted under this demonstration and the separate XXI program.
Higher income children with disabilities ages 0 through 18	Above 300%	Title XIX	**CommonHealth**	CommonHealth	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL

Higher income adults with disabilities ages 19 through 64.	Above 133% Above 150% for 19- and 20-year olds)	Title XIX	**CommonHealth**	CommonHealth ("working")	Such individuals are subject to a one-time only deductible except that there is no deductible for individuals who work 40 hours or more per month. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

Table A. MassHealth Demonstration Expansion Populations *					
Groups with a Categorical Link Made Eligible through the Demonstration ("Hypotheticals")	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
Higher income adults with disabilities who are 65 and older.	Net income above 100% FPL and/or Assets> $2,000	Title XIX	**CommonHealth**	CommonHealth (65+)	Such individuals are subject to a deductible and asset test under the State Plan except there is no deductible or asset test for individuals who have paid employment for 40 hours or more per month. Individuals who met the deductible and asset test under the State plan receive MassHealth Standard. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

Table A. MassHealth Demonstration Expansion Populations *					
Groups with a Categorical Link Made Eligible through the Demonstration ("Hypotheticals")	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
"Out-of-state Former Foster Care Youth" 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 (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.	No FPL requirements	Title XIX	**FFCY**	Out-of-state Former Foster Care Youth	These individuals are limited to those that were or would have been eligible for State Plan coverage as described in the January 22, 2013 CMS notice of proposed rulemaking that permitted the option to cover formerly out-of-state former foster care youth up to age 26 pursuant to section 1902(a)(10)(A)(i)(IX) of the Act. This coverage is now only permissible under the authority of this section 1115 demonstration as outlined in the November 21, 2016 CIB on transitioning coverage for Former Foster Care Youth. Individuals enrolled as Out-of-State Former Foster Care Youth are eligible to receive MassHealth Standard.

Table A. MassHealth Demonstration Expansion Populations (See STC 91 for terminology)					
Populations Made Eligible through the Demonstration	**Federal Poverty Level (FPL) and other qualifying criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**Massachusetts Demonstration Program**	**Additional comments**
Children ages 1 through 18 (Non-disabled) Children less than age 1	150.1 through 200 Above 200 through 300% (effective January 1, 2014) Above 200 through 300% (effective January 1, 2014)	• Title XIX if insured at the time of application • Title XXI via the separate XXI program if uninsured (Funded through title XIX if title XXI is exhausted)	**e-Family Assistance** **Fam Assist XXI** (if XXI is exhausted)	Family Assistance • Premium Assistance • Direct Coverage The premium assistance payments and FFP will be based on the children's eligibility. Parents are covered incidental to the child. No additional wrap other than dental is provided to ESI.	Effective January 1, 2014, children ages 0 through 18 from 200-300% FPL who are insured at the time of application are eligible under the 1115 demonstration. Children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration and the XXI program.

Table A. MassHealth Demonstration Expansion Populations (See STC 91 for terminology)					
Populations Made Eligible through the Demonstration	**Federal Poverty Level (FPL) and other qualifying criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**Massachusetts Demonstration Program**	**Additional comments**
Adults under the age of 65 who are not otherwise eligible for medical assistance who work for a small employer and purchase ESI that meets basic benefit level (BBL) standards	133.1 through 300%	Title XIX	**SBE**	Small Business Employee Premium Assistance	Individuals must not be eligible for any other MassHealth coverage or for APTCs. No additional wraparound benefits are provided. Individuals whose spouse or children are receiving MassHealth premium assistance for a policy that is available to the individual are not entitled to this benefit.

Table A. MassHealth Demonstration Expansion Populations(continued)*					
Populations Made Eligible through the Demonstration	**Federal Poverty Level (FPL) and other qualifying criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**Massachusetts Demonstration Program**	**Additional comments**
Individuals with HIV not otherwise eligible for medical assistance with income above 133% through 200% FPL.	Above 133 to 200%	Title XIX	**e-HIV/FA**	Family Assistance	Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.
Individuals who receive Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children	N/A	Title XIX	**TANF/EAE DC**	MassHealth	Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not an income determination.
Provisional Eligibility	Self-Attested income level to qualify for other group, pending verification	Title XIX	**Provisional Eligibility**	MassHealth	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority in accordance with STC 24.

Table A. MassHealth Demonstration Expansion Populations(continued)*					
Populations Made Eligible through the Demonstration	**Federal Poverty Level (FPL) and other qualifying criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**Massachusetts Demonstration Program**	**Additional comments**
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	Ineligible for MassHealth and Eligible for QHP up to 400% FPL	Title XIX	**End of Month Coverage**	N/A	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 29.
Individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Demonstration Program under the demonstration by qualified hospitals that elect to do so.	HIV-Family Assistance – 133.1 through 200 BCCDT – above 133.1 through 250	Title XIX	**Presumptively Eligible**	Family Assistance Standard	
Individuals determined eligible for the Breast and Cervical Cancer Demonstration Program under the demonstration.	BCCDT – above 133.1% of the FPL through 250 FPL	Title XIX	**BCCDP**	Standard	

V. DEMONSTRATION PROGRAMS AND BENEFITS

29. **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.

30. **Demonstration Program Benefits.** Massachusetts provides health care benefits through the following specific benefit programs. The benefit program for which an individual is eligible is based on the criteria outlined in Table A of Section IV of the STCs. Table B in STC 38, provides a side-by-side analysis of the benefits offered through these MassHealth programs.

31. **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 New 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 49 and 50.

    MassHealth Standard benefits include, for individuals with incomes at or below 133 percent of FPL who are also eligible for Medicare, (1) payment of monthly Medicare Part B premiums, (2) payment of hospital insurance premiums under Medicare Part A; and, (3) payment of deductibles and co-insurance under Medicare Part A and B. 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.

32. **MassHealth CarePlus.** MassHealth's CarePlus ABP is for individuals in the New 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 49 and 50.

33. **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.

34. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under 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 49 and 50. In addition, for CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth will also pay the cost of the monthly Medicare Part B premium. 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 without applying an asset test.

35. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under 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 coordination with STC 49. There are two separate categories of eligibility under Family Assistance:

    a) **Family Assistance-HIV/AIDS**. As referenced in Table A above, for persons with HIV/AIDS whose income is above 133 percent less than or equal to 200 percent of the FPL would be eligible for the New 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 A 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. 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.

36. **MassHealth Small Business Employee (SBE) Premium Assistance.** Under the SBE Premium Assistance Program, the Commonwealth will make premium assistance payments for certain individuals whose gross family income is greater than 133 percent of the FPL and less than or equal to 300 percent of the FPL, who work for employers with 50 or fewer employees, who have access to qualifying ESI, and where the member is ineligible for other subsidized coverage through MassHealth or the Health Connector. Benefits are limited to premium assistance payments for qualifying ESI that meets basic benefit level (BBL) standards.

37. **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.

38. **Former Foster Care Youth.** Individuals enrolled as "Former Foster Care Youth" as described in Table A above are eligible to receive MassHealth Standard.

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

Table B. Summary of MassHealth Direct Coverage Benefits are described in Table Below

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

Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
Chapter 766 Home Assessment* **	X	X	X	
Chiropractic Care	X	X	X	
Chronic Disease and Rehabilitation Hospital Inpatient	X	X	X	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	
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

Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
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
Speech and Hearing Services	X	X	X	X
Targeted Case Management	X	X		

Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X
Vision Care	X	X	X	X

Chart Notes

****Adult Foster Care Services –** 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

***** Chapter 766 Home Assessments –** 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.

****** Day Habilitation Services** – 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.

40. **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. Some of the 24 hour service providers of Diversionary Behavioral Health Services meet the

definition of an Institution for Mental Diseases (IMD). 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. Any MassHealth member under the demonstration who is enrolled in managed care may be eligible to receive diversionary services. Managed care entities and the Prepaid Inpatient Health Plan (PIHP) for behavioral health services identify appropriate individuals to receive diversionary services. Managed care entities maintain a network of diversionary services and arrange, coordinate, and oversee the provision of medically necessary diversionary services, as described in Table C.

Table C. Diversionary Behavioral Health Services Provided Through Managed Care Under the Demonstration

Diversionary Behavioral Health	Setting	Definition of Service
Community Crisis Stabilization	24-hour facility	Services provided as an alternative to hospitalization, including short- term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.
Community Support Program (CSP)	Non-24-hour facility	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 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. 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.

Diversionary Behavioral Health	Setting	Definition of Service
Community Support Program (CSP) (continued)	Non-24-hour facility	When provided to chronically homeless individuals, CSP services fall into the following domains: a. Assisting Members in enhancing daily living skills; • Identifying and addressing barriers to attaining and maintaining community tenure • 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 • Coaching members on budget strategies and/or supporting Members to connect with money management services, including financial counselors and representative payees • Support to gather documentation such as government identification documents, medical records • Linkages to education, vocational training/services b. Providing service coordination and linkages; • Referrals to healthcare providers • 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 publically-subsidized transportation options • Collaborating with state agencies, outpatient or community-based providers, Emergency Services Programs (ESPs), or other significant entities on service and discharge

Diversionary Behavioral Health	Setting	Definition of Service
Community Support Program (CSP) (continued)	Non-24-hour facility	planning • Discharge planning that involves collaterals as appropriate. Collaterals include state agencies, community-based programs, and other non-health care community supports • Provider coordinates care with Members' primary care providers to be knowledgeable of medical conditions, to assess Members' compliance with medical treatment, and to assist with mitigating related barriers c. Assisting Members with obtaining benefits, housing, and health care; • Providers work with housing agencies to obtain documentation of housing status • Working with Members to identify transitional supports for move-in • Connecting Members to housing search assistance, and helping to coordinate search(es) • Linkages to primary and preventive health services Linkages to behavioral health and substance use disorder treatment • 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 • Working with Member to identify resources for home modifications as needed d. Developing a crisis plan in the event of a psychiatric crisis; • Refer the Member to outpatient provider • Refer the Member to an ESP • Implement other interventions such as Member's safety plan

Diversionary Behavioral Health	Setting	Definition of Service
Community Support Program (CSP) (continued)	Non-24-hour facility	• Collaborate with providers (including ESPs) and natural supports e. Providing prevention and intervention; • 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; and key providers) to identify ways to mitigate barriers to accessing clinical treatment and attaining the skills to obtain and maintain community tenure • Developing a service plan/treatment plan (linkages to health, behavioral health, and substance use treatment) • Assisting Members to prepare for transition to permanent supportive housing by linking Members to entities that provide transitional assistance resources. This may include referrals to churches, local housing authorities and non-profit agencies. Transitional assistance includes non-recurring household set-up expenses • Discharge planning that involves collaterals • Early intervention for potential issues/behavior intervention affecting tenancy f. Fostering empowerment and recovery, including linkages to peer support and self-help groups

Diversionary Behavioral Health	Setting	Definition of Service
Community Support Program (CSP) (continued)	Non-24-hour facility	• Recovery, wellness and empowerment principles and practices are incorporated in service delivery, trainings, and quality improvement activities • 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 • Provider educates Members and their natural supports about substance use and psychiatric disorders, recovery and medications, and links with regular health services
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 therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.

Acute Treatment Services for Substance Abuse	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 physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women 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.
Clinical Support Services for Substance Abuse	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 women receive coordination of their obstetrical care.

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, including IMDs	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	Non-24-hour	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.

Diversionary Behavioral Health	Setting	Definition of Service
Structured Outpatient Addiction Program	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 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 women, adolescents and adults requiring 24-hour monitoring.
Program of Assertive Community Treatment	Non-24-hour facility	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. 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.

Diversionary Behavioral Health	Setting	Definition of Service
Emergency Services Program*	Non-24-hour facility	Services provided through designated contracted ESPs, 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.
Community Based Acute Treatment for Children and Adolescents	24-hour facility	Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (which is defined as one- on-one therapeutic monitoring as needed for individuals who may be at immediate risk for suicide or other self- harming behavior); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.
Chart Notes:		
* This service is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment.		
** 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.		

41. **Substance Use Disorder Services**

As part of this demonstration Project, in addition to the Substance Use Disorder (SUD) services described in Charts B and C, above, FFP is available under the demonstration for the Substance Use Disorder (SUD) services described in Chart D, below. By providing improved access to treatment and ongoing recovery support, EOHHS believes individuals with SUD will have improved health and increased rates of long-term recovery. These SUD services will contribute to reduced use of the emergency department and unnecessary hospitalizations.

As is currently the case, MassHealth anticipates that the Department of Public Health,

Bureau of Substance Abuse Services (BSAS), which is the single state authority on SUD services, 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.

Table D. Additional SUD Authorized Services

Service for People with SUD	Population	Setting	Definition of Service
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. Residential Rehabilitation Services includes day programming and individual and group services.

Service for People with SUD	Population	Setting	Definition of Service
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.

Chart Notes: 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 carve out vendor. 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.

VI. 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 (ESI) or student health (SHIP) insurance 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.

42. **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 43-45. MassHealth may require 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 do not choose 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 A) are required to enroll in Managed Care, subject to all other applicable provisions of section **VI: 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 E below for additional details on Managed Care eligibility and enrollment rules.

43. **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 contractor 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.

44. **Managed Care Delivery Systems**

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

Table E. Overview of Managed Care Delivery Systems

Managed Care					
PCCM delivery systems			**MCO-based delivery systems**		
PCC Plan		**Primary Care ACOs** (previously "Model B ACOs")	**MassHealth MCOs**		**Partnership Plans** (previously "Model A ACOs")
Non-Pilot	*ACO Pilot*		*Non-ACO*	*MCO-Administered ACOs (previously "Model C ACOs")*	

45. **PCCM delivery systems:**

a) **The PCC Plan.** The PCC Plan is a managed care option 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. **Enhanced Primary Care Clinician Payments.** In accordance with 42 C.F.R. section 438.6(c), MassHealth may establish enhanced fee-for-service rate payments or capitated rate 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 capitated or other 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.

ii. **ACO Pilot.** In state fiscal years 2017 and 2018, MassHealth will contract with ACOs ("Pilot ACOs") for an ACO Pilot within the PCC Plan; the ACO Pilot is not a separate delivery system or an enrollment option for members. Members in the PCC Plan will not experience fixed enrollment periods for the ACO Pilot, and members will still have access to all PCC Plan benefits and network of providers. Pilot ACOs consist of provider-led entities such as health systems or groups of health care providers that contract with MassHealth to provide care coordination and management and to take financial accountability for cost and quality of care for certain attributed PCC Plan members. Members enrolled in the PCC Plan who are assigned to PCCs that participate with Pilot ACOs will be considered attributed to these Pilot ACOs. MassHealth may establish Referral Circles for Pilot 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 ACO-attributed members, in order to facilitate increased access and coordinated care. MassHealth will hold Pilot 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 exceed potential shared losses). MassHealth will contract with Pilot ACOs selectively. Pilot ACOs are not managed care entities under 42 CFR 438. See Attachment L for additional detail on the ACO Pilot.

b) **Primary Care ACOs.** Primary Care ACOs are managed care options operated by MassHealth using PCCM contractors ("Primary Care ACOs"). MassHealth contracts with Primary Care ACOs to serve as PCCM entities. Primary Care ACOs are not paid directly to provide services. 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 exceed potential shared losses). See Attachment O for additional detail on pricing for Primary Care ACOs.
iv. Similar to the Center for Medicare and Medicaid Innovation (CMMI) "Next Gen" ACO program and its option for population-based payment, MassHealth may also prospectively pre-pay a Primary Care ACO, at the request of both the Primary Care ACO and the providers. Providers and Primary Care ACOs may choose such arrangements to support greater control of service revenue funds within a coordinated system, to increase accountability for total cost of care, to support up-front investments in infrastructure that supports integrated care delivery, or for other purposes in service of MassHealth's delivery system goals. Under such a payment mechanism, MassHealth would continue to maintain the FFS network and receive claims from network providers for payments for services, but would reconcile those claims to prepayments for such services. The Commonwealth will submit a proposal for any such payment mechanism to CMS for approval prior to implementation.
v. 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. Such arrangements will be consistent with 42 CFR 438.6.
vi. MassHealth will contract with Primary Care ACOs selectively. Primary Care ACOs are PCCM entities under 42 CFR 438.

c) **Other features of MassHealth's PCCM 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).

46. **MCO-based delivery systems:**

a) **MassHealth MCOs.** MassHealth contracts selectively with Managed Care Organizations (MCOs) that 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. Over the course of the Demonstration, MassHealth anticipates that enrollees will begin to receive certain of these Direct Coverage services from the MCOs. For example, Long Term Services and Supports (LTSS) are anticipated to be phased into MCO covered services during the Demonstration extension period. 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. See Attachment O for

additional detail on pricing for MassHealth MCOs. MassHealth MCOs are MCOs under 42 CFR 438.

1. The State may limit disenrollment for MCO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
2. MCO contracts will include requirements to use alternative payment methodologies and other arrangements described in STC 43 and Attachment Q, to increase accountability 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 exceed potential shared losses).
3. **MCO-Contracted ACOs.** MassHealth will select certain qualified ACOs through a competitive selection process, for accountability for services furnished through MassHealth ACOs. These "MCO-Contracting ACOs" will be provider-led entities such as health systems or groups of health care providers that contract with MCOs to provide care coordination and management and to take financial accountability for cost and quality of care for certain attributed MCO enrollees. They are not managed care entities under 42 CFR 438 and there will not be a separate delivery system or enrollment option for MCO enrollees attributed to MCO-contracting ACOs; such individuals will receive services from the MCO service delivery system. MCO enrollees who receive primary care from primary care providers who participate in MCO- contracting ACOs are considered attributed to those ACOs for the purposes of this cost and quality accountability. MassHealth MCO contracts will include requirements for MCOs to contract with MCO-Contracted ACOs using a MassHealth-approved alternative payment contract framework that includes risk tracks and schedules set by the state, which will be broadly consistent with 42 CFR 438.6(c). This alternative payment contract framework will hold MCO-Contracted ACOs financially accountable through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses). As with MCO enrollees not attributed to ACOs, these MCO enrollees may experience fixed enrollment to their MCO, and receive services from their MCO's provider network (except for certain Direct Coverage services provided directly by MassHealth, as described above) subject to their MCO's rules for referral, prior authorization, and primary care provider assignment. See Attachment O for additional detail on pricing for MCO-Contracted ACOs.

b) **Accountable Care Partnership Plans ("Partnership Plans").** MassHealth will contract selectively with Partnership Plans 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 covered directly by MassHealth for members enrolled in Partnership Plans. Over the course of the Demonstration, MassHealth anticipates that enrollees will begin to receive certain of these Direct Coverage services from the Partnership Plans. For example, Long Term Services and Supports (LTSS) are anticipated to be phased into Partnership Plan covered services during the Demonstration extension period. 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. See Attachment O for additional detail on pricing for Partnership Plans.

    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 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. Such arrangements will be consistent with 438.6.

iii. MassHealth will contract with Partnership Plans selectively. Partnership Plans are MCOs under 42 CFR 438.

47. 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), all Pilot ACOs, Primary Care ACOs, Partnership Plans, and MCO-Contracted ACOs (all 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 Pilot ACO may not simultaneously participate with another Pilot ACO
b) A primary care provider participating with a Primary Care ACO may not simultaneously participate with another Primary Care ACO, with a Partnership Plan, or with an MCO-Administered ACO. 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.
c) A primary care provider participating with a Partnership Plan may not simultaneously participate with a Primary Care ACO, with another Partnership Plan, or with an MCO- Administered ACO. 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.
d) A primary care provider participating with an MCO-Contracted ACO may not simultaneously participate with a Primary Care ACO, with a Partnership Plan, or with another MCO-Contracted ACO. This primary care provider also may not serve as a PCC in the PCC Plan. This primary care provider may not serve as a network PCP in the network of a MassHealth MCO, except as part of the MCO-Contracted ACO (i.e., the MCO must have a MassHealth-approved ACO contract with the MCO-Contracted ACO). This primary care provider will exclusively serve as a primary care provider for MassHealth MCO enrollees who are attributed to the MCO-Contracted ACO.

Where this 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).

48. Contracts.

a) Managed Care Contracts. All contracts and modifications of existing contracts between the Commonwealth and MCOs or between the Commonwealth and Partnership Plans must be prior approved by CMS. The Commonwealth will provide CMS with a minimum of 90 calendar days to review and approve changes.

i. MassHealth may make periodic payments of the types described below to managed care entities (MCE), including MCOs, Partnership Plans and PIHPs, and direct that these payments be made to hospitals in the MCEs' networks:

For example, starting in MCO Rate Year 2017 (October 1, 2016-September 30, 2017), MassHealth will direct its contracted MCOs to make payments to hospitals in their networks as an incentive for hospitals to report on and subsequently improve access to appropriate medical and diagnostic equipment for members with disabilities.
MassHealth will calculate the payments for which each hospital is eligible based on current year Medicaid Gross Patient Service Revenue and will direct the MCOs to make payments accordingly, contingent on the hospitals meeting requirements set forth by MassHealth. While this program will not be renewed automatically, it will be a multi- year initiative in which the first two years will require reporting by hospitals on access to medical and diagnostic equipment, and future years will include related performance requirements for hospitals. In future years this program may also be administered by Accountable Care Partnership Plans, in accordance with Attachment O and Q.

b) Public Contracts. Contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index), unless the contractual payment rate is set at the same rate for both public and private providers. This requirement does not apply to contracts under the SNCP as outlined in STC 53.

c) Selective Contracting. Procurement processes and the subsequent final contracts developed to implement selective contracting by the Commonwealth with any provider group shall be subject to CMS approval prior to implementation, except for contracts authorized pursuant to 42 C.F.R. section 431.54(d).
d) Capitation Rate Development. Capitation rates for MCOs and Partnership Plans shall comply with the rate development and certification standards in 42 CFR §438. The Commonwealth shall develop its capitation rates in a manner consistent with Attachment O.

49. 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, Massachusetts provides a contribution through reimbursement, direct payment to the insurer, or direct payment to an institution of higher education (or its designee) that offers a Student Health Insurance Plan (SHIP), toward an individual's share of the premium for an employer sponsored health insurance plan or SHIP 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. For individuals eligible for premium assistance only through the SBE ESI program, this same test will apply.

If available and cost effective, the Commonwealth will provide premium assistance on behalf of individuals eligible for Standard (including ABP 1), CarePlus or CommonHealth coverage, to assist them in the purchase of private health insurance coverage. The state 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 state 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 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 under the age of 21, or pregnant.

50. Student Health Insurance (SHIP) Plans. For individuals with access to SHIP plans, the Commonwealth may require enrollment in such plan as a condition of receiving benefits. Once the individual enrolls in the SHIP Plan, premium and cost sharing assistance will be provided for the entire plan year or the duration of the SHIP plan enrollment, if less than one year. The state will also ensure individuals receive comparable benefits to those offered in Medicaid programs the individual is eligible for receiving, for the duration of the individual's enrollment in SHIP. In addition, for those individuals enrolled in SHIP plans with premium assistance, the Commonwealth will provide continuous eligibility that will coincide with the SHIP plan year, or the duration of the SHIP plan enrollment, if less than one year, for which premium assistance is provided.

51. 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:

Table F. Delivery System and Coverage for MassHealth Demonstration Programs

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Standard/Standard ABP					
Individuals with no third party liability (TPL)	Managed Care (PCC Plan, MCO, or Accountable Care)	X			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to 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
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Kaileigh Mulligan eligible children and children receiving title IV-E adoption assistance	Behavioral health is typically provided via BHP PIHP, although a FFS alternative must be available; all other services are offered via Managed Care or FFS.		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 the applicant would have been eligible at the time services were provided." Title IV-E adoption assistance - start date of adoption
Medically complex children in the care/custody of the DCF	Special Kids Special Care MCO		x		Start date of state custody
Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF	All 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 or Accountable Care Partnership Plan	x	x	x	Start date of state custody

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
	in which case, behavioral health is provided through the MCO or Accountable Care Partnership Plan				
Provisionally eligible pregnant women 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 Treatment Program	Managed Care	X			10 days prior to date of application
CommonHealth*					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
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
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
Family Assistance for HIV/AIDS*					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
Family Assistance for Children***					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
CarePlus					
Individuals with no TPL	Managed Care	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			X	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Small Business Employee Premium Assistance					
Individuals with qualifying ESI	Premium assistance for employees			N/A	First month's premium payment following determination of eligibility
Limited					
Individuals receiving emergency services only	FFS			X	10 days prior to 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.
Health Connector Subsidies	Premium and cost sharing assistance	X			Start date of Health Connector benefits
Chart Notes					
*****TPL wrap could include premium payments					
** FFS until member selects or is auto-assigned to MCO, ACO or PCC Plan					
***Presumptive and time-limited during health insurance investigation					
**** All retroactive eligibility is made on a FFS basis.					

VII. COST SHARING

52. Overview. Cost-sharing 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 women. Additionally, no premium payments are required for any individual enrolled in the demonstration whose gross income is less than 150 percent FPL. Please see Attachment B for a full description of cost-sharing under the demonstration for MassHealth- administered programs. The Commonwealth has the authority to change cost-

sharing for the Small Business Employee Premium Assistance programs without amendment. Updates to the cost- sharing will be provided upon request and in the annual reports,

a. State Differential Cost Sharing and Network Adequacy. The Commonwealth's ability to implement premiums and copayments cost sharing that vary by eligibility group, income level, delivery system and service as described in Attachment B through June 30, 2020 may be extended with approval from CMS, based on findings of an evaluation of aggregate provider networks in the ACO and MCO programs relative to the PCC Plan, as further described in Section XI (language below in Evaluation section), using metrics created by the state. If the findings are satisfactory to CMS then the waiver authority and the waiver is extended, such renewal shall not require that the state submit an amendment request to the demonstration.

VIII. THE SAFETY NET CARE POOL (SNCP)

53. 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 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 has been restructured to include the following expenditure categories:

a) Payments that offset Medicaid FFS and managed care underpayment, and uncompensated care for uninsured and underinsured (DSH – shortfall and uninsured).
b) 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) Time-limited incentive based pools, that phase down over the course the five-year extension period; and
d) Expenditures for Health Connector subsidies.

54. 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 52, 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) Payments for Uncompensated Care

i. **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 DSRIP and PHTII 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 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 55. The DSH Pool may include expenditures for:

1. Public Service Hospital Safety Net Care payments to hospitals for care provided to eligible low income uninsured and underinsured patients;
2. Health Safety Net Trust Fund payments to hospitals and community health centers for care provided to eligible low income uninsured and underinsured patients;
3. Payments to Institutions for Mental Disease (IMDs) for care provided to MassHealth Members, to the extent these expenditures are not claimed under the SUD authority described in STC 41;
4. Certified public expenditures for uncompensated care provided by Department of Public Health (DPH) and Department of Mental Health (DMH) hospitals; and
5. Safety Net Provider Payments to qualifying hospitals, as described in (2) below.

ii. **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.

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 2014 Uncompensated Care Cost Report (UCCR) and, if a UCCR is unavailable, Massachusetts 403 hospital cost reports for these calculations:

To be eligible, the hospital must meet the following three 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.

Once meeting the above eligibility criteria, a hospital may only receive a Safety Net Provider payment if its FY14 UCCR or, if an FY14 UCCR is unavailable, its FY14 403 cost report demonstrates that it experienced a shortfall for the combination of its Medicaid FFS, managed care, and Uninsured payments versus costs for Medicaid and Uninsured patients, excluding Safety Net Care Pool payments other than Health Safety Net Trust Fund payments. 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.

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, an increasing portion of Safety Net Provider Payments each year of the demonstration extension period will be tied to ACO performance measures as defined in the approved DSRIP Protocol. The benchmarks for ACO performance and methodology for calculating the ACO Accountability Score and associated payment will be the same as the benchmarks and methodology used in the DSRIP program and specified in the approved DSRIP Protocol. The risk levels for each year are specified below.

The portion of the Safety Net Provider Payments 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. Funds for the 6-month Preparation Budget Period (July 1, 2017 to December 31, 2017) for each safety net provider will be equal to half of the provider's Safety Net

Provider Payments in Demonstration Year 1. Budget Period 1 funds for each safety net provider will be equal to the sum of half of the provider's Safety Net Provider Payments in Demonstration Year 1, and half of the Payments in Demonstration Year 2. Budget Periods 2 through 4 for each safety net provider will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds for each safety net provider will be equal to half of the provider's Safety Net Provider Payments in Demonstration Year 5.

The risk levels for each Budget Period are specified below:

a. 6-month Preparation Budget Period: 5% of each provider's total Safety Net Provider Payments / – hospitals that participate in a MassHealth ACO model will have met the accountability requirement for the 6 month Preparation

Budget Period

b. Budget Period 1: 5% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
c. Budget Period 2: 5% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
d. Budget Period 3: 10% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
e. Budget Period 4: 15% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
f. Budget Period 5: 20% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures

iii. Uncompensated Care (UC) Pool

1. 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 non-Medicaid-eligible, uninsured individuals. Payments to an individual provider cannot exceed uncompensated care expenditures documented in cost reports or other records, except that DSRIP and PHTII incentive payments will not be included as hospital patient care revenues for this purpose. Consistent with the Cost Limit Protocol, incentive payments, including DSRIP and PHTII, will not be included as hospital patient care revenues for this purpose. Expenditures provided under the UCC Pool are not subject to the Provider Cap for the DSH Pool described in STC 52. The UCC Pool will include expenditures for:

a. Health Safety Net payments to hospitals specifically for costs incurred by the hospital in providing care to Health-Safety Net qualified low income, uninsured patients;
b. Certified public expenditures for DPH and DMH hospital expenditures for care provided to uninsured patients, when the source of the non-federal share of such expenditures is not derived from federally-supported funds.

2. Massachusetts will only claim expenditures under the UC Pool to the extent that such expenditures for a particular hospital, when added to amounts paid through the DSH

Pool, do not exceed the hospital's documented uncompensated care (except

as specified below, for critical access hospitals). The methodology used by the state to determine UC payments will ensure that payments to hospitals are in no way subject to any manifest partiality based on sources of nonfederal share or other funding considerations.

3. Prior to the initiation of the Uncompensated Care Pool and at any time in which there is a material change in the pool's distribution methodology, the Commonwealth shall submit an Uncompensated Care Pool Distribution Methodology Report that describes the specific allocation methodology of the pool and demonstrates compliance with the above STCs.

55. Expenditure Limits under the SNCP.

a) Aggregate SNCP Cap. For SFYs 2018-2022 (July 1, 2017 through June 30, 2022) (SNCP extension period), the SNCP will be subject to an aggregate cap of up to $4.514 billion added to the provider cap for the DSH-like pool described in STC 52 (b) below, as well as the overall budget neutrality limit established in section XI of the STCs, provided, however, that allowable expenditures for Health Connector subsidies will not be subject to the aggregate SNCP cap. 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 52(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 53(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, ("DSH"). 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 Pool has been fully expended.

c) Uncompensated Care Pool Cap. The Commonwealth may expend up to $212 million (total computable) for SFY 2018 and up to $100.4 million (total computable) annually in SFYs 2019- 2022 for allowable UC Pool expenditures, as further described in Attachment E. Any unused expenditure authority in SFY 2018 can be expended in SFY 2019, subject to any applicable approval processes described in

STC 74.

d) Budget Neutrality Reconciliation. The Commonwealth is bound by the budget neutrality agreement described in section XIII 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 XIV, STC 109.

56. Cost for Uncompensated Care. The SNCP payments pursuant to STC 54(a) support providers for furnishing uncompensated care. This protocol ensures that all provider payments for uncompensated care pursuant to STC 54(a) 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. DSRIP and PHTII revenues 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% of the cost of providing Medicaid services, and 100% of uncompensated care costs as specified by the provisions of Section 1923(g) of the Act as implemented by 447.295(d).

57. Transition of Specified Safety Net Provider Payments and Public Hospital Transformation and Incentive Initiatives into Medicaid Managed Care/ACO Incentive Payment Mechanisms. As the delivery system reforms are implemented, the Commonwealth and CMS seek to shift payments to risk- based alternative payment models focused on accountability for quality, integration and total cost of care. These payments are described in Attachment Q, MassHealth MCO Incentives.

58. Designated State Health Programs. The Commonwealth may claim as allowable expenditures under the demonstration Health Connector subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide 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 eligible; and (2) whose income is at or below 300 percent of the FPL through 300 percent of the FPL. The state may also claim as allowable expenditures under the demonstration the payments made through its state-funded Health Safety Net (HSN) program to provide gap coverage subsidies for individuals eligible for coverage through the Health Connector with incomes at or below 300% FPL. HSN-Health Connector gap coverage subsidies are provided to eligible individuals during the time designated to select and enroll in a plan through the Health Connector.

Federal financial participation for the premium assistance, gap coverage, and cost-sharing portions of Health Connector subsidies for citizens and eligible qualified non-citizens will be provided through the Designated State Health Programs authority under the SNCP pursuant to this STC. Allowable expenditures for Health Connector subsidies

will not be subject to the aggregate SNCP limit described in STC 52 or other SNCP sub-caps.

59. Cambridge Health Alliance (CHA) Public Hospital Transformation and Incentive Initiatives (PHTII). CHA is the Commonwealth's only non-state, non-federal public acute hospital and has among the highest concentration of patients participating in MassHealth demonstration programs of any acute hospital in the Commonwealth.

The PHTII program, which was established in the previous demonstration extension period, will evolve to focus on two areas that align with the Commonwealth's plans for a restructured MassHealth delivery system centered around ACOs and emphasizing the integration of care across physical and behavioral health care, long term services and supports, and health related social services. The two areas of focus for PHTII are:

a) Participation in an ACO model and demonstrating success on the corresponding ACO performance measures, utilizing the same performance measures as specified for the DSRIP initiative; because CHA relies on PHTII as an important component of its overall MassHealth funding structure, enhancing the level of incentive funding tied to these critical measures will ensure alignment across payment streams and enable CHA to devote attention and resources to improving these outcomes;

b) Continuation and strengthening of initiatives approved through PHTII from the prior demonstration period, including but not limited to initiatives focusing on access to behavioral health services and integration of behavioral health care with physical health care, given CHA's role as a major provider of behavioral health services. These PHTII initiatives will build on work done during the 2014-2017 period and will include a strengthened set of outcome and improvement measure slates that reflect the potential for greater measurable impact over time.

Attachment E specifies the total potential funding available for CHA's Public Hospital Transformation and Incentive Initiatives. An increasing proportion of PHTII funding will be at-risk based on ACO performance, outcome and improvement measures over the course of the demonstration period. For example, the proportion of total PHTII funding tied to CHA's performance on MassHealth DSRIP accountability measures as part of an ACO increases from 5% to 20% over the course of the demonstration period. In addition, 10 percent of total PHTII funding each year will be tied to performance on outcomes and improvement measures associated with continuing PHTII initiatives from the prior demonstration period. The remainder of PHTII incentive funding is contingent on CHA's successful completion of initiative activities and reporting. Further details regarding the Metrics and Evaluation of the initiatives are outlined in Attachment K.

PHTII 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, Public Hospital Transformation and Incentive Initiative payments 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.

To the extent that CHA fails to meet PHTII accountability measures and does not receive PHTII payments, the expenditure authority for PHTII will be reduced by the amount not payable.

Intended Funding Source: The non-federal share of PHTII payments will be provided through permissible intergovernmental transfer provided by CHA (from funds that are not federal funds or are federal funds authorized by federal law to be used to match other federal funds in accordance with 1903(w) of the Act and implementing regulations).

60. Delivery System Reform Incentive Program (DSRIP). The state may claim, as authorized expenditures under the demonstration, up to $1.8 billion (total computable) for five years, performance- based incentive payments to entities that support change in how care is provided to Medicaid beneficiaries through payment and delivery system reforms. 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 67(b).

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

a. **Objective and Goals.** The objective of the DSRIP program is to further key goals of the 1115 demonstration, including: (1) enacting payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improving integration among physical health, behavioral health, long-term services and supports, and health-related social services; and (3) sustainably supporting safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals.

The goal of the DSRIP program is to provide a time-limited investment into the provider community that will facilitate transition away from a fee-for service payment model to one that moves toward alternative payment models. These models assure that health care services are member-driven, integrated, and coordinated and that begins to address social determinants of health while moderating the cost trend.

b. **Accomplishment of Goals.** Massachusetts seeks to accomplish its goals through the creation of three ACO models, certification of and investment in Community Partners, and investments in statewide infrastructure and workforce development. Minimal funds will be used for state implementation and oversight.

c. **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.

d. **Expenditure Limits.** The Commonwealth may claim FFP for up to $1.8 billion in DSRIP expenditures.

i. An increasing amount of state DSRIP expenditure authority will be at-risk over the five-year period (See STC 68).
   a) The State's expenditure authority will be reduced based on the State's DSRIP Accountability Score (See STC68). MassHealth will reduce DSRIP payments in proportion to the reduced expenditure authority.

ii. Enrollment Adjustments. Given that a significant portion of DSRIP expenditure authority will be disbursed on a PMPM bases, lower than anticipated member participation in the ACO or CP programs may lead to lower actual expenditures in a given DSRIP year. Therefore, the state may carry forward prior year DSRIP expenditure authority from one year

to the next. The state may only carry forward expenditure authority from one DSRIP year to the next for reasons related to member participation fluctuations. If the carry forward amount from any given year to the next is more than 15%, the state must obtain CMS approval. The state must ensure that carry over does not result in the amount of DSRIP for DY 25 being greater than the amount for DY 24.

e. **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 enrolled in ACOs, and the number of members who require BH and LTSS CPs services. As such, the state may reallocate funding amounts between funding streams at its discretion. If the actual funding amounts per DSRIP funding stream 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.

Table G. DSRIP Funding Allocation Total Computable (In Millions)

Funding Stream	DY 21	DY 22	DY 23	DY 24	DY 25	Total
ACO Funding	$329.2M	$289.9M	$229.4M	$152.0M	$65.1M	$1,065.6M
Community Partners	$57.0M	$95.9M	$132.2M	$133.6M	$128.0M	$546.6M
Statewide Investments	$24.2M	$24.6M	$23.8M	$24.8M	$17.4M	$114.8M
State Operations and Implementation	$14.6M	$14.6M	$14.6M	$14.6M	$14.6M	$73.0M
Total:	**$425.0**	**$425.0**	**$400.0**	**$325.0**	**$225.0**	**$1,800.0**

61. DSRIP Protocol. The State must develop and submit to CMS for approval a DSRIP Protocol, and work collaboratively with CMS towards an approval date of December 15, 2016. Once approved by CMS, this document will be incorporated as Attachment M of these STCs, and once incorporated 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) **DSRIP Protocol Requirements:** At a minimum the DSRIP protocol must contain the following information:

i. Specify a State review process and criteria to evaluate and monitor each ACOs and Community Partners individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;

ii. Specify a review process and timeline to evaluate DSRIP progress, in which first the State and then CMS must certify that a targets were met as a condition for FFP for the continued release of associated DSRIP funds;

iii. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating entity may be eligible to receive during the implementation of the DSRIP project, and a formula for determining the incentive payment amounts, quality incentive payments, any other outcomes- or performance-based payments, etc.;

iv. Specify that an entity's failure to fully meet performance targets under its DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);

v. Include a process that allows for potential modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which potential protocol modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and

vi. Include a State process of developing an evaluation of DSRIP as a component of the evaluation design as required by STC 85 When developing the DSRIP Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support

the Evaluation Design required in section XI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating entities should use similar metrics for similar projects to enhance evaluation and learning experience. To facilitate evaluation, the DSRIP Protocol must identify a core set performance targets that all participating entities and/or the State must be required to report.

c) **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.

62. ACO & CP 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.

63. 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 43-45 above.

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 flexible services. These services will be delineated in the post-approval Flexible Services Protocol. The Commonwealth will submit the protocol for CMS review and approval by May 2017. The protocol will include 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. 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.
         a) Address medical needs and provide direct benefit and support specific outcomes that are identified in the individual waiver participant's care plan; and
         b) Promote the delivery of covered services in community settings;
         c) Decrease the need for other Medicaid services;
         d) Reduce the reliance on paid support; or
         e) Are directly related to the health and safety of the member in his/her home or community; or
         f) 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 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 and CP during the quarter. If during the course of the demonstration CMS finds that flexible services provided by an ACO or CP 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 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 publically 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) Transitional "glide path" funding for DSTI safety net hospitals: This funding will only be available to ACOs that include a DSTI safety net hospital, and is allocated according to a MassHealth- determined schedule that was developed based on negotiations with CMS regarding the overall funding glide path for DSTI hospitals, inclusive of other funding streams.

f) 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 69).

g) Funding Methodology: The amount of DSRIP payments MassHealth provides to an ACO will be the summed amount of the three funding streams described in these STCs. An ACO's DSRIP funding allocation for startup/ongoing support and for flexible services will be determined by multiplying the number of lives attributed to the ACO by a per member per month (PMPM) rate. DSTI Glide Path funding will be based on a schedule determined by MassHealth for each specific DSTI hospital.

h) Startup/ongoing support: The PMPM amount for startup/ongoing funds decreases over the five year period, and will vary 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).

i) Flexible services support: The PMPM amount for flexible services is the same for every ACO.

j) Sustainability. The base PMPMs used to calculate payment amounts will decrease over the five years so as to avoid a funding cliff at the end of the DSRIP program. At that point, ACOs will be required to absorb incremental costs associated with new care expectations under TCOC management.

64. Assessments and Person-Centered Planning for LTSS. Consistent with the requirements at 42 CFR 438.208(b), the state will develop methods to identify members enrolled in MCO-based delivery systems and Primary Care ACOs who have LTSS needs. The state will establish policies for the scope of services MassHealth MCOs, Partnership Plans, and Primary Care ACOs must include in assessments and person-centered care plans to reflect the phasing in of LTSS accountability over the duration of the Demonstration. Where MassHealth MCOs, Partnership Plans, and Primary Care ACOs are accountable for members' LTSS needs, or as otherwise defined by the state, enrollees with LTSS needs in these delivery systems will have comprehensive assessments and person-centered care plans.

a) **Assessments.** The state will develop policies and procedures to ensure comprehensive assessments are completed for members enrolled in MCO-based delivery systems and Primary Care ACOs with identified LTSS needs. MassHealth MCOs, Partnership Plans,

and Primary Care ACOs will be responsible for comprehensively assessing each enrollee with LTSS needs, consistent with the requirements at 42 CFR 438.208(c)(2). MassHealth will develop and set standards to ensure assessments of LTSS needs are independent, as described in STC 63(c) below.

b) **Person-Centered Planning.** MassHealth MCO, Partnership Plan, and Primary Care ACO enrollees with identified LTSS needs will have a person-centered care plan maintained at the MassHealth MCO, Partnership Plan, or Primary Care ACO, consistent with the requirements at 42 CFR 438.208(c)(3). Person-centered planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level and support systems. The person-centered plan will be developed by a person trained in person- centered planning using a person-centered process and plan with the enrollee, the assistance of the enrollee's providers, and those individuals the enrollee chooses to include. The plan will include the services and supports that the enrollee needs. The plan will be reviewed and revised upon reassessment of functional need, at least every 12 months, if the enrollee's needs change significantly, or at the request of the enrollee. Person-centered plans will be developed in accordance with 42 CFR 441.301(c)(4)(F)(1) through (8).

c) **Avoiding Conflict of Interest for LTSS.** EOHHS will establish policies and procedures to ensure that individuals with LTSS needs enrolled in MassHealth MCOs, Partnership Plans, and Primary Care ACOs receive independent LTSS assessments.

Providers of facility- or community-based LTSS may not conduct LTSS needs assessments, except as explicitly permitted and monitored by the state (e.g. because a provider has select expertise, or is the only qualified and willing entity available). In such circumstances, the state will require that the provider entity establish a firewall or other appropriate controls in order to mitigate conflict of interest. An organization providing only evaluation, assessment, coordination, skills training, peer supports, and Fiscal Intermediary services will not be considered a provider of LTSS.

65. Beneficiary Support System. To support the beneficiary's experience receiving services in an MCO or ACO environment, the state shall create and maintain a permanent beneficiary support system to assist those beneficiaries in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.

a) **Organizational Structure.** The Beneficiary Support System shall operate independently from any MCO or ACO. Additionally, to the extent possible, the program shall also operate independently of the state Medicaid agency.

b) **Accessibility.** The services of the Beneficiary Support System shall be available to all Medicaid beneficiaries enrolled in an MCO or an ACO and must be accessible through multiple entryways (e.g., phone, internet, office) and also provide outreach in the same manner as appropriate.

c) **Functions.** The Beneficiary Support System shall assist beneficiaries to navigate and access covered services, including the following activities:

i. Offer beneficiaries support in the pre-enrollment state, such as unbiased health plan choice counseling and general program-related information.

ii. Serve as an access point for complaints and concerns about health plan enrollment, access to services and other related matters.

iii. Help enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level, and assist them through the process if needed/requested.

d) **Staffing.** The Beneficiary Support System must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs.

e) **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.

f) **Geographic expansion of ACO.** In any geographic location where the state is operating an ACO or where ACO may enroll into an ACO, the state must have the Beneficiary Support System in place at least 30 days prior to enrollment procedures for that geographic location.

66. Community Partners. 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 (adults and children) with serious mental illness (SMI), serious emotional disturbance (SED), and/or serious and persistent substance use disorder (SUD).

Long Term Services and Supports (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. 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.

e. Sustainability. MassHealth will evaluate the Community Partners program to assess whether the program should be continued after the DSRIP period concludes. If MassHealth determines that the CP program should continue, then it will work to identify other funding sources to support the CP program, such as contributions from the budgets of ACOs/MCOs.

67. ACO & CP Reporting Requirements. 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 reports.
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

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

69. 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 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.
   ii. If an ACO decides to exit the DSRIP program prior to the end of the five year 1115 waiver demonstration period, it will be required to return at least 50 percent of DSRIP startup/ongoing and DSTI Glide Path funding received up to that point.

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

70. 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).

71. 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. The 6-month Preparation Budget Period funds will be equal to half of the State's allocated DSRIP Year 1 funds. Budget Period 1 funds will be equal to the sum of half of the State's allocated DSRIP Year 1 funds, and half of DSRIP Year 2 funds. Budget Periods 2 through 4 will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds will be equal to half of the State's allocated DSRIP Year 5 funds. In the Preparation Budget Period and Budget Period 1, 0% of funds will be at-risk. However, in Budget Periods 2 through 5, the portion of at-risk expenditure authority follows the table below:

DSRIP Budget Period	Prep BP and BP 1 July 1, 2017 – December 31, 2018	BP 2 January 1, 2019- December 31, 2019	BP 3 January 1, 2020- December 2020	BP 4 January 1, 2021- December 31, 2021	BP 5 January 1, 2022- December 31, 2022
DSRIP Expenditure Authority	$637.5M	$412.5M	$362.5M	$275M	$112.5M
% of Expenditure Authority At-Risk	0%	5%	10%	15%	20%
Actual Expenditure Authority At-Risk	$0M	$20.625M	$36.25M	$41.25M	$22.5M

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

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.

d) Corrective Action Plan. 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.

e) MassHealth ACO/APM Adoption Rate. 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.

f) Reduction in State Spending Growth. The State and CMS will work together to agree to a detailed methodology for calculating the State's reduction in spending growth. In

general, the State will, by CY2022, be 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 will be 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 will be applied to the base PMPM rate in CY2017 (i.e. pre-ACO). The trend will be 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 will have target reductions smaller than 2.1% off of the trended PMPM.

Prior to CY2019, spending reduction targets will be adjusted to reflect CY2017 baseline performance. In the detailed methodology that CMS and the State will 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.

g) Gap to Goal Methodology. CMS and the State will agree 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% * Reduction Target), then Measure Score = 0%
    ii. If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
    iii. If Actual Reduction ≥ (50% * Reduction Target) AND < (Reduction Target), then Measure Score is equal to: (Actual Reduction - (50% * Reduction Target)) / (Reduction Target - (50% * Reduction Target))

    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%

Overall Statewide Quality Performance. 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.

72. State Public Outreach for ACO Expansion. To provide and demonstrate seamless transitions for MCO and ACO enrollees, the state must (where applicable):

a) Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.

b) Provide continued comprehensive outreach, including educational tours for enrollees and providers. Education for enrollees and providers should include plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g. state's website). The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.

c) Operate a call center independent of the PCC, ACO, and MCO plans. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 days, if all entities are consistently meeting contractual requirements the state can decrease the frequency of the review of call center statistics, but no more than 120 days should elapse between reviews.

d) The state will provide language assistance, including in written materials, in accordance with Section 1557 of the Affordable Care Act.

e) Member materials sent to beneficiaries will be culturally competent, and the state will provide culturally competent and available translation and navigation services. The state will make available navigation resources upon beneficiary request.

73. CMS Evaluation of State.

a) Assessment of Performance, and Interim Evaluation. An interim evaluation of the DSRIP program will be conducted by an independent evaluator, which will use both quantitative and qualitative methodologies, to evaluate whether the investments made through the DSRIP program have contributed to achieving the demonstration goals as described in STC 59. The interim evaluation will provide an overview of the DSRIP program from July 1, 2017 to December 2020, and will be submitted to CMS by the end of June 2021.

74. **Independent Assessor.** The state will identify 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. The independent assessor will complete the mid-point assessment, which will individually and systematically assess the performance of demonstration entities (i.e., ACOs, Community Partners, and key Statewide Investment management vendors as determined by the State), including identification of specific challenges and actionable mitigation strategies for mid-course correction for the State's consideration. The mid-point assessment will cover the time period from July 1, 2017 through December 2019, and an initial draft will be submitted to CMS by the end of June 2020, and a final version to be submitted to CMS by the end of September 2020. 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 report requirements.

    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.

75. **DSRIP Advisory Committee.** The state will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. 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:

    i. Selection of additional metrics for providers that have reached baseline performance thresholds or exceeded performance targets
    ii. 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?

iii. Alignment of measures between systems with purpose, to enable the state to assess the effectiveness in their outcomes across systems
iv. Identify actionable new areas of priority,
v. 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% 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.

76. SNCP Additional Reporting Requirements. All SNCP expenditures must be reported as specified in section XIII, STC 91. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

a) Charts A – C of Attachment E. The Commonwealth must submit to CMS for approval, updates to Charts A – C of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Years (SFYs) 2017-2022, 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 52.

Before it can claim FFP, the Commonwealth must notify CMS and receive CMS approval, for any SNCP payments and expenditures outlined in Charts A-C 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 52. The Commonwealth must submit to CMS for approval updates to Charts A – C 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 52.

The Commonwealth must submit to CMS for approval updates to Charts A – C 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 52.

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.
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 52.

No demonstration amendment is required to update Charts A-C in Attachment E, with the exception of any new types of payments or expenditures in Charts A-C, or for any increase to the Public Service Hospital Safety Net Care payments.

b) DSHP Reporting for Connector Care. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 80. This data must, at a minimum, include:
    1) The number of individuals served by the program;
    2) The size of the subsidies; and
    3) A comparison of projected costs with actual costs.

c) DSRIP Reporting: DSRIP reporting is required as specified in Section X and the approved DSRIP Protocol.

IX. GENERAL REPORTING REQUIREMENTS

77. Submission of Post-approval Deliverables. The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes

stipulated by CMS and within the timeframes outlined within these STCs.

78. **Deferral for Failure to Provide Deliverables on Time.** The state agrees that CMS may require the state to cease drawing down federal funds until such deliverables are submitted in a satisfactory form, until the amount of federal funds not drawn down would exceed $5,000,000. Specifically:
    a. Thirty (30) calendar days after the deliverable was due, CMS is required to issue a written notification to the state providing advance notification of a pending deferral for late or non- compliant submissions of required deliverables.
    b. For each deliverable, the state may submit 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 state has taken to address such issue, the estimated time for submission of the deliverable, and whether additional measures could be taken to expedite the schedule for such submission. CMS will only grant such a request if CMS finds that the state faced unforeseen circumstances, and has taken reasonable measures to submit the deliverable as soon as practicable. CMS could grant the requested extension in whole or in part. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
    c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
    d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
    e. 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 may preclude a state from renewing a demonstration or obtaining a new demonstration.
    f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

79. **Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

80. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration, the state 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 state 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 state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 75.

81. Cooperation with Federal Learning Collaboration Efforts. The state will cooperate with improvement and learning collaboration efforts by CMS.

X. MONITORING

82. Quarterly and Annual Report Timelines. The state must submit three Quarterly Reports and one compiled Annual Report each DY. The Quarterly Reports are due no later than 60 days following the end of each demonstration quarter. The compiled Annual Report is due no later than 90 days following the end of the DY.

83. Quarterly and Annual Report Scope. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting 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 reports will include all required elements 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).

a. **Quarterly and Annual Report Outline.** The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

i. Operational Updates – The reports shall 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.

ii. Performance Metrics – 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.

iii. Budget Neutrality and Financial Reporting Requirements – The state 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 state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

iv. Evaluation Activities and Interim Findings – The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

84. Additional Demonstration Annual Operational Report Requirements. The Annual Report must include all items outlined in STC 81. In addition, the Annual Report must, at a minimum, include the requirements outlined below:

i. All items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;
ii. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
iii. Total contributions, withdrawals, balances, and credits; and
iv. Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

85. Monitoring Calls. CMS will convene periodic conference calls with the state.

a) The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration.
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 state and CMS will jointly develop the agenda for the calls.
d) Areas to be addressed during the monitoring call include, but are not limited to:
    i. Transition and implementation activities;
    ii. Stakeholder concerns;
    iii. QHP operations and performance;
    iv. Enrollment;
    v. Cost sharing;
    vi. Quality of care;
    vii. Beneficiary access;
    viii. Benefit package and wrap around benefits;
    ix. Audits;
    x. Lawsuits;
    xi. Financial reporting and budget neutrality issues;

xii. Progress on evaluation activities and contracts;
xiii. Related legislative developments in the state; and
xiv. Any demonstration changes or amendments the state is considering.

XI. EVALUATION

86. Independent Evaluator. At the beginning of the demonstration period, the state must acquire 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 accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made in advance of running any data or due to mid- course changes in the operation of the demonstration.

87. Evaluation Design and Implementation. The State must submit a draft updated evaluation design for MassHealth 1115 demonstration to CMS no later than June 30, 2018. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the insert old demo name, if applicable. The state must submit a final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval. The state must implement the evaluation design and submit their evaluation implementation progress in each of the Quarterly and Annual Reports as outlined in STC 81.

a) **Evaluation Budget.** A budget for the evaluation shall be provided with the 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 reports 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.

b) **Cost-effectiveness.** While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the demonstration when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

i. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS. Included in the

evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the demonstration compared to what would have happened for a comparable population absent the demonstration.

ii. The state will compare total costs under the demonstration to costs of what would have happened without the demonstration. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

iii. The State will compare changes in access and quality to associated changes in costs within the demonstration. To the extent possible, component contributions to changes in access and quality and their associated levels of investment will be determined and compared to improvement efforts undertaken in other delivery systems.

c) **Evaluation Requirements.** The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.

i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

ii. The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.

d) **Evaluation Design.** The Evaluation Design shall include the following core components to be approved by CMS:

i. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

1. The formation of new partnerships and collaborations within the delivery system
2. The increased acceptance of TCOC risk-based payments among MassHealth providers
3. Improvements in the member experience of care, particularly through increased member engagement in the primary care setting or

closer coordination among providers
4. Reductions in the growth of avoidable inpatient utilization
5. Reductions in the growth of TCOC for MassHealth's managed care-eligible population
6. More robust EHR and other infrastructure capabilities and interconnectivity among providers
7. Increased coordination across silos of care (e.g., physical health, behavioral health, LTSS, social supports)
8. Maintenance or improvement of clinical quality
9. The enhancement of safety net providers' capacity to serve Medicaid and uninsured patients in the Commonwealth
10. Increased coverage of out-of-state former foster care youth and improved health outcomes for this population.
11. The strength of aggregate provider networks in the ACO and MCO programs (excluding Primary Care ACOs) relative to the PCC Plan, in first three years of demonstration, including:

    a) Types of providers
    b) Breadth of providers
    c) Quality of services
    d) Outcomes of services

These hypotheses should be addressed in the demonstration reporting described in STC 86 with regard to progress towards the expected outcomes.

ii. Data: This discussion shall include:

1. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;
2. Method of data collection
3. Frequency and timing of data collection.

The following shall be considered and included as appropriate:

a. Medicaid encounters and claims data,
b. Enrollment data, and
c. Consumer and provider surveys

iii. Study Design: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at

the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

iv. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.

v. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the State may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.

vi. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.

vii. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.

viii. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, and the deliverables outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.

ix. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

x. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

e) **Interim Evaluation Report.** The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending June 30. 2022. The Interim Evaluation Report shall include the same core components as identified in STC 86 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 business days after receipt of CMS' comments.

f) **Summative Evaluation Reports.**

i. The state shall provide the summative evaluation report described below to capture the demonstration period covered by this renewal.

1. The state shall provide a Summative Evaluation Report (SER) for the demonstration period starting July 1, 2017 through June 30, 2022.
   a) A preliminary draft of the SER is due within 18 months after the end of this demonstration period. This report shall include documentation of outstanding assessments due to data lags to complete the interim evaluation.
   b) . The state should respond to comments and submit the final SER within 30 calendar days after receipt of CMS' comments.

ii. The Summative Evaluation Report shall include the following core components:

1. **Executive Summary.** This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
2. **Demonstration Description.** This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
3. **Study Design**. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.
4. **Discussion of Findings and Conclusions.** This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
5. **Policy Implications.** This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the

State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.

6. **Interactions with Other State Initiatives.** This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

g) **State Presentations for CMS.** The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 86. The State will present on its interim evaluation in conjunction with STC 86. The State will present on its summative evaluation in conjunction with STC 86.

h) **Public Access.** The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

XII. CLOSE OUT REPORTING

88. Close out Reports. Within 120 calendar days prior to the end of the demonstration, the state must submit a Draft Final Operational Report to CMS for comments.

a) The draft final reports must comply with the most current Guidance from CMS, and include all components required.
b) The state will present to and participate in a discussion with CMS on the Close-Out reports.
c) The state must take into consideration CMS' comments for incorporation into the final Close-Out Reports.
d) The Final Close-Out Reports are due to CMS no later than 30 days after receipt of CMS' comments.
e) A delay in submitting the draft or final versions of the Close-Out Reports could subject the state to penalties described above.

89. Public Access. The state shall post the final approved Annual Reports, Final Operational Report, Evaluation Design, Interim Evaluation Report(s), Summative Evaluation Report(s), and Final Evaluation Report on the state's Medicaid website within 30 days of approval by CMS.

90. Presentations and Publications. During the demonstration period, and for 24 months following the expiration of the demonstration, CMS will be provided with notification regarding the public release, presentation or publication of Interim, Summative, and/or Final Evaluations and Operational Reports.

1. The state will make every effort to inform the CMS Project Officer, as far in advance as possible, of pending news articles or reports about the demonstration that are of a significant nature. A bibliographic reference of news articles and reports about the demonstration will be included in the next Quarterly Report.

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

91. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section XIII of the STCs.

92. Demonstration Years. The demonstration years under this extension period are as follows:

Demonstration Year 21	July 1, 2017- June 30, 2018	12 Months
Demonstration Year 22	July 1, 2018 - June 30, 2019	12 Months
Demonstration Year 23	July 1, 2019 - June 30, 2020	12 Months
Demonstration Year 24	July 1, 2020 - June 30, 2021	12 Months
Demonstration Year 25	July 1, 2021 - June 30, 2022	12 Months

93. Reporting Expenditures Under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must

report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00030/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

b) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded 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. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c) Pharmacy Rebates. When claiming these expenditures the Commonwealth may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid

Budget and Expenditures (MBES) (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24- 2014.pdf). The Commonwealth must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

Additionally, this information addresses how states must report drug rebates associated with the new adult eligibility group described at 42 CFR 435.119. States that adopt the new adult group may be eligible to claim drug expenditures at increased matching rates. Drug rebate amounts associated with these increased matching rates must be reported at the same matching rate as the original associated prescription drug expenditures.

d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the Commonwealth under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64Narr by demonstration year.

e) Demonstration year reporting. Notwithstanding the two-year filing rule, the Commonwealth may report expenditures and adjustments to particular demonstration years as described below:

i. Beginning July 1, 2014 (SFY 2015/DY 18), all expenditures and adjustments for demonstration years 1-14 previously reported in sections i.-viii. will be reported as demonstration year 14, all expenditures and adjustments for demonstration years 15-17 will be reported as demonstration 17, and separate schedules will be completed for demonstration years 18, 19 and 20.

ii. Beginning July 1, 2017 (SFY 2018/DY 21), all expenditures and adjustments for demonstration years 1-17 previously reported in sections i.-ix. will be reported as demonstration year 17, all expenditures and adjustments for demonstration years 18-20 will be reported as demonstration 20, and separate schedules will be completed for demonstration years 21, 22, 23, 24, and 25.

f) Use of Waiver Forms. For each demonstration year as described in subparagraph (e) above, 29 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following EGs and the Safety Net Care Pool. Expenditures should be allocated to

these forms based on the guidance found below.

1) **Base Families:** Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only)

2) **Base Disabled:** Eligible individuals with disabilities enrolled in Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only)

3) **1902(r)(2) Children:** Medicaid expansion children and pregnant women who are enrolled in MassHealth Standard, as well as eligible children and pregnant women enrolled in MassHealth Limited (emergency services only)

4) **1902(r)(2) Disabled:** Eligible individuals with disabilities enrolled in 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)

5) **BCCDP:** Individuals eligible under the Breast and Cervical Cancer Demonstration Program who are enrolled in Standard

6) **CommonHealth:** Higher income working adults and children with disabilities enrolled in CommonHealth

7) **e-Family Assistance:** Eligible children receiving premium assistance or direct coverage through 200 percent of the FPL enrolled in Family Assistance.

8) **Base Fam XXI RO:** Title XXI-eligible AFDC children enrolled in Standard after allotment is exhausted

9) **1902 (r)(2) XXI RO:** Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted

10) **CommonHealth XXI:** Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted

11) **Fam Assist XXI:** Title XXI-eligible children through 200 percent of the FPL eligible for Family Assistance under the demonstration after the allotment is exhausted

12) **e-HIV/FA:** Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance

13) **SBE:** Subsidies or reimbursement for ESI made to eligible individuals

14) **SNCP-DSRIP:** Expenditures for Delivery System Reform Payments (DSRIP) for the period July 1, 2017 through June 30, 2022

15) **SNCP-PHTII:** Expenditures authorized under the Public Hospital Transformation and Incentives Initiative

16) **SNCP-**DSH-HSNTF: Expenditures authorized under the Health Safety Net program as referenced on Attachment E item 4.

17) **SNCP-**DSH-IMD: Expenditures authorized under the SNCP for IMD services, as referenced on Attachment E item 5, excluding expenditures reported under STC 91(f)(30).

18) **SNCP-DSH-CPE**: 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.

19) **SNCP-UCC:** Expenditures authorized under the Uncompensated Care Pool

20) **SNCP-OTHER:** All other expenditures authorized under the SNCP, including Public Services Hospital Safety Net Care Payments and Safety Net Provider Payments, as referenced on Attachment E items 1 and 8.

21) **Asthma:** All expenditures authorized through the pediatric asthma bundled pilot program

22) **New Adult Group :** 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

23) **DSHP-Health Connector Subsidy:** Expenditures for premium subsidy wrap under the demonstration.

24) **DSHP-CSR:** Expenditures for cost sharing subsidy wrap under the demonstration.

25) **Provisional Eligibility:** Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority consistent with STC 24.

26) **TANF/EAEDC:** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children.

27) **End of Month Coverage:** Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.

28) **Continuous Eligibility:** Expenditures for continuous eligibility period up to 12 months for those enrolled in a student health insurance program.

29) **FFCY** – 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 (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.

30) **SUD:** All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table D of Section V.

94. 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 EG, the 1902(r)(2) Children EG, the CommonHealth EG 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 EGs under the title XIX demonstration apply:

Base Families XXI RO, 1902(r)(2) RO, CommonHealth XXI, and Fam Assist XXI:

a) 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 91 (Reporting Expenditures Under the Demonstration).

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 EGs will:

   i. Count toward the budget neutrality expenditure limit calculated under section XI, STC 109 (Budget Neutrality Annual Expenditure Limit); and

   ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 109, 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 EG will be considered expenditures subject to the budget neutrality agreement as defined in STC 109. 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.

95. Expenditures Subject to the Budget Neutrality Agreement. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in section IV of the STCs, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

96. Premium Collection Adjustment. The Commonwealth must include demonstration premium collections as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis on the CMS-64 Summary Sheet and on the budget neutrality monitoring workbook submitted on a quarterly basis.

97. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the Commonwealth must 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.

98. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the Commonwealth made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must 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.

99. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a) For the purpose of calculating the budget neutrality agreement and for other purposes, the Commonwealth must provide to CMS, as part of the quarterly report required under STC 81, the actual number of eligible member months for each EGs defined in STC 91, except SNCP-DSRIP, SNCP-PHTII, SNCP-UCC, SNCP-DSH-HSNTF, SNCP-DSH-IMD, SNCP-DSH-CPE and SNCP-Other. The Commonwealth must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b) The term "eligible member months" refers to the number of months in which persons 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 month to the total, for a total of four eligible member months.

100. Cost Settlement.

a) Interim Reconciliation– Within 12 months of the provider's cost report filing for each reporting year, the Commonwealth must validate cost data using the CMS-approved cost limit protocol, developed jointly by Massachusetts and CMS. Interim Reconciliation will be based on the results of the Commonwealth's review. Any increasing or decreasing adjustment identified as a result of the settlement must be reported to CMS as an adjustment to reported expenditures and reported through the CMS-64 process.

b) Final Reconciliation – For each provider subject to cost settlement, the Commonwealth must complete final settlement within 12 months after the provider's final and audited (as applicable) cost report become available. The Commonwealth must submit cost

and payment information for that demonstration year as required by the CMS-approved cost limit protocol. Any increasing or decreasing adjustment identified as a result of the settlement must be reported to CMS as an adjustment to reported expenditures and reported through the CMS-64 process. CMS will complete its review of the costs reported using the protocol tool and send concurrence or share its findings with the Commonwealth within 120 calendar days of receipt.

c) **Standard Medicaid Funding Process**. The standard Medicaid funding process must be used during the demonstration. Massachusetts must 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 FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

101. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole for the following, subject to the limits described in section XIII of the STCs:

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) Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period, including expenditures under the Safety Net Care Pool.

102. Sources of Non-Federal Share. The Commonwealth provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The Commonwealth further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a) CMS may review at any time the sources of the non-federal share of funding for the demonstration. The Commonwealth agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program shall require the stateto provide information to CMS regarding all sources of the non-federal share of funding.

c) The Commonwealth assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

103. State Certification of Funding Conditions. The Commonwealth must certify that the following conditions for non-federal share of Demonstration expenditures aremet:

a) Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b) To the extent, the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies as allowable under 42 C.F.R. § 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;

d) The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from state or local monies and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the Commonwealth any portion of the Medicaid payments. 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.

104. Monitoring the Demonstration. The Commonwealth will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

105. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

106. Budget Neutrality Effective Date. Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning July 1, 2017.

107. Limit on Title XIX Funding. Massachusetts will be subject to a limit on the amount of federal title XIX funding that the Commonwealth may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual DSH allotment that would have applied to the Commonwealth absent the demonstration (DSH allotment). Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the Commonwealth using the procedures described in section XIII, STC 91. The data supplied by the Commonwealth to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Commonwealth's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

108. Risk. Massachusetts will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Massachusetts will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Massachusetts at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

109. Expenditures Excluded From Budget Neutrality Test. Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on behalf of enrollees under age 65 who are institutionalized in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded, or a state psychiatric hospital for other than a short-term rehabilitative stay;

b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient, and home and community-based waiver services, except pursuant to STC 108; For demonstration years 1 and 2, LTSS costs will be excluded from budget neutrality. Over the course of the demonstration, LTSS will be included no later than DY 24 into budget neutrality if MassHealth incorporates LTSS into managed care delivery models and TCOC for ACOs.

   i. *Exception.* Hospice services provided to individuals in the MassHealth Basic and Essential programs are subject to the budget neutrality test.

c) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement; and

d) Allowable administrative expenditures.

110. Budget Neutrality Annual Expenditure Limit. The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure limits. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the Commonwealth may receive for expenditures on behalf of demonstration populations as well as demonstration services described in Table B, Table C and Table D of STC 38-40 during the demonstration period.

a) Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:

   i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the Commonwealth under section XIII, STC 91 for each EG, including the hypothetical populations, times the appropriate estimated per member/per month (PMPM) costs from the tables in STCs 109, 110 and 111 below, and summing the results of those calculations. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period;

   ii. Starting in SFY 2006, actual expenditures for the CommonHealth EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline

CommonHealth costs, or actual CommonHealth per member per most cost experience for SFYs 2018-2022;

iii. The amount of actual expenditures included will be the lower of the trended baseline costs, or actual per member per most cost experience for each eligibility group in SFYs 2018-2022;

iv. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior demonstration periods are provided in Attachment D.

b) Limit B. The Commonwealth's annual DSH allotment.

111. Main Budget Neutrality Test. The trend rates and per capita costs estimates for each EG for each year of the demonstration are listed in the table below.

Eligibility Group (EG)	Trend Rate	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
Mandatory and Optional State Plan Groups						
Base Families	3.8%	$753.10	$781.72	$811.42	$842.25	$874.26
Base Disabled/MCB	4.0%	$1,647.49	$1,713.39	$1,781.93	$1,853.21	$1,927.34
1902 (r) 2 Children	3.6%	$597.02	$618.51	$640.78	$663.85	$687.75
1902 (r) 2 Disabled	3.6%	$1,284.97	$1,331.23	$1,379.15	$1,428.80	$1,480.24
1902 (r) 2 BCCDP	3.6%	$4,928.56	$5,105.99	$5,289.81	$5,480.24	$5,677.53
Hypothetical Populations*						
CommonHealth	4.4%	$776.08	$813.33	$852.37	$893.28	$936.16
Out-of-state Former Foster Care Youth	4.3%	$350.41	$365.48	$381.19	$397.58	$414.68

112. Supplemental Budget Neutrality Test: New Adult Group. Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. The state will not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for this group, to be known as Supplemental Budget Neutrality Test.

a) The EG listed in the table below is included in Supplemental Budget Neutrality Test.

Eligibility Group (EG)	Trend Rate	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)

New Adult Group	4.3 percent	$561.68	$585.83	$611.02	$637.29	$664.70

b) If the state's experience of the take up rate for the New Adult Group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the New Adult Group, the state may submit an adjustment to paragraph (a) for CMS review without submitting an amendment. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than April 30 of the demonstration year for which the adjustment would take effect.

c) The Supplemental Budget Neutrality Test is calculated by taking the PMPM cost projection for the New Adult Group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap is obtained by multiplying total computable Supplemental Cap by the Composite Federal Share described in STC 112.

d) The Supplemental Budget Neutrality Test is a comparison between the federal share of the Supplemental Cap and total FFP reported by the State for the New Adult Group.

e) If total FFP for the New Adult Group should exceed the federal share of the Supplemental Budget Neutrality Test after any adjustments made to the budget neutrality limit as described in paragraph (b), the difference must be reported as a cost against the budget neutrality limit described in STC 108.

113. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) adjustment. The Commonwealth must present to CMS for approval a draft evaluation plan outlining the methodology to track the following:

a) Baseline measurement of EPSDT service utilization prior to the EPSDT court- ordered remedial plan in Rosie D. v Romney (the Order) final judgment and final remedial plan established on July 16, 2007;

b) Increase, following entry of the Order, in utilization of:
a) EPSDT screenings;
b) Standardized behavioral health assessments utilizing the Child and Adolescent Needs and Strengths (CANS), or other standardized assessment tool in accordance with the Order; and
c) State plan services available prior to the entry of the Court Order.

c) Cost and utilization of services contained in State Plan amendments submitted by the Commonwealth in accordance with the Order and approved by CMS;

and

d) Methodology for tracking and identifying new EPSDT services for purposes of budget monitoring.

e) The draft evaluation plan with an appropriate methodology to track new EPSDT expenditures must be approved by CMS through the amendment process described in STC 7. Once an appropriate methodology to track new EPSDT expenditures is approved by CMS, these projected expenditures will be included in the expenditure limit for the Commonwealth, with an effective date beginning with the start of the new EPSDT expenditures, and reconciled to actual expenditure experience.

115. 1115A Duals Demonstration Savings. When Massachusetts' section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the Duals demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the Duals Demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal. This evaluation of estimated and certified amounts of actual title XIX savings will reflect addendums and amendments to the 1115A Duals Demonstration contract and adjustment to the MassHealth Component of the capitation rate, including interim and final risk corridor settlements. (Note – PMPMs, MMs, and risk corridor amounts in the table below are illustrative.)

A.	B.	C.	D.	E.	F.	G.
1115A Duals Demo Rate Year/ Demo Year	**MassHealth Component of the Capitation Rate (hypothetical)**	**Medicaid Savings Percentage Applied Per Contract (average)**	**Savings Per Month: (B*C)**	**Member Months of MMEs who participated in 1115A Duals Demonstration and 1115(a) Demonstration (hypothetical)**	**Risk Corridor Payment/ (Recoupment)[1]**	**Amount subtracted from 1115(a) BN savings/ margin: (D*E)-F = net (cost)/savings**
CY 2013/ DY1	$700 PMPM	0.00%	$0 PMPM	1,000 MM	$5,000	($0 PMPM * 1,000 MM) -$5,000 = ($5,000) cost
CY 2014 (Jan - Mar 2014)/ DY1	$700 PMPM	0.00%	$0 PMPM	1,000 MM	$5,000	($0 PMPM * 1,000 MM) -$5,000 = ($5,000) cost

[1] Risk corridors are calculated by Demonstration Year (DY) and will be reported by DY once finalized.

CY 2014 (Apr - Dec 2014)/ DY1	$700 PMPM	1.00%	$7 PMPM	1,000 MM	$5,000	($7 PMPM * 1,000 MM) -$5,000 = $2,000 savings
Fallon Total Care (FTC) CY 2015/ DY2	$700 PMPM	1.50%	$10.50 PMPM	1,000 MM	$0	($10.50 PMPM * 1,000 MM) -$0 = $10,500 savings
CCA and Tufts CY 2015/ DY2	$700 PMPM	0.00%	$0 PMPM	1,000 MM	($2,000)	($0 PMPM * 1,000 MM) -($2,000) = $2,000 savings
CY 2016/ DY3	$700 PMPM	0.00%	$0 PMPM	1,000 MM	($4,000)	($0 PMPM * 1,000 MM) -($4,000) = $4,000 savings
CY 2017/ DY4	$700 PMPM	0.25%	$1.75 PMPM	1,000 MM	($7,000)	($1.75 PMPM * 1,000 MM) - ($7,000) = $8,750 savings
CY 2018/ DY5	$700 PMPM	0.50%	$3.50 PMPM	1,000 MM	($4,000)	($3.50 PMPM * 1,000 MM) - ($4,000) = $7,500 savings

Specifically, OACT will estimate and certify actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration following the methodology below.

The actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration are equal to the savings percentage specified in the 1115A Duals demonstration contract multiplied by the 1115A Duals demonstration MassHealth Component of the capitation rate and the number of 1115A Duals demonstration beneficiaries enrolled in the 1115(a) demonstration. The Duals demonstration capitation rate is reviewed by CMS's Medicare and Medicaid Coordination Office (MMCO), MMCO's contracted actuaries and was certified by the Commonwealth's actuaries. Per the 1115A Duals Demonstration contract, the actual Medicaid rate paid for beneficiaries enrolled in the 1115A Duals demonstration is equivalent to the state's 1115A Duals demonstration MassHealth component minus an established savings percentage (specified in the Duals Demonstration contract), adjusted by any risk corridor payments or recoupments. The Commonwealth must track the number of member months for every Medicare-Medicaid enrollee (MME) who participates in both the 1115(a) and 1115A Duals demonstration.

The table above provides an illustrative example of how the savings attributable to populations and services provided under the 1115A demonstration is calculated. The Commonwealth may adjust the chart to account for risk corridor payment or recoupments.

In each quarterly report, the Commonwealth must provide the information in the above-named chart (replacing estimated figures with actual data). Should rates differ by geographic area and/or rating category within the 1115A demonstration, this table should be done for each geographic area and/or rating category. In addition, the state must show the "amount subtracted from the 1115(a) BN savings" in the updated budget neutrality Excel worksheets that are submitted in each quarterly report.

Finally, in each quarterly CMS-64 submission and in each quarterly report, the state must indicate in the notes section: "For purposes of 1115(a) demonstration budget neutrality reporting purposes, the state reports the following information:

- Number of unduplicated Medicare-Medicaid enrollees served under the 1115A duals demonstration = [Insert number]
- Number of member months = [Insert number]
- PMPM savings per dual beneficiary enrolled from the 1115A duals demonstration = [Insert number]"

The Commonwealth must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A Duals demonstration. The Commonwealth may add columns to identify risk corridor payments and other adjustments in subsequent quarterly reporting. Note, the savings percentages may be updated in the Duals Demonstration contract, and the amount considered in the budget neutrality worksheets must reflect any adjustments, addendums, or amendments made in the Duals Demonstration contract.

116. Composite Federal Share Ratio. The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the Commonwealth on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C. with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. 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.

117. Recognized Budget Neutrality Savings.

a. Beginning July 1, 2017 (SFY 2018/DY21), recognized budget neutrality savings is limited to savings realized beginning in July 1, 2011 (SFY 2012/DY 15). No deficit or savings is carried over from years prior to SFY 2012. Accordingly, the budget neutrality demonstration includes "with waiver" expenditures and "without waiver" expenditure limit calculations beginning in SFY 2012.

b. Savings Phase-out: Beginning July 1, 2017 (SFY 2018/DY21), the net variance between

the without-waiver cost and actual with-waiver cost will be reduced for selected Medicaid population based EGs. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) For the first five years that an eligibility group is enrolled in managed care savings are carried forward in full. For the first five years that a set of services (e.g. LTSS) is subject to managed care, savings are also carried forward in full. The formula for calculating the reduced variance is: reduced variance equals total variance times applicable percentage. The applicable percentages for each EG and DY are determined based how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer established managed care populations.

The EGs affected by this provision and the applicable percentages are shown in the table below, except that if the total variance for an EG in a DY is negative, the applicable percentage is 100 percent.

EG	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
Base Families	25%	25%	25%	25%	25%
Base Disabled/MCB	25%	25%	25%	25%	25%
1902 (r) 2 Children	25%	25%	25%	25%	25%
1902 (r) 2 Disabled	25%	25%	25%	25%	25%
1902 (r) 2 BCCDP	25%	25%	25%	25%	25%

118. Enforcement of Budget Neutrality. CMS shall enforce the budget neutrality agreement over the life of the demonstration as adjusted July 1, 2008, rather than on an annual basis. However, if the Commonwealth exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the Commonwealth must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
DY 21	Cumulative budget neutrality limit plus:	2.0 percent
DY 21 through DY 22	Cumulative budget neutrality limit plus:	1.5 percent
DY 21 through DY 23	Cumulative budget neutrality limit plus:	1.0 percent
DY 21 through 24	Cumulative budget neutrality limit plus:	.5 percent
DY 21 through 25	Cumulative budget neutrality limit plus:	0 percent

In addition, the Commonwealth may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the demonstration will exceed the cap during this extension.

119. Exceeding Budget Neutrality. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 110, composite federal share ratio. 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.

120. Budget Neutrality Monitoring Tool. The state and CMS will jointly develop a budget neutrality monitoring tool (using a mutually agreeable spreadsheet program) for the state to use for quarterly budget neutrality status updates and other in situations when an analysis of budget neutrality is required. The tool will incorporate the Schedule C Report for monitoring actual expenditures subject to budget neutrality. A working version of the monitoring tool will be available for the state's first Quarterly Progress Report in 2018.

121. Impact of Continuous Eligibility on Budget Neutrality. Students enrolled in SHIP will receive continued benefits during any periods within a 12-month eligibility period when these individuals would be found ineligible if subject to redetermination. To this end, 97.4% of the member months will be matched at the enhanced rate, and 2.6% of the member months will be matched at the regular FMAP to account for the proportion of member months that beneficiaries would have been disenrolled due to excess income in the absence of continuous eligibility. Therefore, Massachusetts shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

122. Treatment of DSH Allotment. The amount of any DSH-like payments must be prorated if necessary so that DSH-like payments will not exceed the percentage of the DSH allotment corresponding to the percentage of the federal fiscal year for which payment of DSH-like payments is required.

XV: SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

The state 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	Section Reference
June 30, 2018	Draft Evaluation Design	Section X
Within 60 days of receipt of CMS comments	Final Evaluation Design and Implementation	Section X
Within 180 days after the expiration of the demonstration	Final Report	Section X
Within 18 months after the expiration of this demonstration	Draft Summative Evaluation Report	Section X
Annually		
October 1st	Draft Annual Report,	Section X
30 days of the receipt of CMS comments	Final Annual Report, including DSRIP, ACO, flexible services and expenditures.	Section X
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	Section XIV, XV
No later than 45 days after enactment of the state budget for each SFY	Projected annual DSHP expenditures	Section XIV
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	Section XIV, XV
Quarterly		
60 days following the end of the quarter	Quarterly Operational Reports, including DSRIP, ACO, Flexible Services and payments reporting and eligible member months	Section X
60 days following the end of the quarter	Quarterly Expenditure Reports	Section X