

THE MASSHEALTH WAIVER 2016–2022: DELIVERING REFORM

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Rachel Gershon
Michael Grenier
Robert Seifert
*Center for Health Law and Economics,
University of Massachusetts Medical School*

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EXECUTIVE SUMMARY

Since its launch in 1997, the MassHealth 1115 Demonstration Waiver has served as a vehicle for expanding coverage, encouraging better coordination and cost containment through managed care, and supporting safety net providers. On November 4, 2016, the federal Centers for Medicare and Medicaid Services (CMS) approved the sixth extension of the waiver. This extension seeks to transform the delivery of care for most MassHealth members and to change how that care is paid for, with the goals of improved quality and greater control over spending. The waiver also responds to the epidemic of opioid drug use in Massachusetts.

ELEMENTS OF THE WAIVER EXTENSION

MassHealth eligibility criteria as expanded under earlier extensions of the waiver remain the same. ConnectorCare, which provides subsidies that help 182,000 people in Massachusetts afford coverage, is retained and will benefit from additional federal funding. The key new elements of the waiver are described below.

Accountable Care Organizations

The MassHealth waiver extension encourages the formation of Accountable Care Organizations (ACOs) and Community Partners (CPs) to organize the delivery of care. ACOs are “entities that enter into population-based payment models with payers, wherein the entities are held financially accountable for the cost and quality of care for an attributed Member population.”¹ Generally, MassHealth members under the age of 65 and without other insurance coverage will be eligible to participate in an ACO.

ACO models

ACOs will have the choice of three models, reflecting opportunities for providers with different care delivery approaches to participate in accountable delivery systems.

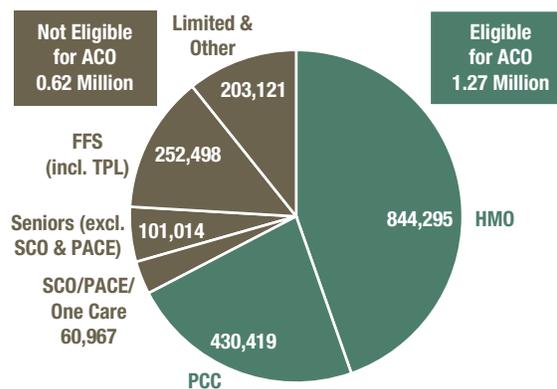
- **Accountable Care Partnership Plans** are managed care organizations (MCOs), each with a closely and exclusively partnered, provider-led

MASSHEALTH WAIVER GOALS

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

MASSHEALTH MEMBERS ELIGIBLE FOR ACO ENROLLMENT BY DELIVERY SYSTEM

TOTAL MASSHEALTH ENROLLMENT 1.89 MILLION
(SEPTEMBER 2016)



Note: The number of ACO-eligible individuals reflects MassHealth members currently enrolled in MCOs and the PCC Plan. A small number of members under 65 who are eligible but not enrolled in managed care are eligible for ACOs but are not reflected in the chart.

¹ Attachment A to MassHealth’s Request for Responses for Accountable Care Organizations (“MassHealth ACO RFR”), issued September 29, 2016. RFR materials, including model contracts, are available online at <https://www.commbuys.com/bs0/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-0000009207&external=true&parentUrl=bid>.

ACO. The MCO and its partner ACO will be financially accountable for providing coordinated care to a defined population of enrolled members.

- **Primary Care ACOs** contract directly and exclusively with MassHealth to take financial accountability for a defined population of enrolled members.
- **MCO-Administered ACOs** contract directly with MassHealth MCO contractors to take financial accountability for the MCO enrollees they serve. MCO-Administered ACOs may contract with multiple MCOs.

Primary care providers (PCPs) will play a central role in all three models to coordinate care for enrollees. PCPs will only be able to participate in one ACO.

ACOs will be required to work with CPs to better serve members with extensive needs for behavioral health care or long-term services and supports (LTSS).

ACOs must be certified by the Massachusetts Health Policy Commission, and Partnership Plans must also maintain state Health Maintenance Organization (HMO) licensure. Other ACO qualifications include previous experience with alternative payment models, capability to provide care coordination and management, a provider-led and member-focused governing board, and state certification (or a waiver) as a Risk-Bearing Provider Organization.

ACO services

ACOs will be accountable for the total cost of care (TCOC) associated with many, but not all, MassHealth-covered services. Accountability will include primary care and other inpatient and outpatient physical health care services, behavioral health services, and prescription drugs. ACOs will not be accountable for the cost of dental services, nor will they be accountable for LTSS for the first years of the demonstration. MassHealth intends to phase in financial responsibility for LTSS, possibly beginning in the third year of the ACO contracts.

ACOs can use Delivery System Reform Incentive Program (DSRIP) funding (described below) for “flexible services” such as services for individuals transitioning from an institution to the community; physical activity and nutrition; and support for individuals who have experienced violence.

Payments to ACOs and from ACOs to providers

MassHealth payment methods reinforce ACO responsibility for quality and cost goals. Payments will be based on the TCOC of the services for which ACOs are being held accountable. Administrative costs (for Partnership Plans and Primary Care ACOs) will be factored into the payment. In addition, payment methods for all three ACO models will incorporate performance on quality measures. Partnership Plans will be paid a prospective monthly per-member fee. Primary Care and MCO-Administered ACOs will be afforded some financial protection with risk corridors. MassHealth will adjust payments to ACOs to account for their members’ health status and for social determinants of health such as housing deficits and other neighborhood-level stressors.

MassHealth intends to push alternative payment approaches to the level of individual providers, particularly PCPs. The contracts for all three ACO models require ACOs to “develop, implement, and maintain value-based payments for PCPs,” holding PCPs accountable “to some degree” for the ACO’s performance.²

Member enrollment and attribution

For MassHealth members who enroll in an MCO, the MCO they choose may be part of a Partnership Plan, and thus they would be enrolled in the Partnership Plan. If the member’s PCP is a participating provider in an MCO-

² See, for example, Attachment A to the MassHealth ACO RFR, page 136.

Administered ACO, the member would be attributed to that ACO. For members who choose the Primary Care Clinician (PCC) Plan, if their PCP is a participating provider with a Primary Care ACO, the member will be attributed to that ACO.

Members may also choose to enroll in the PCC Plan or an MCO but receive care outside an ACO, if they choose a PCP who is not affiliated with an ACO. To promote enrollment in MCOs and ACOs, though, MassHealth may adopt a policy (not before 2018) to charge lower copayments for members who elect MCOs and ACOs.

MCO members now have an annual 90-day “plan selection period,” during which a member who is enrolled in an MCO may select a different MCO or enroll in the PCC Plan. The member then enters a “fixed enrollment period,” during which the member is not permitted to change MCOs or enroll in the PCC Plan until the next plan selection period begins. This fixed enrollment period will also apply to Partnership Plan and Primary Care ACO members when ACOs begin operating. There will be a number of exceptions, outlined in MassHealth regulations, which will permit members to leave an MCO or ACO before the end of the fixed enrollment period.

Member rights and protections

ACOs will be responsible for fulfilling requirements related to consumer protection, such as offering a grievance process and, for Partnership Plan ACOs, an internal appeals process. They must offer culturally and linguistically appropriate care, provide a clinician hotline for members, and ensure access to primary or urgent care during extended hours.

Community Partners

CPs are community-based organizations that will work with ACOs and MCOs to offer support services for individuals with extensive LTSS or behavioral health needs. MassHealth will require ACOs and MCOs to partner with CPs, which will also collaborate with health care providers, social service providers, and other resources in the community. Behavioral health (BH) CPs are responsible for performing care management, care coordination, health promotion, transitional care, member and family support, and referral to community and social supports for identified ACO members. LTSS CPs are responsible for providing support to ACO members with LTSS needs, including choice counseling, needs assessments, member and family support, and referral and navigation assistance.

Delivery System Reform Incentive Program

CMS authorized \$1.8 billion (state and federal combined) over five years for DSRIP, which has four objectives:

- 1. *Supporting ACO development:*** ACOs may use DSRIP funds for (1) ACO startup/ongoing support; (2) “glide path” funding for safety net providers; and (3) support for flexible services. Funds for the first two purposes will be partially at risk, based on an ACO DSRIP accountability score.
- 2. *Supporting Community Partners:*** CPs will use DSRIP funds for (1) care coordination and navigation and (2) infrastructure and capacity building. Similar to ACOs, a portion of the payments will be at-risk, based on a CP accountability score.
- 3. *Statewide investments:*** DSRIP funds also will support statewide investment initiatives, including student loan repayment, primary care residency training, workforce development grants, an alternative payment model preparation fund, and improved accessibility for people with disabilities.
- 4. *Implementation and operations:*** The remaining DSRIP funds will support the Commonwealth’s implementation and oversight of DSRIP.

Funding for DSRIP is scheduled to end at the end of the five-year waiver extension, at which time MassHealth expects the costs of the program to be sustained by the savings projected to be generated by the new care delivery models.

DSRIP FUNDING ALLOCATIONS (\$ Millions)

FUNDING STREAM	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022	TOTAL	PERCENT OF DSRIP FUNDS
ACO	\$329.2	\$289.9	\$229.4	\$152.0	\$65.1	\$1,065.6	60%
Community Partners	\$57.0	\$95.9	\$132.2	\$133.6	\$128.0	\$546.6	30%
Statewide Investments	\$24.2	\$24.6	\$23.8	\$24.8	\$17.4	\$114.8	6%
State Operations & Implementation	\$14.6	\$14.6	\$14.6	\$14.6	\$14.6	\$73.0	4%
TOTAL	\$425.0	\$425.0	\$400.0	\$325.0	\$225.0	\$1,800.0	100%

Increasing percentages of the statewide DSRIP funds will be contingent on Massachusetts meeting goals captured by an overall accountability score. By the fifth year, 20 percent of DSRIP funds will be at risk.

Safety Net Care Pool

The last waiver extension authorized the Safety Net Care Pool (SNCP) for only three of a possible five years and required Massachusetts to restructure it “to align with system-wide transformation.”³ The new waiver extension includes a substantially redesigned SNCP, funded at nearly \$8 billion over the course of the five-year demonstration. Components of the SNCP now include:

- **DSRIP:** Described above.
- **Public Hospital Transformation and Incentive Initiative (PHTII):** Continuation of a program of incentive-based payments to Cambridge Health Alliance (CHA), the state’s only public acute hospital.
- **Payments for uncompensated care:** The waiver extension creates two distinct pools to finance uncompensated care and support safety net providers: the Disproportionate Share Hospital (DSH) pool and the Uncompensated Care Costs (UCC) pool.
- **ConnectorCare premiums and cost sharing subsidies:** The new extension also authorizes for the first time a federal match for cost-sharing (e.g., copayment) subsidies in addition to maintaining federal matching funds on the cost of premium subsidies.

Expanded Substance Use Disorder Services

Substance use disorder services are offered by the Department of Public Health’s Bureau of Substance Abuse Services (BSAS) and by MassHealth. Before demonstration approval, MassHealth services were limited to outpatient counseling, methadone treatment, short-term detoxification services, and short-term residential services. In order to improve state capacity and respond to the opioid crisis, longer-term residential services will now be available through MassHealth as will recovery support services, which include navigators and recovery coaches.

³ Centers for Medicare and Medicaid Services Extension Special Terms and Conditions, MassHealth Medicaid Section 1115 Demonstration Approval Period starting October 2014, STC 48. Available online at <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/1115-demonstration-extension-approval-10-30-14.pdf>.

Other Changes

- **MassHealth premiums:** In 2018 MassHealth is authorized to adjust its premium schedule for members with incomes greater than 150 percent of the federal poverty level (FPL) to link premium amounts to a percentage of family income.
- **Student Health Insurance Plans:** MassHealth may now require MassHealth-eligible college students to enroll in Student Health Insurance Plans offered by their schools if doing so is cost-effective for MassHealth. The state will provide premium assistance, cost-sharing assistance, and a benefit wrap.

IMPLICATIONS

The health care delivery, service, and payment changes the waiver extension ushers in have significant implications for all individuals and institutions involved in MassHealth. **MassHealth members** could benefit greatly, particularly those with complex health care needs. But unintended consequences are possible, and these could affect access to services and choice of providers. New design features that affect member care have consumer safeguards such as appeals processes, grievance processes, and an independent consumer support program. **ACOs** will need to integrate a wider range of services into their care models, including LTSS and behavioral health services, and develop a deeper understanding of these services and the people who use them. Many providers will also be assuming greater financial risk than previously. **PCPs** will forge an exclusive relationship with a single ACO or choose not to affiliate with any ACO, a decision that could over time affect the composition of the physician's patient panel. Payment incentives could place additional pressure on a group of professionals about whom there already is a capacity concern.

Many potential **CPs** will face the challenge of building adequate infrastructure and capacity to meet the MassHealth certification requirements. Financial incentives will put a premium on good management, measurement, and quality service. **Other community organizations** provide the flexible services that can help ACOs manage their TCOC by addressing social determinants of health. The ACO and TCOC concepts offer great promise for these organizations if they are successfully incorporated into the model. **Managed care plans** will be part of the new system design and will also be in a variety of new relationships with ACOs, which may alter the scope of their responsibilities.

MassHealth's bold move to reform the delivery and payment systems could result in a great payoff for MassHealth members, providers, and the state budget. The plan is not without risks, however. Financial risks will require increased administrative support. Communication with members will be critical as members learn the new system, especially its effect on how and from whom they receive care. It is a daunting but not insurmountable management challenge for MassHealth leaders.

INTRODUCTION

MassHealth, the Massachusetts Medicaid and Children’s Health Insurance Programs, continues to be a critical component of the state’s health care system—a safety net for a large portion of the state’s residents and a model of innovation for how health care is organized and delivered. The latest chapter began on November 4, 2016, when the federal Centers for Medicare and Medicaid Services (CMS) approved an amendment to and extension of the MassHealth 1115 Demonstration Waiver, the sixth extension of the waiver that began in 1997. This extension seeks to transform the delivery of care for most MassHealth members and to change how that care is paid for, with the goals of improved quality and greater control over spending. The waiver also responds to the epidemic of opioid drug use by expanding substance use disorder services to MassHealth members. As these ambitious changes unfold, MassHealth also seeks to maintain the gains in coverage that were the focus of past waiver extensions.

After setting the stage with background and context, this issue brief describes the key elements of the new waiver extension, including the shift to a delivery system centered on Accountable Care Organizations (ACOs) and Community Partners (CPs), a Delivery System Reform Incentive Program (DSRIP), the redesigned Safety Net Care Pool (SNCP), and the expansion of services for treatment of substance use disorders. It concludes with a discussion of implications of the new system for major stakeholder groups.

BACKGROUND AND CONTEXT

Massachusetts has been in the vanguard of health care reform for many years. Over the last two decades, Massachusetts often has used the MassHealth 1115 waiver as a key instrument for reform. Since its launch in 1997, the 1115 waiver has served as a vehicle for expanding coverage, encouraging better coordination and cost containment through managed care, and supporting safety net providers—hospital systems and health centers to which many low-income people turn for their health care. The waiver has provided authority for important innovations. CommonHealth is a source of access to essential services for people with disabilities. And Commonwealth Care, a central feature of the state’s health care reform law, Chapter 58 of the Acts of 2006, provided subsidies for low-income people to purchase insurance coverage through the Commonwealth Health Insurance Connector (the Health Connector). Born in the MassHealth waiver, these innovations became national models. In 2014, as states implemented the marketplace and subsidy concepts that were fundamental to the Affordable Care Act (ACA) and that were pioneered in Massachusetts, Commonwealth Care was modified and became ConnectorCare in the state’s 1115 waiver.

The waiver has also been a conduit for federal health care funds flowing to Massachusetts.⁴ In addition to federal reimbursement for a share of the benefits provided to MassHealth members, the waiver is a mechanism for direct

⁴ The federal government approves 1115 waivers on the condition of budget neutrality—that is, the state must ensure that its Medicaid program under a waiver will require no more federal funds than it would without the waiver. There is a further discussion of budget neutrality later in this brief.

support to safety net providers, subsidies for purchasing coverage and, recently, incentive payments for providers to alter significantly how they deliver care to make it more person-centered, higher quality, and more cost effective.⁵

The SNCP is the accounting structure within the waiver where funds for uses other than direct MassHealth services to members are allocated. Among other things, SNCP funds are used for supplemental payments for safety net hospitals to make system improvements; subsidies for low-income people to purchase health insurance; and payment to hospitals and community health centers (CHCs) for care they provide people with no or inadequate health insurance. With its approval of the last extension of the waiver in 2014, the federal government required that Massachusetts restructure the SNCP by July 2017 so that payments to the SNCP “sustainably support and align with system-wide transformation.”⁶ Without an agreement for a redesigned SNCP, Massachusetts risked losing nearly \$1 billion in funding per year.

The SNCP deadline was an important motivation for the state to update its waiver. Another, more systemic motivation has been the increasing financial pressure that MassHealth puts on the state budget. In state fiscal year 2017, which began July 1, 2016, MassHealth accounts for 42 percent of the total state budget of \$38.9 billion.⁷ While more than half of MassHealth spending will come back to the state as federal revenue, the overall percentage of the budget devoted to MassHealth has been growing steadily over the past decade (it was 27 percent in 2007), as growth in MassHealth spending—largely driven by increased enrollment—has outpaced the growth in state revenues.⁸ MassHealth officials consider the growth in MassHealth spending to be unsustainable.⁹ To maintain the coverage gains the state has achieved with the 1115 waiver, MassHealth needs to find more efficient and effective ways of using Medicaid resources. Trends in health care delivery, an emerging national consensus around system transformation, and state mandates for payment reform offer opportunities.

Chapter 224 of the Acts of 2012 (a state law seeking to slow the growth of health care spending) required MassHealth to adopt alternative payment methodologies (APM) to promote more coordinated, efficient care for most of its members.¹⁰ This mandate reflects general acceptance across the country that delivering fragmented, a la carte health care, paid for per service rather than as part of a comprehensive health strategy, contributes to uncoordinated and suboptimal care, wasted resources, and excess costs. The energy in health care reform nationally is now directed toward addressing undesirable fragmentation by creating incentives that promote value, and tying payment for care to results—quality, efficiency, and better health outcomes.

This trend is apparent in the ascendance of accountable care models of health care delivery. In these models, providers are accountable for the health of their patient panels, and at least part of their pay is contingent on achievement of health outcomes and other quality targets. Providers are not paid simply for providing additional services. In exchange for agreeing with payers to accept accountability and its attendant financial risk, providers in

5 For more background on the MassHealth waiver, see Robert Seifert, Michael Grenier, and Jean Sullivan, “The MassHealth Waiver Extension for State Fiscal Years 2015–2019: Foundation for Coverage, Engine for Innovation.” Blue Cross Blue Shield of Massachusetts Foundation, February 2015. Available online at <http://bluecrossfoundation.org/publication/summary-masshealth-1115-waiver>.

6 MassHealth Medicaid Section 1115 Demonstration, Approval Period 10/30/2014–6/30/2019, STC 54 (Technical Correction 1/20/2015).

7 Massachusetts Medicaid Policy Institute, “Budget Brief: FY2017 General Appropriations Act Budget for MassHealth (Medicaid) and Health Reform Programs.” Blue Cross Blue Shield of Massachusetts Foundation, October 2016. Available online at <http://bluecrossfoundation.org/publication/fy2017-general-appropriations-act-budget-masshealth-medicare-and-health-reform-programs>.

8 Massachusetts Medicaid Policy Institute and Center for Health Law and Economics, University of Massachusetts Medical School. “MassHealth: The Basics. Facts and Trends.” Blue Cross Blue Shield of Massachusetts Foundation, June 2016. Available online at <http://bluecrossfoundation.org/publication/updated-masshealth-basics-june-2016>.

9 Massachusetts Executive Office of Health and Human Services, “MassHealth Delivery System Restructuring: Overview.” Available online at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/mass-health-restructuring-overview-document.pdf>, accessed October 31, 2016.

10 For more information on the implications of Chapter 224 for MassHealth, see Robert Seifert and Rachel Gershon, “Chapter 224 of the Acts of 2012: Implications for MassHealth.” Blue Cross Blue Shield of Massachusetts Foundation, September 2012. Available online at <http://bluecrossfoundation.org/publication/chapter-224-acts-2012-implications-masshealth>.

many versions of accountable care share in the savings that improved care delivery and outcomes may generate. This arrangement is a prime example of the sort of “alternative payment model” that Chapter 224 requires MassHealth to adopt.

Though the label is relatively new, accountable care concepts in some form have been part of the health care system for years. There are elements of accountable care in prepaid health plans in which managed care plans accept a fixed payment per member and the financial risk that entails. The ACA authorized Medicare demonstrations of accountable care arrangements. More recently, CMS has urged states to transform their Medicaid programs using accountable care delivery and payment structures. An early version of this approach is in MassHealth’s Delivery System Transformation Initiative (DSTI), which CMS first authorized in the 2011 waiver extension. Since then, several states—New York, Oregon, and Texas being the most prominent examples—have undertaken more ambitious transformations under the auspices of their 1115 Medicaid demonstration waivers. CMS has used the waiver process as a vehicle for actively promoting the transition of Medicaid’s delivery and payment structures from favoring the delivery of more services to favoring care that achieves positive health outcomes.

With this waiver extension, MassHealth commits to its own ambitious transformation, over five years, to change how care is delivered to most of its members. The waiver terms encourage the formation of ACOs and CPs to connect members who have significant behavioral health or long-term services and supports (LTSS) needs with community services. An accompanying payment reform creates incentives to better coordinate health care, incorporate social services that improve health into care plans, and emphasize community-based over institutional care. The waiver restructures the SNCP so that the state retains the federal funding important for these new initiatives, improves the ConnectorCare subsidy program, and continues to support the safety net and the ongoing operation of the MassHealth program. The waiver also includes expanded treatment options for MassHealth members with substance use disorders as part of a statewide strategy to stem the opioid addiction crisis, during which opioid-related deaths in Massachusetts have nearly tripled in six years.¹¹

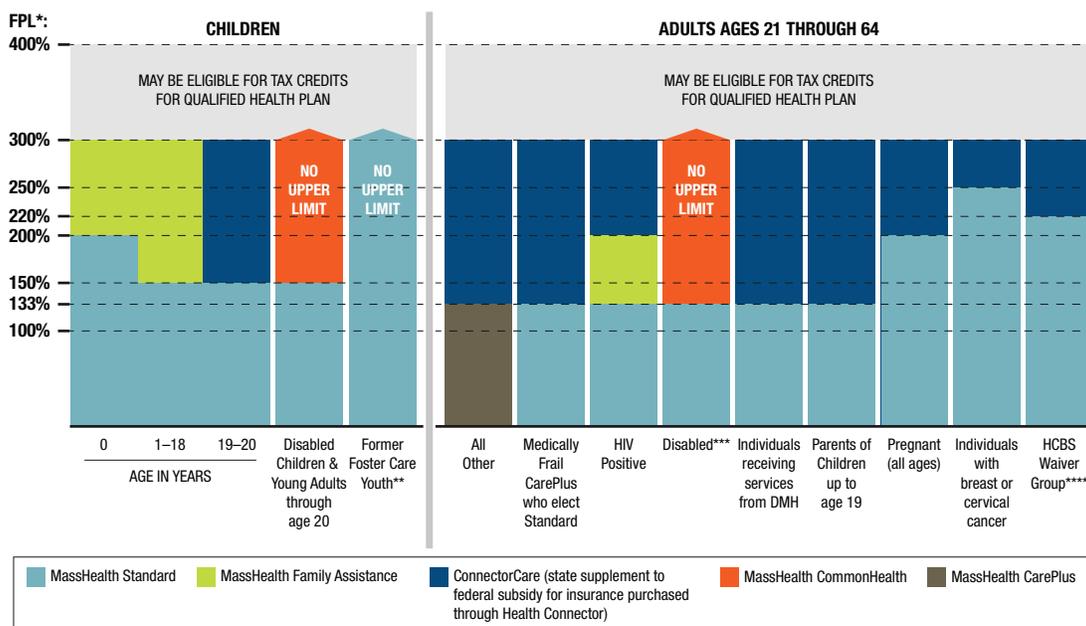
The remainder of this brief explains key details of the waiver extension and discusses implications for various stakeholders in the health care system.

¹¹ From 525 in 2010 to an estimated 1,526 in 2015. Mass. Department of Public Health, *An Assessment of Opioid-Related Deaths in Massachusetts (2013–14)*, September 2016. Available online at <http://www.mass.gov/eohhs/docs/dph/stop-addiction/chapter-55-opioid-overdose-study-data-brief-9-15-2016.pdf>.

ELEMENTS OF THE AMENDMENT AND EXTENSION

Under this new agreement, the waiver is extended for five years: state fiscal years (SFY) 2018 through 2022 (July 1, 2017 – June 30, 2022). MassHealth eligibility criteria, as expanded under earlier extensions of the waiver, remain the same (see Figure 1). ConnectorCare, which provides subsidies that help 182,000 people in Massachusetts afford coverage, is retained and will benefit from additional federal funding.¹² There are some changes to covered services specifically related to treatment for substance use disorders, and opportunities for certain members to receive health-related social services MassHealth does not typically cover, which are described in detail below. A few changes to the demonstration became effective on the date of CMS approval, November 4, 2016. These changes are technically an *amendment* to the current waiver agreement.¹³ All other demonstration changes are effective July 2017 and are authorized under an *extension* of the waiver.

FIGURE 1. MASSHEALTH ELIGIBILITY



Note: In general, the eligibility level for seniors age 65 and older is 100 percent FPL and assets of up to \$2,000 for an individual or \$3,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs.

* FPL = income as percent of federal poverty level; in 2016 100 percent FPL for a family of four is \$24,300.

** Former foster care youth are eligible for MassHealth Standard up to age 26 for citizens and qualified noncitizens. Former foster care youth who are qualified noncitizens barred, or nonqualified individuals lawfully present are eligible for MassHealth Standard up to age 21.

*** As of November 4, 2016, CommonHealth eligibility under the 1115 waiver extends to individuals with disabilities age 65 and older who have paid employment for 40 hours or more per month. Prior to this date, MassHealth was providing CommonHealth to such individuals at 100% state cost.

**** Eligibility for the Home and Community Based Services (HCBS) waiver is based on 300 percent of the Federal Benefit Limit (FBL) which is slightly lower than FPL. In 2016, 300 percent FBL was roughly 220 percent FPL.

12 Massachusetts Health Connector. CCA Board Report Metrics, November 4, 2016. Available online at

https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2016/2016-11-10/Summary-Report-October2016.pdf.

13 The amendment includes authorization for an ACO pilot beginning December 2016, expansion of substance use disorder services, and some changes to the Safety Net Care Pool.

The waiver extension has five goals:

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.
5. Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services.

ACCOUNTABLE CARE ORGANIZATIONS

The introduction of ACOs is a significant shift in MassHealth’s approach to organizing and delivering care to most of its members, and is the central element of the waiver extension. Many other important features of the waiver, such as DSRIP and the restructured SNCP, are designed to support the launch and growth of ACOs. Pre-existing structures—including managed care organizations (MCOs) and the MassHealth Primary Care Clinician (PCC) Plan provider network—are incorporated into the ACO design. The overall emphasis is on coordination, quality, and cost effectiveness, with a strong member focus. Generally, MassHealth members under the age of 65 without other insurance coverage are eligible to participate in an ACO.¹⁴ As shown in Figures 2 and 3, roughly 1.27 million MassHealth members will be offered the option of enrolling with an ACO.

Accountable Care Organizations (ACOs) are provider-led entities that enter into population-based payment models with payers, wherein the ACO is held financially accountable for the cost and quality of care for an attributed member population.

FIGURE 2. MASSHEALTH MEMBERS ELIGIBLE FOR ACO ENROLLMENT BY DELIVERY SYSTEM

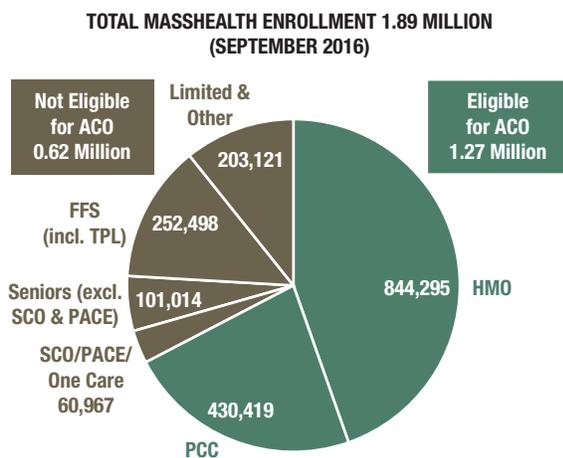
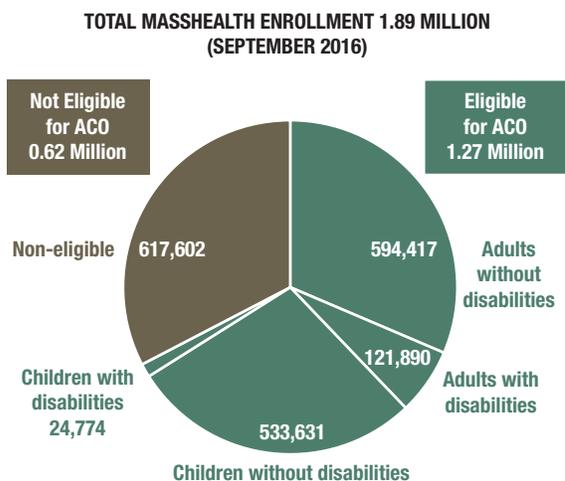


FIGURE 3. MASSHEALTH MEMBERS ELIGIBLE FOR ACO ENROLLMENT BY POPULATION



Note: The number of ACO-eligible individuals reflects MassHealth members currently enrolled in MCOs and the PCC Plan. A small number of members under 65 who are eligible but not enrolled in managed care are eligible for ACOs but are not reflected in the chart.

¹⁴ MassHealth 1115 Request submitted to CMS on July 7, 2016, page 22.

MassHealth ACOs, like most other ACOs around the country, will be responsible for providing quality health care for their attributed populations while controlling costs. They will collaborate with CPs, community-based organizations focused on members with significant behavioral health and LTSS needs. MassHealth's payment methods for ACOs are designed to encourage ACOs to meet cost and quality targets. Support for achieving the targets will come in part through DSRIP. Further discussion of ACO payments, DSRIP, and CPs appears below.

Procurement of MassHealth ACOs is underway.¹⁵ ACOs can submit bids for multiple ACO models (described below) and different geographic coverage areas but ultimately will participate as only one type of ACO.¹⁶ MassHealth anticipates that it will select ACOs in the spring of 2017, ACOs will enter into contracts with MassHealth in the summer of 2017, and ACOs will begin operation in December 2017.¹⁷ In the short term, an ACO pilot will run from December 2016 to late 2017.¹⁸ The pilot ACOs will operate in a manner similar to that of the Primary Care ACO model described below.

ACO Models

MassHealth's ACO program includes three ACO models, reflecting opportunities for providers with different care delivery approaches to participate in accountable delivery systems.¹⁹

- **Accountable Care Partnership Plans** (“Partnership Plans”) are MCOs. Partnership Plans are partnered with a provider-led ACO that does not otherwise participate as an ACO in the MassHealth ACO program. The Partnership Plan and provider-led ACO collaborate to provide integrated, coordinated care.
- **Primary Care ACOs** are provider-led ACOs that contract directly with MassHealth as Primary Care Case Management entities to take financial accountability for a defined population of enrolled members.
- **MCO-Administered ACOs** are provider-led ACOs that contract directly with MassHealth MCO contractors to take financial accountability for the MCO enrollees they serve.²⁰ MCO-Administered ACOs may contract with multiple MCOs.

Each ACO model can be characterized by the type of organization that enters into the ACO contract and the party with which it contracts (see Figure 4).

ACOs will be required to have exclusive participation from a number of primary care providers (PCPs) and affiliations with hospitals in order to coordinate care. PCPs may only be affiliated with one ACO; hospitals may contract with multiple ACOs. ACOs will also be required to work with CPs to better serve members with extensive needs for behavioral health care or LTSS. ACOs will need to contract with a sufficient number of certified CPs to ensure appropriate access for their members.

¹⁵ MassHealth ACO RFR.

¹⁶ MassHealth ACO RFR at 3.1.B.

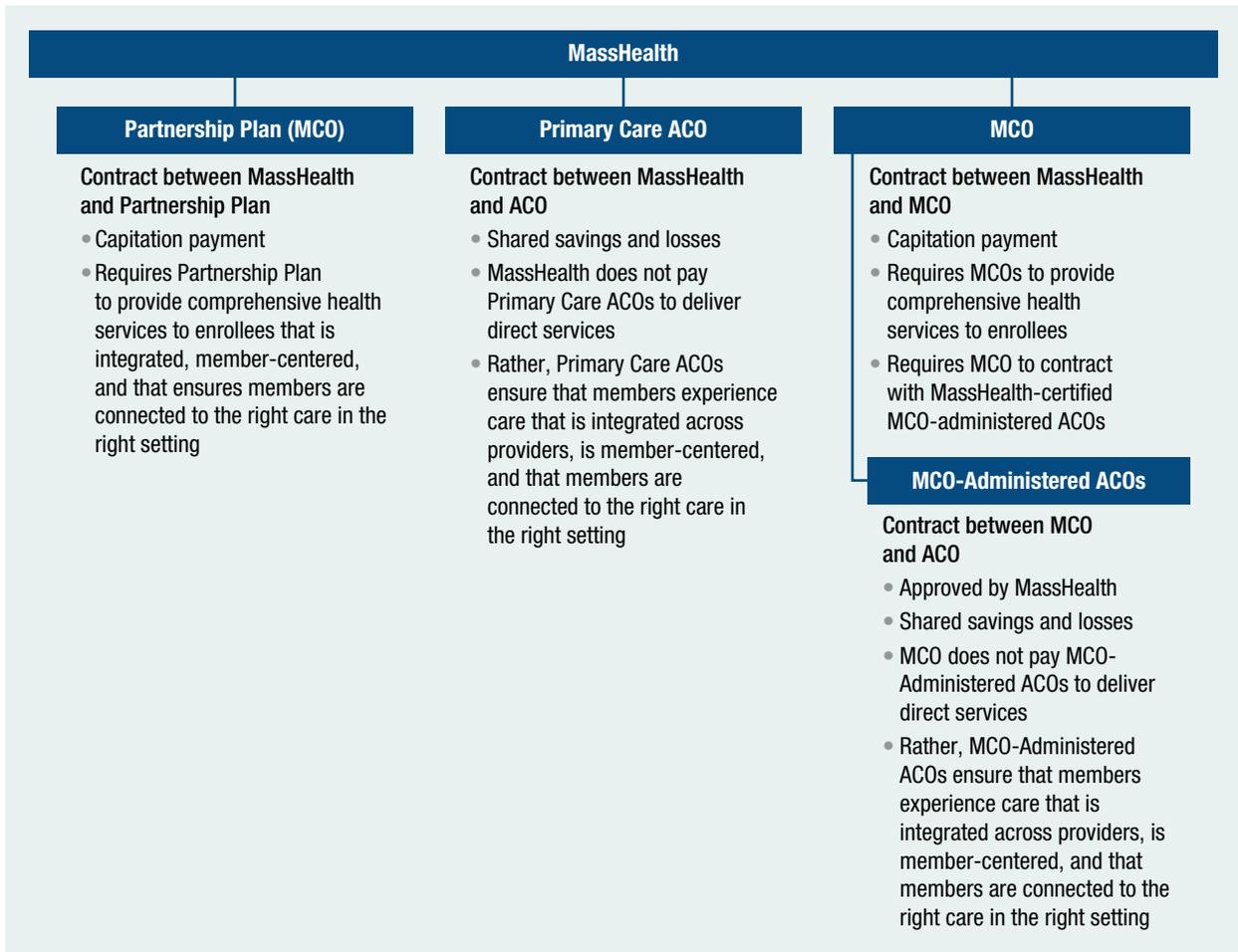
¹⁷ Summary of the MassHealth waiver, available online at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/ma-1115-waiver-summary.pdf>.

¹⁸ MassHealth Request for Responses for Pilot ACOs at 5, as amended June 17, 2016. Available online at <https://www.commbuys.com/bs0/external/bidDetail.sdo?docId=BD-16-1039-EHS01-EHS02-0000008175&external=true&parentUrl=bid>.

¹⁹ Accountable Care Partnership Plans were previously called Model A ACOs. Primary Care ACOs were called Model B ACOs. MCO-Administered ACOs were called Model C ACOs.

²⁰ An MCO may contract with more than one ACO for its provider network, and an MCO-Administered ACO may contract with multiple MCOs.

FIGURE 4. MASSHEALTH ACO MODELS



Care Coordination, Care Integration, and Flexible Services

As is true for patients in the larger health system, MassHealth members who receive care from multiple providers can face barriers to effective care when their providers do not communicate with each other or do not address the full range of the member’s needs in a coordinated approach. ACOs are expected to promote communication between providers and ensure that members’ needs (including social service needs) are addressed. An ACO may itself provide the care planning and care coordination or ensure that another organization is performing that function. For members with significant behavioral health or LTSS needs, CPs are expected to partner with ACOs and MCOs in care planning and coordination.

ACOs may use a pre-specified portion of their DSRIP funds to newly fund “flexible services” not typically available under Medicaid. Flexible services may include transition services for individuals transitioning from an institution to the community; physical activity and nutrition; and support for individuals who have

FLEXIBLE SERVICES

The waiver extension allows MassHealth to spend DSRIP funds on goods and services not typically covered by MassHealth. These services must fit certain criteria, including being health related and cost effective. By May 2017, MassHealth is required to send further details on eligibility criteria and service definitions to CMS for review and approval.

experienced violence.²¹ DSRIP funding is time-limited and will phase out over the five years of this waiver extension. By then, ACOs may find that care management, care coordination, and other nontraditional services improve quality and reduce the TCOC and may therefore continue to provide these services, even if they are not directly reimbursed.

Services for ACO Members and Financial Accountability for ACOs

All ACO members are entitled to medically necessary MassHealth-covered services. Generally, ACO members will receive services from the MassHealth provider network or from their MCO. Depending on the ACO model, an ACO member may be encouraged to seek care from certain providers in a network or in a “referral circle.” Members seeking care from a specialty provider in their “referral circle” will not require a referral from their PCP.

ACOs will be financially accountable for savings or losses associated with many but not all service types. Partnership Plans, unlike other ACOs, have responsibility for service authorization and utilization management. Table 1 describes how members will get certain types of care and the ACOs’ financial responsibility for that care.

TABLE 1. SERVICE ACCESS AND FINANCIAL ACCOUNTABILITY BY ACO MODEL

MODEL	PRIMARY CARE	INPATIENT AND OUTPATIENT PHYSICAL HEALTH CARE	PHARMACY	BEHAVIORAL HEALTH	DENTAL	LTSS
ACCOUNTABLE CARE PARTNERSHIP PLAN						
How/where members will access service type	Through the Partnership Plan. Each Partnership Plan has an exclusive group of PCPs that will deliver primary care to its members.	Through the Partnership Plan. Partnership Plans may develop a network of providers and require its members to use the network, with limited exceptions.	Through the Partnership Plan.	Through the Partnership Plan. Partnership Plans may develop a network of providers and require its members to use the network, with limited exceptions. Alternatively, the ACO can contract with a behavioral health carve-out vendor (currently MBHP).	Through MassHealth’s dental vendor (no difference from current system).	Through the Partnership Plan starting in year 3 or 4 of the 1115 extension; prior to that through the MassHealth fee-for-service network with certain utilization management and other functions conducted by a new LTSS third-party administrator.
Will ACO be held financially accountable for service type?	Yes	Yes	Yes	Yes	No	Yes, starting on or about year 3 of the demonstration

continued

21 MassHealth Extension STCs at 61 (STC 60). Further discussion of flexible services is on pages 17–18 of this report.

continued

MODEL	PRIMARY CARE	INPATIENT AND OUTPATIENT PHYSICAL HEALTH CARE	PHARMACY	BEHAVIORAL HEALTH	DENTAL	LTSS
PRIMARY CARE ACO						
How/where members will access service type	Through a PCP who is exclusively partnered with the Primary Care ACO.	Through the MassHealth fee-for-service network available to PCC Plan members. If members wish to seek care without a referral, they can use a provider within the Primary Care ACO's referral circle.	Through MassHealth.	Through the PCC Plan behavioral health carve-out vendor (currently MBHP).	Through MassHealth's dental vendor (no difference from current system).	Through the MassHealth fee-for-service network with certain utilization management and other functions conducted by a new LTSS third-party administrator.
Will ACO be held financially accountable for service type?	Yes	Yes	Yes	Yes	No	Yes, starting on or about year 3 of the demonstration
MCO-ADMINISTERED ACO						
How/where members will access service type	Through a PCP who is exclusively partnered with an MCO-Administered ACO.	Through a provider within the MCO provider network.	Through the MCO.	Through the MCO's provider network.	Through MassHealth's dental vendor (no difference from current system).	Through the MCO starting in year 3 or 4; prior to that via MassHealth fee-for-service with certain utilization management and other functions conducted by a new LTSS third-party administrator.
Will ACO be held financially accountable for service type?	Yes	Yes	Yes	Yes	No	Yes, starting on or about year 3 of the demonstration

Note: Members may receive family planning services from any provider without consulting their PCP or ACO and are not required to obtain prior approval.

This chart is based on information found in the 1115 request, STCs, and RFR, which are subject to change. Some exceptions apply. Partnership Plans' list of covered services is available at the ACO RFR, Appendix C to Attachment A. TCOC-included services are available for Primary Care ACOs in the ACO RFR, Appendix A to Attachment B, and for MCO-Administered ACOs in Appendix A to Attachment C.

MassHealth Payments to ACOs

MassHealth payment methods are designed to reinforce ACO responsibility for quality and cost goals. Partnership Plans will be paid a prospective monthly capitation similar to what MCOs receive. Both Primary Care and MCO-Administered ACOs will share savings and losses, pursuant to contracts with MassHealth (for Primary Care ACOs) or MCOs (for MCO-Administered ACOs). Primary Care ACOs will be paid fee-for-service, later reconciled against the TCOC, and will share savings and losses (see Appendix 1 for an explanation of the shared savings/losses calculation). The waiver also makes possible a prepayment mechanism for Primary Care ACOs, with the agreement of the ACO and its providers. MCO-Administered ACOs will be paid by their MCOs according to

financial agreements approved by MassHealth. Eligible ACOs will also receive funding through DSRIP, which is described later in this brief.

TABLE 2. PAYMENT APPROACH BY ACO MODEL

ACO MODEL	NON-DSRIP PAYMENT	DSRIP PAYMENT
Accountable Care Partnership Plan	Capitation paid by MassHealth to the Partnership Plan.	Time-limited DSRIP funds available to eligible ACOs. DSRIP amount is subject to accountability metrics.
Primary Care ACO	Savings and losses shared between the ACO and MassHealth. Initially, savings and losses will be shared retrospectively, but in the future Primary Care ACOs may receive prepayments.	
MCO-Administered ACO	Savings and losses shared between an MCO and an MCO-Administered ACO, pursuant to an agreement subject to MassHealth approval.	

Membership attributed to ACOs and risk adjustment

All ACOs will be paid according to the population of MassHealth members that enroll with or are attributed to them. Members will be able to actively enroll in Partnership Plans, Primary Care ACOs, MCOs, and the PCC Plan. Members enrolled in MCOs will be attributed to MCO-Administered ACOs based on their primary care selection or assignment within those MCOs’ networks. Members who do not actively select an enrollment option will be assigned by MassHealth; MassHealth intends to conduct this assignment in a way that prioritizes preserving existing primary care relationships for any enrollments that are effective at the beginning of the new program.

An ACO will be held financially accountable for the members attributed to (or enrolled in) that ACO. This means that the cost of an attributed (or enrolled) member’s care will be considered when calculating the ACO’s payment.

MassHealth will adjust capitation rates and TCOC benchmarks for ACOs to account for their members’ acuity, using a risk adjustment model that considers each member’s claims history, demographics, and health status, as well as members’ social determinants of health (SDH), such as housing deficits and other neighborhood-level stressors.²² The incorporation of SDH into risk modeling is a new innovation for MassHealth, and an important part

of the broader reform. Risk adjustment is an evolving field, and the techniques to adjust for social determinants are expected to be an important factor in ACO outcomes. The accuracy and effectiveness of risk adjustment, and the variation among ACO member populations, may have an impact on ACOs’ financial performance and competitiveness.

Total cost of care

All ACOs will be paid based in part on the expected TCOC for their attributed members. Services included in the TCOC reflect the aspects of care for which ACOs are responsible, as described in Table 2 above, and will determine payment to ACOs; these services will thus be ACOs’ targets for cost control strategies.

Total cost of care (TCOC) refers to an ACO’s expenditures for a member’s care. Total cost of care is only calculated for “TCOC-included services.”

Role of quality measures

Performance on quality measures will be a factor in MassHealth payment to ACOs. MassHealth will develop quality measures in these domains: (1) Prevention and Wellness; (2) Chronic Disease Management; (3) Behavioral Health/Substance Use Disorder; (4) LTSS; (5) Progress Towards Integration Across Physical Health, Behavioral

²² See the University of Massachusetts report on risk adjustment, available online at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/1610-umass-modeling-sdh-summary-report.pdf>.

Health, LTSS, and Health-Related Social Services; (6) Avoidable Utilization; and (7) Member Care Experience.²³ See Appendix 2 for further information.

Risk corridors

MassHealth's ACO payment models include a range of risk mitigations, including risk corridors. These risk corridors will take the form of minimum losses required before shared loss payments are required, as well as a cap on losses that can be shared. There are equivalent limits on shared savings, so that a minimum level of savings must be achieved before an ACO can receive a share of those savings. The amount of shared savings is capped at a maximum.

Appendices 1 and 2 describe how shared savings and losses will be calculated, including how quality performance will be factored into the calculations.

Additional risk mitigations in the ACO program include rate cell-level savings and losses calculations (which protect ACOs from risk due to population shifts among rate cells), adjustments to TCOC benchmarks for program changes, member-level stop-loss, adjustments for high-cost Hepatitis C Virus pharmacy, and other adjustments for high-cost pharmacy.

Administrative costs

Partnership Plan capitation rates will include actuarially set administrative rates. MassHealth may also pay Primary Care ACOs smaller administrative rates.²⁴

ACO QUALIFICATIONS

MassHealth's ACO requirements accommodate a range of ACO sophistication and include support for ACOs to build capacity.

Type of entity: A MassHealth ACO is generally a provider-led entity. It may partner with a single MCO (Partnership Plans), contract with one or more MCOs for its administrative and financial functions (MCO-Administered ACOs), or deal directly with MassHealth (Primary Care and pilot ACOs). ACOs must include PCPs and hospitals in their organization and may also include specialists, behavioral health providers (except Primary Care ACOs, which will use MassHealth's managed behavioral health vendor), social service providers, and, eventually, LTSS providers. ACOs must be certified by the Health Policy Commission (or, in the case of Partnership Plans, have a certified ACO partner).

In addition, Partnership Plans must maintain state Health Maintenance Organization (HMO) licensure, and their provider network must meet federal managed care requirements, including those for network adequacy and language access

ACO must serve a minimum number of members: 20,000 for Partnership Plans, 10,000 for Primary Care ACOs, and 5,000 for MCO-Administered ACOs.

Experience: MassHealth will consider a bidder's previous experience with alternative payment or alternative care contracts when selecting an ACO.

Capabilities: All ACOs will be expected to deliver a coordinated and improved member experience and must provide evidence that the ACO has the capacity to provide care coordination and care management.

Governance: ACOs of all types must have a provider-led, member-focused governing board, including a majority of providers or their representatives, at least one voting member who is a consumer or consumer advocate, a Patient and Family Advisory Committee, and a Quality Committee. Also, they must give notice of any "material changes" to their operations or governance structure in order to comply with state antitrust reporting law.

Finances: ACOs will be at financial risk for their performance and so will face certain solvency and financial protection requirements. Partnership Plans will face the same financial requirements as MassHealth MCOs. Primary Care and MCO-Administered ACOs will need to be certified by the Division of Insurance (DOI) as a Risk Bearing Provider Organization (RBPO) or have a waiver from the DOI. Primary Care and MCO-Administered ACOs must have a repayment agreement with MassHealth or their administering MCO, and mechanisms in place—such as a performance bond or line of credit—to guarantee a portion of potential shared-losses payments.

²³ MassHealth ACO RFR, Attachment A Appendix O, Attachment B Appendix B, and Attachment C Appendix B.

²⁴ Section 4.2 of the Primary Care ACO Model Contract.

ACO Payments to Providers

MassHealth, in its agreement with CMS and as included in requirements in the model ACO contracts, intends to push alternative payment concepts to the level of individual providers, particularly PCPs. The contracts for all three ACO models require ACOs to “develop, implement, and maintain value-based payments for PCPs.”²⁵ Such payments are meant to shift incentives away from the volume of services to the value of the services by holding each PCP accountable “to some degree” for the ACO’s performance and basing payments in part on performance, including TCOC and quality measures.²⁶

Member Enrollment and Attribution

As noted above, not all MassHealth members will be eligible for an ACO; only those under age 65 without other insurance will be eligible. Eligible members will enroll in an ACO or be attributed to one, with the option to change ACOs or leave the ACO program during plan selection periods. If a PCP participates in an ACO, eligible members will generally only be able to join that PCP’s panel through the ACO; that PCP will not also be available for selection in the PCC Plan. PCPs are not required to be part of an ACO; a member may choose to stay out of the ACO program by enrolling in the PCC Plan or an MCO and choosing an available PCP that is not part of an ACO.

Each of the ACO models has a different process for a MassHealth member to enroll in or be attributed to that ACO. Once enrolled, members are subject to limits on their ability to change enrollment options, according to MassHealth’s fixed enrollment policies, described below.

ACOs available through the MCO delivery system

MassHealth members may enroll in a Partnership Plan or in an MCO. Members who enroll in Partnership Plans or MCOs will also choose or be assigned by their plan to a PCP. If an MCO enrollee selects or is assigned to a PCP that is part of an MCO-Administered ACO, the enrollee will also be considered attributed to that MCO-Administered ACO.

ACOs available outside the MCO delivery system

Members may instead choose to enroll in available Primary Care ACOs. To enroll in a Primary Care ACO, a member must also select or be assigned by MassHealth to a PCP that participates in that Primary Care ACO.

TABLE 3. ENROLLMENT POLICIES BY ACO MODEL

ACO MODEL	ATTRIBUTION AND ENROLLMENT	LIMITS TO DISENROLLMENT
Accountable Care Partnership Plan	Members may enroll in and disenroll from a Partnership Plan. A member enrolled in a Partnership Plan must have a PCP that participates in that Partnership Plan’s network.	MassHealth may limit disenrollment from the ACO after a plan selection period. However, the member may change PCPs within an ACO at any time.
Primary Care ACO	Members may enroll in and disenroll from Primary Care ACOs. A member enrolled in a Primary Care ACO must have a PCP that participates with that Primary Care ACO.	MassHealth may limit disenrollment from the ACO after a plan selection period. However, the member may change PCPs within an ACO at any time.
MCO-Administered ACO	Members who enroll in MCOs may be attributed by their MCOs to MCO-Administered ACOs that are in their MCOs’ networks, based on the members’ PCP assignments. Members may leave the ACO by changing their PCP or disenrolling from the MCO.	MassHealth may limit disenrollment from the MCO after a plan selection period. However, MCO members may change their MCO-Administered ACO by changing their PCP within the MCO network.

²⁵ See, for example, Partnership Plan Model Contract at 136.

²⁶ See, for example, Primary Care ACO Model Contract Section 2.2.A.2.

Fixed enrollment periods

To further align the MCO and ACO delivery systems, MassHealth is implementing several changes to its MCO program. Previously, MassHealth members were able to change MCO plans or move from the MCO delivery system to the PCC Plan at any time. As of October 1, 2016, MassHealth implemented a new policy that curtails members' ability to switch easily between plans. Members now have an annual 90-day "plan selection period," during which a member who is enrolled in an MCO may select a different MCO or enroll in the PCC Plan. Following this 90-day period, the member enters into a "fixed enrollment period," during which the member is not permitted to change MCOs or enroll in the PCC Plan until the next plan selection period begins. Similar enrollment restrictions are common in employer-sponsored coverage because they provide greater stability for MCOs to predict their costs. MassHealth will have a number of exceptions to permit some members to change plans within the fixed enrollment period, including members who move outside their plan's service area or members with a specific service, language, or accessibility need for which the plan is unable to provide. Other exceptions are outlined in MassHealth regulations.

This enrollment period will also apply to ACO members. Members in Accountable Care Partnership Plans and Primary Care ACOs will have fixed enrollment periods for their selected ACOs. Members in MCO-Administered ACOs will have fixed enrollment periods for their MCOs but may change their ACO at any time. The fixed enrollment policy will not apply to PCC Plans, so MassHealth members enrolled in PCC Plans may enroll in MCOs or ACOs at any time (after which they too will face a fixed enrollment period).

Member Rights and Protections

With ACOs able to influence provider choice and control costs, member protections are important. ACOs will be responsible for fulfilling requirements related to consumer protection, such as offering a grievance process and, for Partnership Plan ACOs, an internal appeals process. They must offer culturally and linguistically appropriate care, provide a clinician hotline for members, and ensure access to primary or urgent care during extended hours. The waiver includes these protections:

- A requirement that ACOs inform members of their rights.
- Continuity of care protections for members enrolling in a Partnership Plan (meaning that members have uninterrupted access for a specified period of time to medically necessary care when changing plans).²⁷
- Access to all appeals and grievance processes available today.²⁸
- ACO-specific grievance processes.
- Internal appeals processes for Partnership Plans and other ACOs seeking risk certification from DOI.
- An independent consumer support program provided by MassHealth.
- Cultural and linguistic access.
- Disability access.

The waiver agreement requires MassHealth to establish and maintain an **independent consumer support program**.

This program is designed to offer support to members in health plan choice, enrollment, access to services, and understanding grievance and appeal rights. It will also train MCOs and ACO providers on community-based resources.

The consumer support center must be independent from ACOs, MCOs, and, to the extent possible, the state Medicaid agency.

²⁷ RFR, Attachment A at page 25.

²⁸ Waiver application at 33.

Member Incentives to Enroll in ACOs

Through this delivery system redesign, MassHealth has expressed a clear preference for better-coordinated and -managed care. To that end, MassHealth may charge lower copayments as an incentive for members to choose MCOs and ACOs. MassHealth has indicated that changes to cost sharing will not occur until at least 2018 and will be implemented only after a public comment period.

COMMUNITY PARTNERS

CPs are community-based organizations that will work with ACOs and MCOs to offer support services for individuals with extensive LTSS or behavioral health needs. MassHealth will require ACOs and MCOs to partner with CPs, which will also collaborate with health care providers, social service providers, and other resources in the community. There are two types of CPs: behavioral health (BH) CPs and LTSS CPs. MassHealth has released a notice of upcoming procurement with draft criteria and functions for BH and LTSS CPs for public comment and plans to launch the CP application process early in 2017.²⁹

Community Partner Qualifications

CPs must be community-based.³⁰ BH CPs must show experience in serving members with complex behavioral health needs. They must show that they are able to deliver outpatient mental health and substance use disorder services in a culturally competent manner and to perform specific care coordination and referral services. Community Service Agencies (CSA), which now serve children and youth in MassHealth's Children's Behavioral Health Initiative, will be eligible for DSRIP infrastructure funds.³¹

LTSS CPs must show experience in serving members with complex LTSS needs, including members with disabilities. They must show expertise in coordinating between the physical health and LTSS systems, and have experience assessing needs and counseling members to access appropriate LTSS providers.

Community Partners (CPs) are organizations that provide expertise to ACOs and MCOs and support MassHealth members with significant behavioral health or long-term services and support needs.

Community Partner Responsibilities

Both BH and LTSS CPs are responsible for partnering with ACOs. ACOs are responsible for assessing members for behavioral health and LTSS needs, counseling members on care options, and supporting member access to the relevant (BH/LTSS) portions of the member's care plan.³² BH CPs are responsible for performing care management, care coordination, health promotion, transitional care, member and family support, and referral to community and social supports for identified ACO and MCO members. LTSS CPs are responsible for providing support to ACO members with LTSS needs. ACOs are required to delegate responsibilities to LTSS CPs for choice counseling, needs assessments, member and family support, and referral and navigation assistance. While CPs provide coordination and participate on the care team, they do not authorize services or do utilization management.

²⁹ CP RFI; Waiver Summary at 13. CP RFI materials are available online at <https://www.commbuys.com/bsa/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-0000009852&external=true&parentUrl=bid>.

³⁰ Advance Notice of Upcoming Procurement documents numbered: 17EHSBHCPFR and 17EHSLTSSCPFR, December 16, 2016. Available at online at <https://www.commbuys.com/bsa/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-11588&external=true&parentUrl=bid> and <https://www.commbuys.com/bsa/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-11586&external=true&parentUrl=bid>.

³¹ Waiver application at 36. There currently are 32 Community Service Agencies in the state.

³² Attachments A and B to the CP RFI.

Payment to Community Partners

CPs will initially be paid through DSRIP.³³ Some DSRIP funding will be at risk, based on the CP's ability to provide quality care and control costs. DSRIP funding is time-limited; MassHealth projects that as ACOs mature, CP functions will be supported by the ACOs' TCOC budget.³⁴

Member Experience with Community Partners

MassHealth will determine criteria for ACOs and CPs to identify members eligible for CP services. ACOs are required to partner with multiple CPs; the process for how members will be assigned to or choose their CP is still to be determined.³⁵

CHANGES TO LONG-TERM SERVICES AND SUPPORTS

MassHealth intends to phase in financial responsibility for LTSS in MCOs and ACOs. MassHealth currently does not include LTSS in the MCO capitation rates, but the change will be made through the MCO reprocurement process, which began in late 2016, with new contracts expected to be in place in late 2017.³⁶ MassHealth has stated that it plans to model the phase-in of LTSS to MCOs on the One Care program, the Commonwealth's demonstration program for dually eligible (MassHealth and Medicare) members ages 21–64. Before accepting responsibility for LTSS delivery and costs, MCOs will be required to pass a comprehensive review in which they demonstrate capabilities in completing comprehensive LTSS needs assessments, providing person-centered care, supporting independent living principles, and delivering community-based LTSS. During the five-year term of this extension, possibly beginning around year 3, MCOs will be required to have a provider network that allows the MCO to authorize LTSS services for its under-65, non-Medicare-eligible members.

MassHealth also has indicated that it intends to phase in responsibility for LTSS for each of the three ACO models. The model ACO contracts indicate that this may happen beginning in the third year of the contracts.

Long-term services and supports (LTSS) are services and supports provided to individuals who have functional limitations and/or chronic illnesses, and they have the primary purpose of supporting the ability of the individuals to live or work in the setting of their choice. LTSS assist individuals with activities such as bathing, dressing, medication management, and meal preparation.

LONG-TERM SERVICES AND SUPPORTS THAT MAY BE PHASED INTO ACO CONTRACTS *(Around Year 3)*

- Inpatient chronic disease and rehabilitation hospital services (post-100 days of services)
- Outpatient chronic disease and rehabilitation hospital services (post-100 days of services)
- Nursing facility services (post-100 days of services)
- Adult foster care services
- Group adult foster care services
- Day habilitation services
- Continuous skilled nursing services (post-100 days of services)
- Personal care attendant services (including transitional living program)

³³ Attachments A and B to the CP RFI.

³⁴ Waiver application at 49.

³⁵ CP RFI question 3.

³⁶ See the September 2016 update on MassHealth delivery system reform efforts, available online at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/masshealth-delivery-system-reform-efforts-2016-sept.pdf>, p 2.

DELIVERY SYSTEM REFORM INCENTIVE PROGRAM

To support providers in transitioning to the new care delivery model, the waiver extension includes a new DSRIP. Several other states have used DSRIP as part of their broader 1115 waiver demonstrations to effectuate broad system changes, such as improving population health, promoting integrated care, and providing incentives for high-quality care.

The new Massachusetts program will provide \$1.8 billion in combined state and federal funding over the next five years to further four key objectives: supporting ACO development, supporting the development of CPs, investing in statewide infrastructure, and funding state expenses to implement and operate DSRIP. As described in further detail below, the state share of this funding is primarily financed through a \$250 million annual increase in the hospital provider assessment.

DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP)

DSRIP has been included in several states' 1115 waivers to provide supplemental payments to hospitals and other care providers. These payments are used to implement changes in the care delivery system, support infrastructure development, or provide incentives for cost-effective quality care. As of March 2015, eight states had an approved DSRIP.³⁷

Funding for DSRIP is scheduled to end at the end of the five-year waiver extension, at which time MassHealth expects the ongoing costs of the program to be sustained by the savings generated by the new care delivery models. As shown in Table 4, the annual amount of funding is expected to phase down over the course of the five-year period, beginning at \$425 million in years 1 and 2, down to \$225 million in year 5. MassHealth has flexibility to adjust these annual allocations depending on how quickly programs are implemented, but the goal is to gradually reduce payments over the five-year period to avoid a funding "cliff" for providers.

TABLE 4: DSRIP FUNDING ALLOCATIONS (\$ millions)

FUNDING STREAM	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022	TOTAL	PERCENT OF DSRIP FUNDS
ACO	\$329.2	\$289.9	\$229.4	\$152.0	\$65.1	\$1,065.6	60%
Community Partners	\$57.0	\$95.9	\$132.2	\$133.6	\$128.0	\$546.6	30%
Statewide Investments	\$24.2	\$24.6	\$23.8	\$24.8	\$17.4	\$114.8	6%
State Operations & Implementation	\$14.6	\$14.6	\$14.6	\$14.6	\$14.6	\$73.0	4%
TOTAL	\$425.0	\$425.0	\$400.0	\$325.0	\$225.0	\$1,800.0	100%

MassHealth must submit a DSRIP Protocol to CMS for approval. This document will provide additional details regarding requirements for DSRIP participants, funding distribution, and procurement of statewide investments. The target date for approval of the protocol is January 2017.

In establishing this DSRIP pool, MassHealth has made a commitment to CMS to reduce costs and utilization and improve quality. Over the five-year demonstration period, some of the DSRIP funds will be at risk, meaning that CMS will not release a portion of the funds to MassHealth if MassHealth does not meet its established goals, as measured by an accountability score. None of the funds will be at risk in the first year of the program, but in year 2, 5 percent of the funds will be at risk, and the amount will increase by 5 percent each year until it reaches 20 percent in year 5.³⁸ The accountability score will comprise three domains, as described in Table 5.

³⁷ The eight states are California, Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Texas. See National Academy for State Health Policy (2015). *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools*. M. Schoenberg et al. Available online at <https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf>.

³⁸ Extension STCs, page 70.

TABLE 5: STATEWIDE DSRIP ACCOUNTABILITY SCORE CALCULATION

CATEGORY	MEASURE	TARGET
ACO/APM Adoption	Percent of MassHealth ACO-eligible lives enrolled in ACOs or receiving services from providers paid using APMs.	TBD
Spending	Reduction in PMPM spending for ACO-eligible members, beginning year 3.	By year five, 2.5 percent reduction in PMPMs for the ACO-enrolled population.
ACO Quality and Utilization	Maintain or improve quality using a composite measure that includes measures for: <ul style="list-style-type: none"> • Prevention and wellness • Chronic disease management • Behavioral health/substance abuse • LTSS • Avoidable hospital utilization • Progress toward integration across physical health, behavioral health, LTSS, health-related social services • Member care experience 	TBD

Further details regarding the target amounts for APM adoption and ACO quality and utilization, and the weights of the three domains in the score, will be included in the DSRIP Protocol.

Supporting ACO Development

Nearly 60 percent of the DSRIP funds are earmarked to support ACOs. Funding is available to ACOs that have signed contracts to engage in one of the three MassHealth ACO models. There are three uses of the ACO support funds:

- ***ACO startup/ongoing support***, which will provide funding to new and existing ACOs to develop capacity to serve the MassHealth population. ACOs may use the funds to enhance information technology, care coordination capacity, and population health analytics. ACOs may also use the funds to support the cost of running their infrastructure.
- ***“Glide path” funding for safety net providers***, which will provide funding to ACOs that include a DSTI safety net hospital.³⁹ Under the October 2014 extension, these hospitals received funding from the DSTI, which will be eliminated under the new waiver extension.
- ***Funding for flexible services***, which will allow ACOs to address health-related social needs. MassHealth is required to submit a flexible supports protocol for CMS review and approval by May 2017.⁴⁰ This protocol will outline service definitions, eligibility requirements, payment methods, and the needs assessment process for eligible members. CPs are expected to play a key role in helping ACOs identify key areas of member needs that would benefit from flexible support services. Additional details regarding the flexible services are in Table 6.

³⁹ These hospitals include Boston Medical Center, Cambridge Health Alliance, Holyoke Medical Center, Lawrence General Hospital, Mercy Medical Center, Signature Brockton Hospital, and Steward Carney Hospital.

⁴⁰ Extension STCs, page 61.

TABLE 6: FLEXIBLE SUPPORTS USES AND LIMITATIONS⁴¹

Permissible uses of the flexible supports funding include:

- Transition supports and home- and community-based services for people transitioning from institutions to the community
- Services to maintain a safe and healthy living environment
- Physical activity and nutrition
- Support for those who have experienced violence
- Other goods and services that:
 - Address medical needs and support an individual’s care plan
 - Promote the delivery of services in community settings
 - Decrease the need for Medicaid services
 - Reduce the reliance on paid supports
 - Are directly related to the health and safety of the member in his or her home or community setting

Flexible services must meet the following criteria:

- Be health-related
- Be not an otherwise covered state plan or waiver service
- Be documented in the member’s care plan
- Be cost-effective

Flexible services may include classes, programs, and equipment that will improve health outcomes or prevent health deterioration.

The waiver approval outlines many limitations on the flexible services. Some of the key items that flexible services dollars may *not* be spent on include:

- Items with another payment source
- Services that duplicate another service the member is receiving
- Alternative medicine
- Copayments, premiums
- Ongoing rent or mortgage payments
- Utilities
- Student loan repayment
- Educational and vocational training

Funds for ACO startup/ongoing support and the glide path payments will be partially at risk, based on an “ACO DSRIP accountability score” that measures performance on ACO TCOC and on quality and utilization. The ACO startup/ongoing support will be up to 50 percent at risk by year 5, while the glide path will be up to 20 percent at risk in year 5. The ACO measures are linked to the statewide quality and utilization measures. Year 1 of the program will be based on reporting only, and ACOs will be measured on performance for years 2 through 5. MassHealth may increase the amount of an ACO’s risk if the ACO fails to meet the predetermined performance thresholds for two consecutive years. An ACO that withdraws from DSRIP will be required to return 50 percent of DSRIP funds it has received.⁴² The amount of funds at risk and the payment methods for each funding stream are described in Appendix 3.

Funding for these three components (i.e., ACO startup/ongoing support; “glide path” funding for safety net providers; and, funding for flexible services) will gradually decrease over the five years of the demonstration. At the end of the demonstration, ACOs will be expected to assume and manage these costs as part of their TCOC payments.

Supporting Community Partners

MassHealth is allocating approximately 30 percent of the DSRIP funds to support CPs. Funding will be available for two broad purposes. The first is supporting ACOs and MCOs in care coordination and management and mitigation activities for members with complex behavioral health and LTSS needs. DSRIP funds will support BH CPs in delivering the six core activities that will be required of them: comprehensive care management, care coordination,

⁴¹ Extension STCs, pages 61–62.

⁴² Extension STCs, page 68.

health promotion, transitional care, member and family support, and referral to community and social supports. For LTSS CPs, the funding will be used to provide independent assessments, counseling, and referrals to LTSS providers.

The second purpose of the DSRIP CP funding, for both BH and LTSS CPs, will be to support infrastructure and capacity building. CPs will be required to submit a plan for MassHealth approval outlining how the CP will use the funds. Funds may be used for specific types of investments, including workforce capacity, health information technology, performance management, contracting and networking, and project management.

CPs will be paid on a per-member per-month (PMPM) basis. Similar to the DSRIP ACO funding, CP funding will be partially at risk on the basis of a CP accountability score. The accountability score will include the following measures:

- Quality and member experience
- Progress toward integration across physical health, LTSS, and behavioral health
- Efficiency measures

Statewide Investments

Approximately 6 percent of the DSRIP funds (\$115 million over the five-year period) will support statewide investment initiatives that align with overall DSRIP goals. Many of the details—such as eligibility, amount of funding, and permissible uses of these funds—will be further detailed in the DSRIP protocol. The investment categories and the purpose of each are described in Table 7.

TABLE 7: STATEWIDE INVESTMENT CATEGORIES

STATEWIDE INVESTMENT	PURPOSE
Student loan repayment	Student loan repayment program for a two-year service commitment from (a) PCPs who practice at CHCs or (b) behavioral health professionals or licensed clinical social workers at CHCs, community mental health centers, or emergency service programs.
Primary care integration models and retention	Support for CHC PCPs to participate in accountable care implementation projects.
Investment in primary care residency training	Support for CHC and hospital community health residency programs.
Workforce development grant program	Support for workforce development and training under new accountable care models.
Technical assistance	Support for technical assistance for ACOs, CPs, or related organizations to operate under accountable care.
Alternative payment model preparation fund	Support for providers that are working toward APM adoption.
Enhanced diversionary behavioral health activities	Payment for new or enhanced diversionary behavioral health services to reduce the number of members boarded at emergency departments.
Improved accessibility for people with disabilities	Grants to providers to enhance accommodations for people with disabilities. The enhancements may include physical site improvements or programmatic access to accommodate physical, cognitive, or sensory disabilities.

DSRIP Implementation and Operations

The remaining DSRIP funds—approximately 4 percent, or \$73 million, over the five-year period—will support the Commonwealth’s implementation and oversight of DSRIP. These activities will include administering the grant programs, hiring needed staff and vendors, and providing general oversight.

Delivery System Reform Implementation Advisory Council

MassHealth will create a Delivery System Reform Implementation Advisory Council to advise the Executive Office of Health and Human Services (EOHHS) on the implementation of the ACO and CP programs. The council will advise EOHHS on integrating LTSS into the ACO and MCO models, examine quality and access issues, and review issues raised through the independent consumer support program. There will also be a DSRIP Clinical Advisory Committee. This committee will support the clinical performance improvement cycle of DSRIP activities and will offer expertise in health care quality measurement, quality performance initiatives, and clinical data. The committee will advise MassHealth on the selection of new measures for providers that have achieved performance goals. It will also assist MassHealth in assessing and aligning measures across systems and identifying new priority areas for clinical improvement.

The committee will be composed of nine to 15 members, including no more than three members from ACOs, hospitals, and CPs. At least 30 percent of the committee will have significant clinical expertise in performance measurement at hospitals, CHCs, primary care and other providers, and health plans. The clinical experts will include some practitioners with specific expertise in behavioral health, substance use disorder, and LTSS. The committee will also include representatives from CHCs and consumers or consumer advocates, including a representative for people with disabilities and a representative for people with complex medical conditions.

REDESIGNED SAFETY NET CARE POOL

The SNCP has been a core component of the Massachusetts waiver since July 2005. Initially, the SNCP consolidated funding from the state's federal disproportionate share hospital (DSH) allotment and supplemental payments that had been paid to MassHealth MCOs. Today, the fund is sourced from a combination of federal dollars, state contributions, and an intergovernmental fund transfer from the City of Cambridge. The Commonwealth has historically used SNCP funds to provide financial support to safety net providers, to fund certain state health programs, and to make payments to hospitals and CHCs for services provided to uninsured and low-income individuals. The state's Health Safety Net (HSN) program is funded in part by the SNCP. The two most recent waiver extensions have allocated a greater portion of the SNCP to incentive-based payments to promote delivery system transformation initiatives.⁴³

In the October 2014 waiver extension, CMS authorized only three of a possible five years of the SNCP. The extension agreement specifically noted that CMS and the Commonwealth were to "collaborate to reach agreement on a redesigned SNCP structure for [fiscal years 2018 and 2019] that ensures that the Commonwealth can sustainably support delivery of care to low-income populations and align with system-wide transformation."⁴⁴ As a result of the discussions between CMS and the Commonwealth, the new waiver extension includes a substantially redesigned SNCP, funded at nearly \$8 billion over the course of the five-year demonstration. Annual spending from the SNCP will increase approximately 8 percent over the last renewal period. Appendix 4 provides a summary of the key changes to the SNCP since SFY2012.

The Safety Net Care Pool (SNCP) is the accounting structure within the waiver where funds for uses other than direct MassHealth services to members are allocated. Among other things, SNCP funds are used for supplemental payments for safety net hospitals to make system improvements; subsidies for low-income people to purchase health insurance; and payment to hospitals and CHCs for care they provide people with no or inadequate health insurance.

⁴³ An interim evaluation of the prior demonstration, including the Delivery System Transformation Initiative (DSTI), is available online at <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/07-022-16-appendix-e-interim-evaluation.pdf>.

⁴⁴ Centers for Medicare and Medicaid Services Extension Special Terms and Conditions, MassHealth Medicaid Section 1115 Demonstration Approval Period starting October 2014, STC 48.

DSRIP, described above, is a new SNCP program accounting for \$1.8 billion of the total SNCP. The program's objective is to support the transition to the new accountable care model by providing funding to ACOs and CPs. Much of this funding is incentive based, with payments linked to provider performance on quality and cost measures.

The **Public Hospital Transformation and Incentive Initiative (PHTII)** was introduced in the October 2014 waiver extension to provide incentive-based payments to Cambridge Health Alliance (CHA), the state's only public acute hospital. In the 2014 extension, \$220 million per year was allocated to implement primary and behavioral health care initiatives and other delivery system transformation projects. Up to 30 percent of the funding was incentive based, depending on CHA's performance on quality measures. The new waiver amendment allocates an average of \$107 million annually for the five-year period, and 100 percent of the funding will be incentive based. The payments will be based on enhanced DSRIP incentives and a continuation of certain PHTII initiatives.

Provider Payments for Uncompensated Care

The SNCP has been the major source of funding to hospitals for uncompensated care provided to uninsured and Medicaid-eligible individuals. While most states use their federal DSH allotments to make direct payments to providers, since 2005 Massachusetts has used its DSH allotment as a funding source for the SNCP. The new waiver extension continues this support but creates two pools within the SNCP: a Disproportionate Share Hospital (DSH) pool and an Uncompensated Care Costs (UCC) pool.

The **Disproportionate Share Hospital (DSH)** pool will be funded exclusively by the federal DSH allotment, estimated at \$3.4 billion over the five-year demonstration period. The DSH pool will provide funding to support payments for uncompensated care provided to Medicaid and low-income uninsured individuals. Four components of the DSH pool were authorized in the prior waiver:

- HSN payments to hospitals and CHCs for services provided to low-income uninsured and underinsured individuals.
- Public service hospital payments to Boston Medical Center for services provided to HSN-eligible individuals.
- Certified public expenditures for hospitals operated by the Departments of Public Health and Mental Health for uncompensated care.⁴⁵
- Payments to Institutions for Mental Disease (IMDs)⁴⁶ for MassHealth members, excluding payments made under the new substance use disorder expenditure authority described below.

A new component of the DSH pool is Safety Net Provider Payments, which are intended to provide ongoing financial support to 14 of the state's safety net hospitals.⁴⁷ These hospitals serve a higher than average proportion of Medicaid and uninsured patients and a budget shortfall as a result of providing uncompensated care. A portion of these payments, ranging from 5 percent in year 1 to 20 percent in year 5, will be at risk. Hospitals receiving these payments will be required to meet the same performance goals as established for DSRIP.

⁴⁵ Certified public expenditures allow governmental units to certify that certain expenditures are eligible for federal financial participation under Medicaid rules. Based on the unit's certification, the state may then claim such participation.

⁴⁶ IMDs are defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services." 42 CFR 435.1010.

⁴⁷ Boston Medical Center, Holyoke Medical Center, Lawrence General Hospital, Mercy Medical Center, Signature Healthcare Brockton Hospital, Steward Carney Hospital, Baystate Medical Center, North Shore Medical Center, Southcoast Hospital Group, Tufts Medical Center, Steward Morton Hospital, Franklin Medical Center, Berkshire Medical Center, and Steward Good Samaritan Hospital.

The **Uncompensated Care Costs** pool includes payments made to providers for providing uncompensated care to uninsured individuals. The Commonwealth will only claim expenditures under the UCC pool if the allowable expenses are above the amount available through the DSH pool. Unlike expenses claimed under the DSH pool, those claimed under the UCC pool must be related to the provision of care to uninsured individuals. The UCC pool includes:

- HSN payments to hospitals and CHCs for low-income, uninsured patients; and,
- Certified public expenditures for hospitals operated by the Departments of Public Health and Mental Health for care provided to the uninsured.

The total amount of payments to a hospital from the DSH and UCC Pools may not exceed the hospital's unreimbursed costs for providing care to Medicaid-eligible and uninsured individuals.⁴⁸ MassHealth is required to collect annual cost report data from hospitals and calculate this limit to ensure compliance with this requirement.

A federal match for the state's **ConnectorCare premium subsidies** was authorized in the SNCP included in the October 2014 waiver renewal. The new 2016 extension authorizes for the first time a federal match for the cost-sharing (e.g., copayment) subsidies provided by the state. These are estimated at approximately \$860 million over the five-year period.

Discontinued SNCP Programs

Several programs previously included in the SNCP were discontinued with this extension. These include:

- **Delivery System Transformation Initiative (DSTI):** This program provided funding to certain safety net hospitals to promote delivery system changes and improve quality and access. Hospitals that had been receiving these funds will now be eligible to receive safety net provider payments. If they are part of an ACO, they will also be eligible for the transitional funding component of DSRIP dollars.
- **Infrastructure and Capacity Building Grants:** These grants were made to hospitals and CHCs that were ineligible for DSTI funds. These grants allowed recipients to invest in projects that benefited the Medicaid and uninsured populations.
- **Designated State Health Programs (DSHP) for non-ConnectorCare programs:** The DSHP program allowed the Commonwealth to claim federal matching funds for non-Medicaid programs that benefited the Medicaid and low-income uninsured populations. Examples of DSHP include Prescription Advantage and many Department of Public Health (DPH) programs. While these programs will continue, they will no longer be eligible for a federal match under the waiver. CMS had long intended the federal match for these programs to be temporary, and several successive waiver renewals included provisions to sunset the match, only to have it renewed with subsequent amendments. ConnectorCare premium and cost-sharing assistance are now the only allowable expenses eligible for a match under DSHP.

EXPANDED SUBSTANCE USE DISORDER SERVICES

Substance use disorder services are offered by the DPH's Bureau of Substance Abuse Services (BSAS) and by MassHealth. Before demonstration approval, MassHealth services were limited to outpatient counseling, methadone treatment, short-term detoxification services, and short-term residential services. BSAS has an array

⁴⁸ Critical access hospitals may receive 101 percent of their cost of providing Medicaid services (p. 55 of the MassHealth Waiver Extension). These hospitals include Athol Memorial Hospital, Fairview Hospital, and Martha's Vineyard Hospital.

of longer-term residential substance use disorder services. Though Massachusetts has a range of services already, MassHealth requested authority to provide more services in order to improve state capacity and respond to the opioid crisis.

Response to the opioid crisis is a multi-agency effort. DPH is in the process of licensing hundreds of new beds for acute and residential services.⁴⁹ Under this new waiver extension, Massachusetts increases its federal revenue for substance use disorder and expands services. A standardized substance use disorder assessment will be adopted across all providers. Longer-term residential services will now be available through MassHealth. Residential services include those geared to individuals with co-occurring conditions requiring high-intensity services. Recovery support services, which include navigators and recovery coaches, will also be available. Recovery support navigators coordinate clinical and nonclinical services, participate in discharge planning from acute treatment programs, and work with members to help them meet health management goals. Recovery coaches are individuals with lived experience with substance use disorder. Recovery coaches provide problem-solving and advocacy support to help members meet recovery goals. With the exception of recovery coach services (which are limited to MassHealth members in an MCO or ACO), all MassHealth members except those in MassHealth Limited are eligible for expanded substance use disorder services.⁵⁰

COMMONHEALTH FOR MEMBERS AGE 65 AND OVER

Prior to waiver approval, MassHealth provided CommonHealth coverage for working people with disabilities after they turn 65, if they didn't otherwise qualify for MassHealth Standard, at 100 percent state cost.⁵¹ With the waiver amendment, the state will include these members as CommonHealth adults and receive federal reimbursement. MassHealth also will continue to provide CommonHealth coverage without applying an asset test.

CHANGES TO MASSHEALTH PREMIUMS

MassHealth charges premiums to certain MassHealth members with incomes greater than 150 percent of the federal poverty level (FPL)—about \$18,000 for an individual and \$30,000 for a family of three. The premium rates vary depending on the coverage type. For instance, a member with income at 150 percent FPL who is covered under Family Assistance for Children would pay a premium of \$12 per month per child, while someone with the same income covered under the Family Assistance for HIV+ Adults program would pay \$15 per month. Certain individuals, such as pregnant women, are exempt from premium requirements.⁵² During the demonstration extension, premiums will still be required for certain members with incomes over 150 percent FPL, but in 2018 MassHealth may adjust the existing premium schedule to link the premium amount to a percent of family income. MassHealth expects that this change will reduce fluctuations that occur when a family's income or circumstances change.

STUDENT HEALTH INSURANCE PLANS

MassHealth also received approval to require MassHealth-eligible college students to enroll in Student Health Insurance Plans offered by their schools if doing so is cost-effective for MassHealth. The state will provide premium and cost-sharing assistance to students when they enroll in these plans. MassHealth will also provide

⁴⁹ MassHealth 1115 Request submitted to CMS at 67.

⁵⁰ Typically, individuals over 65 are not included in the waiver, but in this case they are included.

⁵¹ 42 CMR 519.012. These individuals have to work a certain number of hours to qualify (40 hours per month or 240 hours in the last 6 months before application or eligibility review). Id; 42 CMR 505.004.

⁵² The full premium and cost-sharing schedule is available online at <http://www.mass.gov/eohhs/docs/masshealth/membappforms/aca-1-english-mb.pdf>, p. 29.

appropriate benefit wrap coverage to ensure that the students' benefits are equivalent to MassHealth and out-of-pocket costs are no higher than if they were receiving services directly through MassHealth.

FINANCING

MassHealth is largely financed through state and federal contributions. The federal government matches state dollar contributions at a predetermined rate, so to leverage additional federal matching funds, the Commonwealth must also increase its state share contribution.⁵³ To that end, the SFY2017 budget included an increase to the state's hospital assessment. The state's acute hospitals currently pay a health care–related tax of \$160 million annually. This assessment, combined with a \$160 million surcharge paid by payers and a contribution from the General Fund, funds the state's HSN Trust Fund. The 2017 state budget increased the hospital assessment by \$250 million. MassHealth has announced that this increase is temporary and will last only for the five years of this waiver extension. The new \$250 million will be used as the state share of the new DSRIP investment. Federal matching funds on these expenditures will also enable MassHealth to provide \$250 million in supplemental payments to hospitals. MassHealth intends to distribute the supplemental payments based on each hospital's share of Medicaid charges. Because the assessment is based on private sector charges, the disbursement plan will result in a net gain for the state's safety net hospitals and a loss for hospitals that have a high private sector payer mix. In its waiver extension request, MassHealth highlighted the benefit to the state's safety net hospitals, noting that the assessment impact provides a “gradual trajectory” for these hospitals to adjust to the lower amount of funding that will be provided to them relative to FY2017 levels.⁵⁴

Budget Neutrality: As required under federal law, MassHealth must demonstrate to CMS that the 1115 Waiver will not result in higher spending than would have occurred absent the waiver. This analysis is referred to as “budget neutrality.” (See box below.) In prior years, states were permitted to carry forward estimated savings from previous years, resulting in a large amount of budget neutrality “room.” CMS recently limited this rollover. Accordingly, the budget neutrality calculation for the current extension does not include savings prior to SFY2012. Budget neutrality calculations for future waiver extensions may only carry forward savings from the most recent approval period—SFY2018–2022 in Massachusetts. Further, for this and future extensions, CMS will allow just 25 percent of the calculated savings that are related to managed care—a long-time component of the Massachusetts waiver—to apply to budget neutrality, the rationale being that savings resulting from managed care do not carry forward indefinitely.

Later in this waiver extension, the budget neutrality calculation will include LTSS spending on waiver populations for the first time; Massachusetts will have to submit a new budget neutrality analysis that includes LTSS costs at that time.

⁵³ Massachusetts has a standard Federal Medical Assistance Percentage (FMAP) of 50 percent but receives enhanced rates for certain populations such as children and childless adults enrolled in CarePlus.

⁵⁴ MassHealth 1115 Request submitted to CMS at 61.

CALCULATING BUDGET NEUTRALITY

The budget neutrality requirement for 1115 waivers requires a state to demonstrate that federal payments under a waiver program will not exceed what federal payments would have been in the state's traditional Medicaid program. The state first determines the waiver spending limit (also called the budget neutrality ceiling or cap) by projecting what it would have spent on populations who could have been covered under traditional Medicaid in the absence of the waiver. These calculations are made on a per-member per-month (PMPM) basis, with different PMPM amounts for categories of families and children, people with disabilities in or out of CommonHealth, and women in the Breast and Cervical Cancer Treatment Program. Spending for most long-term care services is not included in the budget neutrality calculation for the MassHealth waiver. To calculate its projections, the state and CMS identify a base year off of which it will build these "without waiver" spending projections. In this waiver extension, the base year is SFY2012. Using a trend rate based either on historical program costs and enrollment or on the underlying Medicaid growth rate in the President's federal budget proposal (whichever is lower), the state projects what program spending would have been without a waiver over the extension period.

The state then projects what it expects to spend on the waiver-covered populations, including any new expansions of population groups or services not normally eligible for coverage under Medicaid, with the waiver. By new principles CMS adopted in 2015, the difference between the "with waiver" and "without waiver" figures is then reduced, in Massachusetts' case to 25 percent of the variance, for the portion of savings that is attributable to managed care. These discounted projected savings must be positive to meet the budget neutrality requirement for waiver approval. If they are, the state has a budget neutrality "cushion." The state typically creates a cushion by adopting policies or implementing programs under the waiver that deliver care more cost-effectively. To be able to cover new populations or services not traditionally authorized by Title XIX, the state must create sufficient savings or a cushion to absorb the expansion costs. While the waiver includes annual amounts for each year of the extension, the budget neutrality limit is enforced on a cumulative basis over the course of the extension period. For enforcement purposes, actual spending per member is compared with the "without waiver" PMPM amounts. The state is at risk only for per capita spending, not for spending resulting from changes in enrollment, because enrollment changes affect both sides of the equation equally. If the state exceeds the budget neutrality limit, it must return the excess federal financial participation (FFP) funds to CMS. The state reports expenditures to CMS quarterly for monitoring purposes.

Any budget neutrality calculation is the result of state-specific negotiations with CMS, which can exercise broad discretion in testing and approving a state's demonstration of budget neutrality. This is primarily because of the theoretical nature of the calculation; over time, base year/trend calculations may no longer represent the true "without waiver" scenario, and CMS may, in certain cases, make corresponding adjustments. Additionally, as actual waiver expenditures for both "without waiver" and "with waiver" populations are realized, the cushion varies, and the state's projection of the cushion in future years must be updated regularly.

IMPLICATIONS

The health care delivery, service, and payment changes the waiver extension ushers in have significant implications for all individuals and institutions involved in MassHealth and, because of the program's size and influence, for the entire Massachusetts health care system. Some of the implications are clear; others, currently more opaque, will become clearer with time as program details are fleshed out and ACOs, CPs, and other new entities begin to function.

IMPLICATIONS FOR MASSHEALTH MEMBERS

ACOs offer consumers the potential for improvements in how their care is delivered. MassHealth's ACOs could greatly benefit members, particularly those with complex health care needs. For example, a member newly diagnosed with cancer may find that her ACO offers help to navigate the array of specialists who will now touch her case. A member with behavioral health issues may qualify for CP services, which may include help finding housing. Other states' Medicaid ACO models have shown promise in maintaining or improving quality of care while moderating costs.⁵⁵

As with any model that attempts to reduce health care costs, there are possible unintended consequences for access to services, access to providers, and consumer protections. Details in implementation and monitoring will be key to attaining MassHealth's goal of better coverage at lower cost. One key component of implementation will be development of clear member education materials to make sure that members are fully aware of their options and the implications of these choices.

Some members may have reasons to choose not to be in an ACO and to remain instead in the PCC Plan, receiving care from a PCP not affiliated with an ACO. These members may face additional financial pressure in the future if MassHealth exercises its authority to set higher copayments for members in the PCC Plan relative to those in ACOs and MCOs.

Access to Services

Members will be offered additional services, such as care coordination, care management, substance use disorder services and flexible support services. Some of these services will be available only to ACO members. As ACO status changes—by choice or because a member ceases to be part of an ACO-eligible group (by turning 65, for example)—so will access to certain services. MassHealth is working on education materials to help MassHealth members understand their options.

Choice of Provider

As is the case today, members' choice of providers will depend on the network of providers available through their health plan selection—be it the Partnership Plan ACO provider network, the PCC Plan provider network available to members of a Primary Care ACO, or an MCO's provider network. New federal Medicaid managed care regulations provide additional protections regarding access to services.⁵⁶ However, with the fixed enrollment period rules MassHealth introduced in the fall of 2016, members may face new barriers to accessing specific providers,

⁵⁵ Tricia McGinnis, the Commonwealth Fund. A Unicorn Realized? Promising Medicaid ACO Programs Really Exist. March 11, 2016.

⁵⁶ 42 CFR 438.

if such providers are not part of their ACO's or MCO's network.⁵⁷ Prior to implementation of the fixed enrollment period provisions, members had the option to change plans at any time, for example if they wished to seek care from a particular provider only available through a particular MCO network or the PCC Plan.

The fixed enrollment period policy, combined with the requirement that PCPs participate exclusively in only one ACO, will limit members to choosing only PCPs that are part of that ACO's network, except during the 90-day plan selection period or for other specific reasons (such as moving out of the service area, demonstrated poor quality of care, or lack of access to providers with experience in dealing with the member's health care needs).⁵⁸

Transitioning from one set of providers to another can be disruptive, particularly for members with complex needs. MassHealth has included provisions in the Partnership Plan contracts regarding continuity of care during such transitions and will likely include similar provisions in the new MCO contracts when those are released. These provisions state that Partnership Plans must have procedures for continuity of care for members who are pregnant, have complex medical conditions or autism spectrum disorder, or are undergoing certain treatments (such as dialysis, chemotherapy, and behavioral health or substance use disorder treatment) that cannot be interrupted. LTSS is not yet part of Partnership Plans' responsibility, but when it becomes so, the continuity of care issues associated with those services will be very important to the quality of life for members needing such services. The continuity of care provisions require the Partnership Plan ACOs to permit new enrollees to continue to seek care from their current providers for at least 30 days. Partnership Plans will have the discretion to lengthen this time period. The provisions also require the ACO to honor all prior authorizations for services and make accommodations for ongoing treatment and pre-existing prescriptions.

For some MassHealth members who are enrolled with a Primary Care ACO, their ACO may have a "referral circle" which could facilitate access to specialty care. In such circumstances, the normal requirements of a PCP referral for accessing specialty care will be waived.

As MassHealth implements these new changes, it will be critical that members are informed what providers are in an ACO's network and that ACOs ensure that their PCPs and other providers affiliated with the ACO network can offer care that is culturally and linguistically appropriate to its membership and offer accessible care for people with disabilities. In addition, MassHealth is also developing contract requirements and funding streams to increase language, cultural, and disability access. The advent of CPs may help members with complex behavioral health and LTSS needs better navigate and access those services.

As the ACO models are finalized and implemented, monitoring members' experiences with accessing care will be important indicators of the success of ACOs.

Consumer Protections

New design features that affect member care should have consumer safeguards. MassHealth addresses a number of consumer protection issues by spelling out member access to appeals processes, grievance processes, and a newly created consumer support program. As with all new procedures, oversight, clear communication, and accessibility of these processes will help make sure that the system is running smoothly and consumers receive the protections they need.

⁵⁷ MassHealth introduced fixed enrollment periods for MCOs in October 2016. Though this provision is not part of the 1115 waiver, it will directly affect enrollment dynamics in the MassHealth ACOs.

⁵⁸ 130 CMR 508.004(C)(3) lists reasons a member may disenroll during a fixed enrollment period.

IMPLICATIONS FOR ACCOUNTABLE CARE ORGANIZATIONS

Massachusetts already has significant experience with accountable care organizations. The state's Health Policy Commission established certification standards for ACOs in April 2016. Several Massachusetts ACOs have participated in Medicare ACO demonstrations—the Pioneer ACO demonstration, Medicare Shared Savings program, and the Next Generation ACO demonstrations. In addition, MassHealth initiated an ACO pilot in December 2016.

Safety net providers, which rely on MassHealth for a large portion of their income, will now have a strong incentive to join with other providers to participate in one or more MassHealth ACOs. In doing so, many will assume greater responsibility for their member populations than they now have, requiring a transformation in how they deliver care. (Many CHCs already take this population approach and may not require as radical a change as safety net hospitals.) ACOs will be required to provide greater care coordination and care management for their members and integrate a wider range of services, including LTSS and BH services. They will need to develop an understanding of these services and the people who use them that is deeper than most health plans typically have, including an appreciation of social models of disability and recovery. To be successful in managing the TCOC for their members, ACOs and their constituent providers will need to develop robust population-health analytic tools and care-delivery strategies to ensure that members receive timely and cost-effective care.

Most providers have already taken steps to transform their practices, but this new demonstration will require many of them to assume an even greater financial risk. Partnership Plans include health plans, so they will already have experience assuming a comparable level of risk. But for Primary Care and MCO-Administered ACOs, the level of financial risk will likely be greater than their prior risk experience, as all risk tracks require some level of downside risk.⁵⁹ Primary Care and MCO-Administered ACOs will be required to hold some level of reserve or a line of credit as a way to manage the downside risk. They must also be certified as a Risk-Bearing Provider Organization by the state Division of Insurance (DOI) or have a waiver from DOI.

IMPLICATIONS FOR PRIMARY CARE PROVIDERS AND SPECIALISTS

The accountable care models could change the relationship many PCPs have with MassHealth and its members. A PCP will have an exclusive relationship with a single ACO and therefore be available to MassHealth members only through that ACO. A PCP may also choose, for a variety of reasons, not to affiliate with any ACO and participate as a PCP in the PCC Plan and/or as a PCP available through one or more MCOs. If a member who is in that provider's panel chooses to stay there, the member would enroll with the PCC Plan or MCO with which that PCP participates. Alternatively, if the member is attracted to the features and—a possibility in the future—financial advantage of being in an ACO, the member could choose a new, ACO-affiliated PCP.

More than ever, PCPs will be at the center of a person-centered constellation of medical and other service providers responsible for referrals and coordination. Many PCPs likely will have payment incentives tied to their performance. This could provide additional revenue streams for primary care providers that achieve strong performance, but could also place additional pressure on a group of professionals about whom there already is a capacity concern. Some DSRIP funds directed to ACOs and for statewide investment are intended to address PCP workforce, care coordination, and related issues.

⁵⁹ As a contrast, of the 433 ACOs in Medicare's Shared Savings Program nationally, only 22 (5 percent) are in a risk arrangement that includes downside risk. Centers for Medicare and Medicaid Services, "Fast Facts: All Medicare Shared Savings Program (Shared Savings Program) ACOs." April 2016. Available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>, accessed November 30, 2016.

It is likely that the manner in which some physicians are compensated will change under the ACO model. In today's system, physicians may be paid fee-for-service rates or through an alternative method, such as capitated (per-member per-month) arrangements. The method will depend on whether the physician is paid by MassHealth directly or by an MCO and whether she is in a large or small practice, among other factors.

Although MassHealth will not dictate how ACOs compensate physicians, ACOs may modify existing compensation arrangements to provide greater incentives to physicians to improve the quality and efficiency of care they deliver. This may include more capitated arrangements or bonuses for meeting quality targets. Some ACOs may elect to share savings or losses with physicians. ACOs are most likely to provide greater incentives to PCPs, as they will be the lead providers in managing members' care and directing them to specialists and ancillary services. ACOs may also modify compensation for specialists to provide similar incentives.

An additional area of concern for providers interacting with the ACO model is uncertainty around the applicability of federal laws regarding fraud and abuse, anti-kickback rules, and physician self-referral. Some ACO practices meant to provide incentives to providers, such as sharing savings with participating providers, may run afoul of these laws. Similarly, combining incentives and expected referral practices could potentially be an issue. When it implemented the Medicare Shared Savings Program, CMS granted waivers to Medicare ACOs from several of these requirements. Providers will likely ask for guidance about the applicability of these rules to MassHealth ACOs.

IMPLICATIONS FOR COMMUNITY PARTNERS

The concept of CPs is at once both familiar and novel. On the one hand, many organizations that deliver CP-like services already are established as MassHealth providers and have formal relationships with MassHealth and the MCOs. Indeed, one existing class of providers—CSAs—will be eligible for DSRIP infrastructure funds. On the other hand, organizations will face a new set of certification criteria to become CPs and will need to forge relationships with a new type of entity, the ACO. Many potential CPs will face the challenge of building adequate infrastructure and capacity to meet the certification requirements that MassHealth will establish. There are DSRIP funds to support this and, if successful, such capacity building could yield a stronger and better integrated delivery system. LTSS CPs in particular will find themselves in a new environment, as will their partners, medical care-based ACOs. Both CPs and ACOs will seek to craft a mutually beneficial relationship that responds to DSRIP incentives. There is financial risk within the incentives as well, and this puts a premium on good management, measurement, and quality service.

IMPLICATIONS FOR COMMUNITY-BASED SOCIAL SERVICE PROVIDERS

In addition to the organizations that will become CPs, a legion of other community organizations provide the flexible services that can help ACOs manage their TCOC by addressing SDH. ACOs and CPs might refer members to supportive housing providers or local nonprofit recreation organizations, for example. There is no requirement for formal relationships with these groups and, as with CPs, many health care providers are somewhat unfamiliar with the value of their services and how to access them. The ACO and TCOC concepts offer great promise for these organizations if they are successfully incorporated into the model. This will require an effort by the ACOs and CPs to strengthen referral relationships with groups that will help them succeed.

IMPLICATIONS FOR MANAGED CARE ENTITIES

Managed care entities (MCE)—including the MassHealth MCOs and the behavioral health vendor, MBHP—currently perform care management, coordination, and referral functions similar to those for which ACOs and CPs

will be responsible. These entities will continue to be part of the new system design (Primary Care ACOs will be required contractually to coordinate with MassHealth's behavioral health vendor) but will also be in a variety of new relationships with ACOs, which may alter MCEs' scope of responsibilities. During the development of MassHealth's waiver proposal, MCOs expressed support but also a number of concerns. For example, the MCOs urged MassHealth to avoid duplicating administrative and systems capacity by asking ACOs to undertake functions that MCOs already perform. In comments on MassHealth's draft waiver proposal, MCOs invoked a history of assisting providers in moving toward new payment models with support for budgeting, data analysis, medical management, and other services. MCOs also raised concerns about network adequacy because of the required exclusivity of PCPs, which will limit the primary care capacity of MCOs, particularly in certain geographic regions of the state.⁶⁰ As MassHealth revises its contracts with MCOs in the coming year and MCOs forge formal relationships with new ACOs, MCOs' role in the reformed system will become clearer.

IMPLICATIONS FOR MASSHEALTH AND MASSACHUSETTS

Massachusetts is making a bold move away from fragmented fee-for-service care toward a redesigned system. The payoff could be great for MassHealth members, providers and the Commonwealth's budget. The plan is not without risks, however. Most directly, there are financial risks if MassHealth does not meet the performance targets in its DSRIP agreement. Meeting those targets will require increased administrative support for implementation of the design and oversight of ACOs and CPs, including important information functions such as collection and reporting of the measure sets. Communication with members will be critical, particular in the first year or two following launch of the ACOs, as members learn the new system, how it differs from what they knew before, and what it means for how and from whom they receive care. It is a daunting but not insurmountable management challenge for MassHealth leaders.

CONCLUSION

The MassHealth 1115 waiver continues to be a vital component of Massachusetts' approach to coverage for and delivery of health care to its residents. More than one of every four people in the state relies on MassHealth for access to health care; without the robust coverage the waiver makes possible, there would be many more uninsured people in Massachusetts than there are today. The new waiver extension addresses challenges that MassHealth faces—escalating costs and fragmented, uncoordinated care—while preserving the coverage and benefit innovations and support for safety net providers achieved over the waiver's first two decades. The direction MassHealth leaders have chosen, after a long, comprehensive planning process, is ambitious and in tune with changes happening elsewhere in the health care system, in Massachusetts and nationwide. As the plan takes effect—as ACO contracts are signed, CPs are engaged, and DSRIP dollars begin to flow—a new MassHealth reality will start to take shape for many of its members. How those members fare, in terms of access and health outcomes, will in no small part determine the success of the demonstration and the future direction of MassHealth.

⁶⁰ Massachusetts Association of Health Plans, response to draft Section 1115 Demonstration Waiver. Letter to Secretary Sudders and Assistant Secretary Tsai, July 17, 2016.

APPENDIX 1: SHARED SAVINGS EXAMPLE FOR A PRIMARY CARE ACO

The amount of a Primary Care or MCO-Contracted ACO's shared savings or shared losses is a function of the difference between two figures. The **TCOC benchmark**—essentially a calculation of an expected total cost of care (TCOC)—is a blending of the ACO's historic TCOC and the market-rate TCOC, which is the average anticipated cost of the ACO's members in the performance year, risk-adjusted. The **TCOC performance** is the ACO's actual total cost of care during the performance year.

A TCOC benchmark that exceeds the TCOC performance results in shared savings; the reverse results in shared losses. For a Primary Care ACO, shared savings and losses payments will be calculated according to the tables below. Saving and losses less than 2 percent of the TCOC benchmark will result in no payment, and savings and losses are capped at 10 percent of the TCOC benchmark for purposes of calculating shared savings and losses payments. ACOs will choose one of two risk tracks.

RISK TRACK 1: SHARED ACCOUNTABILITY

PERFORMANCE YEAR	SHARED SAVINGS				SHARED LOSSES			
	TCOC BENCHMARK EXCEEDS TCOC PERFORMANCE BY:				TCOC BENCHMARK LESS THAN TCOC PERFORMANCE BY:			
	0 – <2%	2 – 3%	>3 – 10%	>10%	0 – <2%	2 – 3%	>3 – 10%	>10%
1	0%	50% <i>of savings</i>	25% <i>of add'l savings >3%</i>	0% <i>of savings >10%</i>	0%	40% <i>of losses</i>	20% <i>of add'l losses >3%</i>	0% <i>of losses >10%</i>
2	0%	60%	30%	0%	0%	40%	20%	0%
3	0%	70%	35%	0%	0%	40%	20%	0%
4	0%	70%	35%	0%	0%	70%	35%	0%
5	0%	70%	35%	0%	0%	70%	35%	0%

RISK TRACK 2: FULL ACCOUNTABILITY

PERFORMANCE YEAR	SHARED SAVINGS				SHARED LOSSES			
	TCOC BENCHMARK EXCEEDS TCOC PERFORMANCE BY:				TCOC BENCHMARK LESS THAN TCOC PERFORMANCE BY:			
	0 – <2%	2 – 3%	>3 – 10%	>10%	0 – <2%	2 – 3%	>3 – 10%	>10%
1	0%	70% <i>of savings</i>	35% <i>of add'l savings >3%</i>	0% <i>of savings >10%</i>	0%	50% <i>of losses</i>	25% <i>of add'l losses >3%</i>	0% <i>of losses >10%</i>
2	0%	85%	42.5%	0%	0%	50%	25%	0%
3	0%	100%	50%	0%	0%	50%	25%	0%
4	0%	100%	50%	0%	0%	100%	50%	0%
5	0%	100%	50%	0%	0%	100%	50%	0%

The amounts of shared savings and losses will be adjusted by the ACO's quality score (see Appendix 2), a factor between 0 and 1, as follows:

Savings: Apply the quality score to all calculated shared savings.

Losses: Multiply 20 percent of shared losses by 1 minus the quality score; add to that 80 percent of the shared losses.

AN EXAMPLE

Acme Health is a Primary Care ACO in risk track 1 (shared accountability). In year 1 of its contract with MassHealth, Acme's TCOC benchmark is \$20 million and its TCOC performance is \$19.2 million, resulting in savings of **\$800,000**, or 4 percent of the benchmark. Acme's shared savings are

- 50 percent of the first 3 percent of savings relative to its TCOC benchmark ($50\% \times \$600,000 = \$300,000$), plus
- 25 percent of the savings over 3 percent ($25\% \times \$200,000 = \$50,000$), bringing the total to **\$350,000**.

Acme's quality score in year 1 is 0.85. Applying the quality score to the shared savings ($0.85 \times \$350,000$) yields a final shared savings payment to Acme of **\$297,500**.

MCO-Contracted ACOs will have a similar payment system for shared savings and losses, governed by the MCO's contracts with MassHealth and with its providers. Shared savings and losses for equivalent levels of savings and loss will be lower for the MCO-Contracted ACOs.

APPENDIX 2: ACO QUALITY SCORE

An ACO's performance on quality and certain utilization measures affects the ACO's payment, both through DSRIP and non-DSRIP payments. EOHHS will measure each ACO's quality performance as follows.

ACO performance will be measured across seven domains. For the first performance year, ACOs will be scored based on whether they report on these domains. For subsequent performance years, ACOs will be scored based on their performance on these domains. The domains are:

1. Prevention and wellness
2. Chronic disease management
3. Behavioral health/substance use disorder
4. Long-term services and supports (LTSS)
5. Avoidable utilization
6. Progress towards integration across physical health, behavioral health, LTSS, and health-related social services
7. Member care experience

Each domain has between one and 10 quality measures or utilization reduction targets. For quality measures, ACOs will be scored on whether they meet benchmarks for each measure. ACOs can receive additional points if they improve on quality measures from year to year. For utilization reduction targets, ACOs will be scored on whether they reach targets (e.g., for potentially preventable admissions). ACOs showing high rates of avoidable utilization at the beginning of the program will face steeper reduction targets.

Performance on each domain will be calculated and then combined. Some domains, such as progress toward integration, carry more weight than other domains:

DOMAIN	# OF MEASURES (PAY-FOR-PERFORMANCE [P4P]/ TRANSPARENCY)	# OF CLINICAL P4P MEASURES	PERFORMANCE YEAR 1*	PERFORMANCE YEARS 2-5
Prevention & Wellness	10 (10/0)	4	20%	10%
Chronic Disease Management	5 (5/0)	2	20%	15%
Behavioral Health / Substance Use Disorder	9 (9/0)	3	25%	15%
Long-Term Services and Supports	1 (1/0)	1	10%	5%
Avoidable Utilization	3 (2/1)	0	0%	20%
Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	10 (5/5)	4	25%	20%
Member Care Experience	TBD	0	0%	15%
TOTAL	38+ (32+/6+)	14	100%	100%

*Reporting only, focused on Clinical Quality Measures.

EOHHS will use the resulting quality score to modify the capitation rate, shared savings and losses, and DSRIP ACO payments.

APPENDIX 3: DSRIP RISK AND PAYMENT METHODS

	AMOUNT AT RISK	PAYMENT METHOD
ACO startup/ongoing	Year 0: 0% Year 1: 5% Year 2: 15% Year 3: 30% Year 4: 40% Year 5: 50%	<p>Per-enrollee amount multiplied by number of enrollees.</p> <p>Per-enrollee amount is determined using a base, with a sliding scale increase determined by the ACO's payer mix, with larger increases given to ACOs with higher percentages of Medicaid and uninsured charges.</p> <p>The scale includes 5 categories:</p> <p>Category 5: Base rate + 40% Category 4: Base rate + 30% Category 3: Base rate + 20% Category 2: Base rate + 10% Category 1: Base rate</p> <p>If the ACO is a Primary Care ACO in risk track 1 (shared accountability), the base rate is increased by another 30%. If it is in risk track 2 (full accountability), the base rate is increased by another 40%.</p> <p>If the ACO is in the MCO-Administered model, the base rate is increased by another 10% for risk track 2 (moderate accountability), and by 30% for risk track 3 (increased accountability).</p>
Glide Path	Year 0: 0% Year 1: 5% Year 2: 5% Year 3: 10% Year 4: 15% Year 5: 20%	Based on a schedule determined by MassHealth for each DSTI hospital.
Flexible Supports	Not at risk	Fee-for-service basis, up to maximum of the ACO's allotment.

APPENDIX 4: SAFETY NET CARE POOL FUNDING BY CATEGORY

(\$ Millions)

PAYMENT TYPE	SFY2012	SFY2013	SFY2014	SFY2015	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
Delivery System Reform Incentive Program (DSRIP)	–	–	–	–	–	–	\$425.0	\$425.0	\$400.0	\$325.0	\$225.0
Public Hospital Transformation & Incentive Initiative	–	–	–	\$220.0	\$220.0	\$220.0	\$309.0	\$243.0	\$100.0	\$100.0	\$100.0
Delivery System Transformation Initiatives	\$209.3	\$209.3	\$209.3	\$230.3	\$230.3	\$230.3	–	–	–	–	–
Public Service Hospital	\$332.0	\$332.0	\$332.0	\$140.0	\$140.0	\$140.0	\$20.0	\$20.0	\$20.0	\$20.0	\$20.0
Health Safety Net (HSN)*	\$147.4	\$159.4	\$156.3	\$156.3	\$156.3	\$156.3	\$287.0	\$297.0	\$298.0	\$298.0	\$300.0
Institutions of Mental Disease	\$20.0	\$22.0	\$24.0	\$24.0	\$24.0	\$24.0	\$32.0	\$32.0	\$32.0	\$32.0	\$32.0
Department of Public Health Hospitals	\$40.0	\$43.0	\$45.0	\$45.0	\$45.0	\$45.0	\$116.0	\$67.0	\$67.0	\$67.0	\$67.0
Department of Mental Health Hospitals	\$70.0	\$74.0	\$77.0	\$77.0	\$77.0	\$77.0	\$252.0	\$182.0	\$182.0	\$182.0	\$182.0
Safety Net Provider Payments	–	–	–	–	–	–	\$180.0	\$177.0	\$176.0	\$176.0	\$174.0
Commonwealth Care	\$364.9	\$387.7	\$255.3	–	–	–	–	–	–	–	–
Designated State Health Programs (DSHP): Other State Programs	\$360.0	\$310.0	\$130.0	\$385.0	\$257.0	\$129.0	–	–	–	–	–
DSHP: ConnectorCare Subsidies	–	–	–	\$41.8	\$75.2	\$165.7	\$250.0	\$250.0	\$250.0	\$250.0	\$250.0
DSHP: Commonwealth Care Transitional	–	–	–	\$175.4	\$0.0	\$0.0	–	–	–	–	–
DSHP: MassHealth Temporary Coverage	–	–	–	\$560.2	\$0.0	\$0.0	–	–	–	–	–
Infrastructure and Capacity Building Grants	\$30.0	\$30.0	\$30.0	\$30.0	\$30.0	\$30.0	–	–	–	–	–
TOTAL	\$1,573.6	\$1,567.4	\$1,258.9	\$2,085.0	\$1,254.8	\$1,217.3	\$1,871.0	\$1,693.0	\$1,525.0	\$1,450.0	\$1,350.0

* Funds for the HSN are made under waiver authorities and state plan authorities. Therefore, the amounts shown here are not the full amounts of funding for the HSN.

The increase beginning in SFY2018 is due in part to the inclusion of HSN payments to community health centers (CHCs) in this category. Previously, the CHC HSN payments were claimed as DSHP.



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