



January 20, 2015

Robin Callahan
Acting State Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place
11th Floor
Boston, MA 02108

Dear Ms. Callahan:

The Centers for Medicare and Medicaid Services (CMS) is issuing technical corrections to Massachusetts' section 1115 demonstration project, entitled MassHealth (Project Number 11-W-00030/1) under authority of section 1115(a) of the Social Security Act (the Act), to ensure that the Special Terms and Conditions (STCs) reflect how the state is currently operating its demonstration.

Specifically, we are revising the Waiver List, Expenditure Authorities and STCs approved on October 30, 2014 to reflect the following:

- Included references to the Alternative Benefit Plan (ABP) state plan amendment approved on November 13, 2014;
- Updated the STC cross references in Attachments F and H;
- Changed the title of the Commonwealth Care Transition designated state health program to Commonwealth Care Orderly Closeout to be consistent throughout the STCs; and
- Added four new designated state health programs to Chart C of Attachment E.

These approvals are conditioned upon written acceptance from the state that it agrees with the amendments, waiver list, expenditure authorities, and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

Your project officer is Ms. Elizabeth Matthews, who may be reached at (410) 786-5433 and through e-mail at elizabeth.matthews@cms.hhs.gov. Ms. Matthews is available to answer any questions concerning your section 1115 demonstration. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Matthews at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

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Official communications regarding program matters should be sent simultaneously to Ms. Matthews and to Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
JFK Federal Building
Room 2325
Boston, MA 02203
Telephone: (617) 565-1226
E-mail: Richard.McGreal@cms.hhs.gov

If you have questions regarding this approval, please contact Eliot Fishman Director of the Children and Adults Health Programs Group in the Center for Medicaid & CHIP Services at (410) 786-5647.

Congratulations on the approval of this amendment to your section 1115 demonstration.

Sincerely,

/s/

Manning Pellanda
Director
Division of State Waivers and Demonstrations

Enclosures

cc: Eliot Fishman, CMCS
Richard McGreal, Associate Regional Administrator, Region I
Elizabeth Matthews, CMCS
Julie McCarthy, Region I

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

AWARDEE: Massachusetts Executive Office of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Massachusetts for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension (date of the approval letter through June 30, 2019), unless otherwise specified, be regarded as expenditures under the State's title XIX plan. All previously approved expenditure authorities for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the Commonwealth of Massachusetts (State/Commonwealth) to operate its MassHealth section 1115 Medicaid demonstration.

I. Demonstration Population Expenditures

1. **CommonHealth Adults.** Expenditures for health care-related costs for adults aged 19 through 64 who are totally and permanently disabled and not eligible for comprehensive coverage under the Massachusetts state plan, but who are:
 1. Employed; or
 2. Not employed and meet a one-time only deductible.
2. **CommonHealth Children.** Expenditures for health care-related costs for children from birth through age 18 who are totally and permanently disabled with incomes greater than 150 percent of the Federal poverty level (FPL) and who are not eligible for comprehensive coverage under the Massachusetts state plan .
3. **Family Assistance [e-Family Assistance and e-HIV/FA].** Expenditures for health care-related costs for the following individuals:
 - a. Individuals who are HIV-positive, if they are age 64 or younger, are not institutionalized, with incomes above 133 through 200 percent of the FPL and are not otherwise eligible under the Massachusetts Medicaid state plan. These expenditures include the 90-day period between the time an individual submits an application and the time that the individual provides to the Commonwealth proof of his or her HIV-positive health status.

- b. Non-disabled children with incomes above 150 through 300 percent of the FPL who are not otherwise eligible under the Massachusetts Medicaid state plan due to family income.
4. **Breast and Cervical Cancer Treatment Program [BCCTP].** Expenditures for health care-related costs for uninsured individuals under the age of 65 with breast or cervical cancer, who are not otherwise eligible under the Massachusetts state plan and have income above 133 percent but no higher than 250 percent of the FPL.
5. **MassHealth Small Business Employee Premium Assistance.** Expenditure authority to make premium assistance payments for certain individuals whose MAGI income is between 133 and 300 percent of the FPL, who work for employers with 50 or fewer employees who have access to qualifying Employer Sponsored Insurance (ESI), and who are ineligible for other subsidized coverage through MassHealth or the Health Connector.
6. **TANF and EAEDC Recipients.** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not an income determination.
7. **End of Month Coverage.** End of Month Coverage for Members Determined Eligible for Subsidized Qualified Health Plan (QHP) Coverage through the Massachusetts Health Connector But Not Enrolled in a QHP. Expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP, during the period specified in STC 28.
8. **Provisional Coverage Beneficiaries.** Expenditures for MassHealth Coverage for individuals who self-attest to any eligibility factor, except disability, immigration and citizenship as specified in STC 24.
9. **Presumptively Eligible Beneficiaries.** Expenditures for individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration by qualified hospitals that elect to do so.

II. Service-Related Expenditures

1. **Premium Assistance.** Expenditures for premium assistance payments to enable individuals enrolled in CommonHealth (Adults and Children) and Family Assistance to enroll in private health insurance to the extent the Commonwealth determines that insurance to be cost effective.
2. **Pediatric Asthma Pilot Program.** Expenditures related to a pilot program, as outlined in STC 39, focused on pediatric asthma. The authority for this pilot program to receive FFP is subject to CMS approval of the protocols and amendments to such protocols as

outlined in STC 39(g) and (h).

3. **Intensive Early Intervention Services for Children with Autism Spectrum Disorder.** Expenditures related to evidence-based intensive early intervention and other services to MassHealth-eligible children, ages 0 to three years with a confirmed diagnosis of an autism spectrum disorder (ASD) who have an Individual Family Services Plan (IFSP) that identifies medically necessary Applied Behavioral Analysis-based (ABA) services, and who are not otherwise enrolled through the State's currently approved section 1915(c) home and community-based services (HCBS) waiver, entitled "Children's Autism Spectrum Disorder Waiver," CMS base control number 40207, and because the child has not been determined to meet institutional level of care (LOC) requirements. The authority for this program to receive FFP is not effective until CMS approval of the protocol as outlined in STC 40(h).
4. **Diversions Behavioral Health Services.** Expenditures for benefits specified in Table C of Section V, STC 38 to the extent not available under the Medicaid state plan.
5. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** Expenditures to provide full MassHealth Standard plan benefits to presumptively eligible pregnant women (including Hospital Presumptive Eligibility) with incomes at or below 200 percent of the FPL.
6. **Medicare Cost Sharing Assistance.** Expenditures for monthly Medicare Part A and Part B premiums and for deductibles and coinsurance under Part A and Part B for MassHealth members with incomes at or below the 133 percent of the FPL, who are also eligible for Medicare (without applying an asset test).

Expenditures to cover the costs of monthly Medicare Part B premiums for CommonHealth members who are also eligible for Medicare with gross income between 133 and 135 percent FPL (without applying an asset test).

- III. **Medicaid Eligibility Quality Control.** Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.
- IV. **Safety Net Care Pool (SNCP).** Expenditures for the following categories of expenditures, subject to overall SNCP limits and category-specific limits set forth in the STCs.

1. **Designated State Health Programs (DSHP).** Expenditures for designated programs that provide health services that are otherwise state-funded, for health services with dates of service as specified below and in Attachment E of the STCs.

a. Commonwealth Care Orderly Closeout - Effective January 1, 2014

through February 28, 2015, expenditure for costs incurred by a state-funded program for an orderly closeout of the Commonwealth Care premium assistance program, as described in Attachment E of the Special Terms and Conditions (STCs).

b. Temporary Coverage - Effective January 1, 2014 through February 28, 2015, expenditures for costs incurred by a state-funded program to ensure temporary Fee-For-Service State operated coverage for individuals who are not able to receive a full eligibility determination for MassHealth or Marketplace coverage.

c. Other State-Funded Programs – Effective as of the date of the approval letter through June 30, 2017, expenditures for designated programs that provide or support the provision of health services and that are otherwise state-funded, as specified in Attachment E of the STCs.

d. Health Connector Subsidies. Effective January 1, 2014 through June 30, 2019, the state may claim as allowable expenditures under the demonstration, the payments made through its state-funded program to provide subsidies for individuals with incomes above 133 percent of the FPL through 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income, as determined by the state Marketplace, is above 133 percent of the FPL through 300 percent of the FPL.

2. **Providers**. As described in Attachment E, effective beginning July 1, 2014 and limited to the extent permitted under the SNCP limits under STC 51, expenditures for payments to providers, including: acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, Medicaid managed care, and low-income uninsured individuals, and expenditures for payments for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).
3. **Infrastructure and Capacity-building**. Expenditures limited to five percent of the aggregate SNCP cap over the period from the date of the approval letter through June 30, 2017, for capacity-building and infrastructure for the improvement or continuation of health care services that benefit the uninsured, underinsured, MassHealth, demonstration, and SNCP populations. Infrastructure and capacity-building funding may also support the improvement of health care services that benefit the demonstration populations as outlined in STCs 39 and 42(c). Activities funded under this expenditure authority are not eligible for Delivery System Transformation Initiative (DSTI) incentive payments.

4. **Delivery System Transformation Initiatives.** Expenditures pursuant to STCs 50 (d) and 52 for incentive payments to providers for the development and implementation of a program that supports hospital's efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve and that will transform the current payment and delivery system models.
5. **Public Hospital Transformation and Incentive Initiatives.** The Commonwealth may claim as allowable expenditures under the demonstration payments that support Cambridge Health Alliance's transformative work through its Public Hospital Transformation and Incentive Initiatives program. The Public Hospital Incentive Initiatives must have a protocol that is approved by CMS.

V. **Streamlined Redeterminations for Adult Populations.** Expenditures for parents, caretaker relatives, and childless adults who would not be eligible under either the state plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.

Streamlined Redeterminations for Children's Population. Expenditures for children who would not be eligible under the Title XIX state plan, Title XXI state child health plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.

All requirements of the Medicaid program expressed in law, regulation, and policy statements that are explicitly waived under the Waiver List herein shall similarly not apply to any other expenditures made by the state pursuant to its Expenditure Authority hereunder. In addition, none of the Medicaid program requirements as listed and described below shall apply to such other expenditures. All other requirements of the Medicaid program expressed in law, regulation, and policy statements shall apply to such other expenditures.

The Following Title XIX Requirements Do Not Apply to These Expenditure Authorities.

1. **Cost Sharing**

Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A

To enable Massachusetts to impose premiums and cost-sharing in excess of statutory limits on individuals enrolled in the CommonHealth and Breast and Cervical Cancer Treatment programs.

2. **Out-of-State Services**

Section 1902(a)(16)

To exempt the state from making payments for otherwise covered services rendered to individuals enrolled in these demonstration programs when such benefits are rendered out-of-state.

In Addition to the Above, the Following Title XIX Requirements Do Not Apply to Expenditures for Family Assistance Coverage.

3. **Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)** **Section 1902(a)(43)**

To exempt Massachusetts from furnishing or arranging for EPSDT services for individuals enrolled in the Family Assistance demonstration programs.

4. **Assurance of Transportation** **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To enable Massachusetts to provide benefit packages to individuals enrolled in the Family Assistance demonstration programs that do not include transportation.

5. **Reasonable Promptness** **Section 1902(a)(8)**

To enable Massachusetts to cap enrollment and maintain waiting lists for the Family Assistance demonstration programs.

6. **Mandatory Services** **Section 1902(a)(10)(A) insofar as it incorporates Section 1905(a)**

To exempt the state from providing all mandatory services to individuals enrolled in the Family Assistance demonstration programs.

The Following Title XIX Requirements Do Not Apply to Expenditures for Medicare Cost Sharing Assistance:

7. **Resource Limits** **Section 1902(a)(10)(E)**

To enable Massachusetts to disregard assets in determining eligibility for Medicare cost sharing assistance.

No Title XIX Requirements are Applicable to Expenditures for the Safety Net Care Pool.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

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

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning on the date of the approval letter, through June 30, 2019, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs). All previously approved waivers for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable the Commonwealth of Massachusetts (State/Commonwealth) to carry out the MassHealth Medicaid section 1115 demonstration.

1. Statewide Operation Section 1902(a)(1)

To enable Massachusetts to provide managed care plans or certain types of managed care plans, only in certain geographical areas of the Commonwealth.

2. Comparability/Amount, Duration, and Scope Section 1902(a)(10)(B)

To enable the Commonwealth to provide benefits that vary from those specified in the State plan, as specified in Table B of STC 37, and which may not be available to any categorically needy individuals under the Medicaid state plan, or to any individuals in a statutory eligibility group.

**3. Eligibility Procedures and Standards Section 1902(a)(10)(A),
Section 1902(a)(10)(C)(i)-(iii), and
Section 1902(a)(17)**

To enable Massachusetts to use streamlined eligibility procedures including simplified eligibility redeterminations for certain individuals who attest to no change in circumstances and streamlined redeterminations for children, parents, caretaker relatives, and childless adults.

4. **Annual Redeterminations** **Section 1902(a)(17)**

To the extent necessary to enable the Commonwealth not to perform required redeterminations of eligibility between October - December 2013 and January - December 2014.

5. **Disproportionate Share Hospital (DSH) Requirements** **Section 1902(a)(13) insofar as it incorporates Section 1923**

To exempt Massachusetts from making DSH payments to hospitals which qualify as a Disproportionate Share Hospital in any fiscal year in which Massachusetts is authorized to make provider payments from the Safety Net Care Pool (the amount of any DSH payments must be prorated if necessary so that DSH payments will not exceed the percentage of the DSH allotment corresponding to the percentage of the federal fiscal year for which payment of DSH payments is required).

6. **Financial Responsibility/Deeming** **Section 1902(a)(17)**

To enable Massachusetts use family income and resources to determine an applicant's eligibility even if that income and resources are not actually made available to the applicant, and to enable Massachusetts to deem income from any member of the family unit (including any Medicaid-eligible member) for purposes of determining income.

7. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable Massachusetts to restrict freedom of choice of provider for individuals in the Demonstration, as outlined in Table D, STC 46, including to require managed care enrollment for certain populations exempt from mandatory managed care under section 1932(a)(2), limiting primary care clinician plan (PCC) plan enrollees to a single Prepaid Insurance Health Plan (PIHP) for behavioral health services, limiting enrollees who are clients of the Departments of Children and Families and Children and Youth Services to a single PIHP for behavioral health services, unless such enrollees chose a managed care plan, requiring children with third party insurance to enroll into a single PIHP for behavioral health services; in addition to limiting the number of providers within any provider type as needed to support improved care integration for MassHealth enrollees, and limiting the number of providers who provide Anti-Hemophilia Factor drugs.

8. **Direct Provider Reimbursement** **Section 1902(a)(32)**

To enable Massachusetts to make premium assistance payments directly to individuals who are low-income employees, self-employed, or unemployed and eligible for continuation of coverage under federal law, in order to help those individuals access qualified employer-sponsored insurance (where available) or to purchase health insurance on their own, instead of to insurers or employers providing the health insurance coverage.

9. **Retroactive Eligibility**

Section 1902(a)(34)

To enable the Commonwealth not to provide retroactive eligibility for up to 3 months prior to the date that the application for assistance is made and instead provide retroactive eligibility as outlined in Table D, STC 46.

10. **Extended Eligibility**

Section 1902(a)(52)

To enable Massachusetts to not require families receiving Transitional Medical Assistance to report the information required by section 1925(b)(2)(B) absent a significant change in circumstances, and to not consider enrollment in a demonstration-only eligibility category or CHIP (title XXI) eligibility category in determining eligibility for Transitional Medical Assistance.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts MassHealth section 1115(a) Medicaid demonstration (hereinafter “Demonstration”). The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (which is the single state agency that oversees the MassHealth program), (State/Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the Commonwealth’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the State’s expenditures relating to dates of service during this demonstration extension, unless otherwise specified. The demonstration is set to expire on June 30, 2019.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Demonstration Programs and Benefits
- VI. Delivery System
- VII. Cost Sharing
- VIII. The Safety Net Care Pool
- IX. General Reporting Requirements
- X. General Financial Requirements Under Title XIX
- XI. Monitoring Budget Neutrality for the Demonstration
- XII. Evaluation of the Demonstration
- XIII. Schedule of Deliverables for the Demonstration Extension Period
- Attachment A. Overview of Children’s Eligibility in MassHealth
- Attachment B. Cost Sharing

Attachment C.	Quarterly Operational Report Content and Format
Attachment D.	MassHealth Historical Per Member/Per Month Limits
Attachment E.	Safety Net Care Pool Payments
Attachment F.	Pediatric Asthma Pilot Program Protocols
Attachment G.	Reserved for Autism Payment Protocol
Attachment H.	Safety Net Care Pool Uncompensated Care Cost Protocol
Attachment I.	Hospitals Eligible for DSTI
Attachment J.	Reserved for Master DSTI Plan and Payment and Funding Protocol
Attachment K.	Reserved for Cambridge Health Alliance Public Hospital Transformation and Incentive Initiatives Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

The MassHealth demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types and benefit levels. The demonstration was initially implemented in July 1997, and expanded Medicaid income eligibility categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility was also expanded to certain non-categorically eligible populations, including unemployed adults and non-disabled persons living with Human Immunodeficiency Virus (HIV). Finally, the demonstration also authorized the Insurance Partnership program, which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings. However, the Commonwealth's preferred mechanism for achieving coverage has consistently been employer-sponsored insurance, whenever available and cost-effective.

The implementation of mandatory managed care enrollment under MassHealth changed the way health care was delivered resulting in a new focus on primary care, rather than institutional care. In order to aid this transition to managed care, the demonstration authorized financial support in the form of supplemental payments for two managed care organizations (MCOs) operated by safety net hospital providers in the Commonwealth to ensure continued access to care for Medicaid enrollees. These payments ended in 2006.

In the 2005 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars to further expand coverage directly to the uninsured, funded in part by redirecting certain public funds that were dedicated to institutional reimbursement for uncompensated care to coverage programs under an insurance-based model. This agreement led to the creation of the Safety Net Care Pool (SNCP). This restructuring laid the groundwork for health care reform in Massachusetts, because the SNCP allowed the Commonwealth to develop innovative Medicaid reform efforts by supporting a new insurance program.

Massachusetts' health care reform legislation passed in April 2006. On July 26, 2006, CMS approved an amendment to the MassHealth demonstration to incorporate those health reform

changes, which expanded coverage to childless adults, and used an insurance connector (Marketplace) and virtual gateway system to facilitate enrollment into the appropriate program. This amendment included:

- the authority to establish the Commonwealth Care program under the SNCP to provide sliding scale premium subsidies for the purchase of commercial health plan coverage for uninsured persons at or below 300 percent of the FPL;
- the development of payment methodologies for approved expenditures from the SNCP;
- an expansion of employee income eligibility to 300 percent of the FPL under the Insurance Partnership; and
- increased enrollment caps for MassHealth Essential and the HIV/Family Assistance Program.

At this time, there was also an eligibility expansion in the Commonwealth's separate title XXI program for optional targeted low-income children between 200 percent and 300 percent of the FPL, which enabled parallel coverage for children in households where adults are covered by Commonwealth Care. This expansion ensured that coverage is equally available to all members of low-income families.

In the 2008 extension of the demonstration, CMS and the Commonwealth agreed to reclassify three eligibility groups (those aged 19 and 20 under the Essential and Commonwealth Care programs and custodial parents and caretakers in the Commonwealth Care program) with a categorical link to the title XIX program as "hypotheticals" for budget neutrality purposes as the populations could be covered under the state plan. As part of the renewal, the SNCP was also restructured to allow expenditure flexibility through a 3-year aggregate spending limit rather than annual limits; a gradual phase out of federal support for the Designated State Health Programs; and a prioritization in the SNCP to support the Commonwealth Care Program.

Three amendments were approved in 2010 and 2011 to allow for additional flexibility in the Demonstration. On September 30, 2010, CMS approved an amendment to allow Massachusetts to (1) increase the MassHealth pharmacy co-payment from \$2 to \$3 for generic prescription drugs; (2) provide relief payments to Cambridge Health Alliance totaling approximately \$216 million; and (3) provide relief payments to private acute hospitals in the Commonwealth totaling approximately \$270 million.

On January 19, 2011, CMS approved an amendment to: (1) increase authorization for Designated State Health Programs for state fiscal year 2011 to \$385 million; (2) reclassify Commonwealth Care adults without dependent children with income up to and including 133 percent of the federal poverty level (FPL) as a "hypothetical" population for purposes of budget neutrality as the population could be covered under the state plan; and (3) allow the following populations to be enrolled into managed care: (a) participants in a Home and Community-Based Services Waiver; (b) Katie Beckett/ Kaileigh Mulligan children; and (c) children receiving title IV-E adoption assistance.

Additionally, on August 17, 2011, CMS approved an amendment to authorize expenditure authority for a maximum of \$125.5 million for state fiscal year (SFY) 2012 for Cambridge

Health Alliance through the SNCP for uncompensated care costs. This funding was approved with the condition that it be counted toward a budget neutrality limit eventually approved for SFY 2012 as part of the 2011 extension.

In the 2011 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars for the following purposes:

- support a Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children with high-risk asthma;
- offer early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
- utilize Express Lane eligibility methodologies to conduct renewals for parents and caretakers to coincide with the Commonwealth's intent to utilize Express Lane eligibility for children; and
- further, expand the SNCP to provide incentive payments to participating hospitals for Delivery System Transformation Initiatives focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

In the extension granted on December 20, 2011 the Commonwealth's goals under the demonstration were:

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

Under the September 2013 amendment, the Commonwealth revised the demonstration and waiver authorities to comply with the provisions of the Affordable Care Act. Additionally, the amendment supported the Commonwealth's ability to sustain and improve its ability to provide coverage, affordability and access to health care under the demonstration. The amendment allowed Massachusetts to continue certain programs and realign other programs to comply with the Affordable Care Act provisions that became effective January 1, 2014. For example, the amendment allowed Massachusetts to sunset certain demonstration programs such as MassHealth Basic, MassHealth Essential and the Medical Security Program December 31, 2013. These changes were made to reflect the fact that effective January 1, 2014, the individuals eligible under certain demonstration programs with income up to 133 percent of the federal poverty level (FPL) became eligible under the Medicaid state plan and those with income above 133 percent of the FPL became eligible to purchase insurance through Massachusetts' health insurance Marketplace, the Health Connector. With the combination of previous expansions and

the recent health reform efforts, the MassHealth Medicaid section 1115 demonstration now covers approximately 1.8 million individuals.

In the 2014 extension of the demonstration, the Commonwealth continued its commitment to the same goals articulated for the 2011-2014 extension period. In accordance with these goals, CMS and the Commonwealth agreed to:

- Extend the demonstration for a five-year period based upon the authority under Section 1915(h)(2) of the Social Security Act which authorizes five-year renewal terms for states that provide medical services for dual eligible individuals through their demonstration. The five-year renewal period will support the Commonwealth's dual eligibles demonstration as some of the authorities for the duals demonstration are contained in the in the section 1115(a) demonstration.
- Continue authority for the Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children ages 2-18 with high-risk asthma;
- Continue authority to offer intensive early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
- Continue Health Connector Subsidies to provide premium assistance to individuals receiving Qualified Health Plan (QHP) coverage through the Marketplace with incomes up to 300 percent of the FPL;
- Continue and expand the authority for the Commonwealth to conduct streamlined eligibility redeterminations using Supplemental Nutrition Assistance Program (SNAP) verified income data.
- Provide for payment of the cost of the monthly Medicare Part A and Part B premiums and the cost of deductibles and coinsurance under Part A and Part B for Medicare-eligible individuals who have incomes up to 133 percent of the FPL, and pay the costs of the Medicare Part B premium only for CommonHealth members with incomes between 133 and 135 percent FPL; and
- Through June 30, 2017, provide incentive payments to participating hospitals for Delivery System Transformation Initiatives and the Public Hospital Transformation and Incentive Initiatives, and provide support for Infrastructure and Capacity Building investments focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

During the extension period granted in 2014, the goals of the demonstration are:

- Maintain near universal coverage for all residents of the Commonwealth and reduce barriers to coverage;
- Continue the redirection of spending from uncompensated care to insurance coverage;
- Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements.

- Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such a change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b) If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day, such state legislation becomes effective, or on the last day, such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state Plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
 - a) An explanation of the public process used by the Commonwealth consistent with the requirements of STC 15 to reach a decision regarding the requested amendment;
 - b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment;
 - c) An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment, if necessary; and
 - e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 10.

- a) As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.
 - b) Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.
9. **Compliance with Transparency Requirements 42 C.F.R. §§ 431.412:** As part of any demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 C.F.R. §§ 431, 412 and the public notice and tribal consultation requirements outlined in STC 15 as well as include the following supporting documentation:
- lii. Demonstration Summary and Objectives. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.
 - liv. Special Terms and Conditions. The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
 - lv. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
 - lvi. Compliance with the Budget Neutrality Cap. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.
 - lvii. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.
10. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a) **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's

suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

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

- b) **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c) **Phase-out Procedures:** The state must comply with all notice requirements found in 42 C.F.R. section 431.206, section 431.210, and § 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 C.F.R. section 431.220 and section 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 C.F.R. section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.
- d) **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to, normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- e) **Post Award Forum:** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 60 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 62.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. The CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
14. **Adequacy of Infrastructure.** The Commonwealth will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements at outlined in the state's approved state plan, when any program changes to the demonstration including (but not limited to) those referenced in STC 6, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state must to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 C.F.R. section 447.205 for changes in statewide methods and standards for setting payment rates.
16. **Quality Review of Eligibility.** The Commonwealth will continue to submit by December 31st of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by federal regulations at 42 C.F.R. section 431.812(c). Based on the approved MEQC activities, the Commonwealth will be assigned a payment error rate equal to the FFY 1996 state error rate for the duration of this section 1115 demonstration project.
17. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

18. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The State shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

IV. ELIGIBILITY AND ENROLLMENT

18A. Eligible Populations. This demonstration affects mandatory and optional Medicaid state plan populations as well as populations eligible for benefits only through the demonstration. Table A at the end of section IV of the STCs shows each specific group of individuals; under what authority they are made eligible for the demonstration; the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed; and the corresponding demonstration program under which benefits are provided. Attachment A provides a complete overview of MassHealth coverage for children, including the separate title XXI CHIP program, which is incorporated by reference.

Eligibility is determined based on an application by the beneficiary or without an application for eligibility groups enrolled based on receipt of benefits under another program.

MassHealth defines the age of a dependent child for purposes of the parent/caretaker relative coverage type as a child who is younger than age 19. A caretaker relative is eligible under this provision only if the parent is not living in the household.

19. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance to STC 46, Table D.
20. **Calculation of Financial Eligibility.** Financial eligibility for demonstration programs is determined by comparing the family's Modified Adjusted Gross Income (MAGI) with the applicable income standard for the specific coverage type, with the exception of adults aged 19 and above who are determined eligible on the basis of disability and whose financial eligibility is determined as described below. MAGI income counting methodologies will also be applied to disabled adults in determining eligibility for MassHealth Standard and CommonHealth; however, household composition for disabled adults will always be determined using non-tax filer rules, regardless of whether the individual files income taxes or is claimed as a dependent on another person's income taxes. In determining eligibility for MassHealth Standard and CommonHealth for disabled adults, the Commonwealth will apply the five percent income disregard that is also applied to non-disabled adults.
21. **Streamlined Redeterminations.** Under the streamlined renewal process, enrollees are not required to return an annual eligibility review form if they are asked to attest whether they have any changes in circumstances (including household size and income) and do not have any changes in circumstances reported to MassHealth. The process applies to the following populations:

- a) Families with children under the age of 19 who have gross income as verified by MassHealth at or below 150 percent FPL and who are receiving SNAP benefits with SNAP verified income at or below 180 percent FPL.
- b) Families with children up to age 21 whose SNAP verified income is at or below 180 percent FPL, effective to the extent that the state uses an Express Lane eligibility process under its state plan for children up to the age of 21.
- c) Childless adults whose SNAP verified income is at or below 163 percent FPL.

The authority to use streamlined eligibility redetermination procedures will also remain in effect for families with children notwithstanding sunset dates for Express Lane Eligibility applicable to the companion state plan amendments.

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

23. Hospital-Determined Presumptive Eligibility for Additional Eligibility Groups. Qualified hospitals that elect to do so may make presumptive eligibility determinations for individuals who appear eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan.

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

24. Provisional Eligibility. MassHealth will accept self-attestation for all eligibility factors, except for disability status, immigration and citizenship status, in order to determine eligibility, and may require post-eligibility verification from the applicant. If MassHealth is unable to verify eligibility through federal and state data hubs, or if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, MassHealth can enroll individuals for a 90-day “provisional eligibility period,” during which MassHealth will require further verifications from the applicant.

Necessary verifications are required within 90 days of the date the individual receives notice of the provisional eligibility determination in order to maintain enrollment. The date the

notice is received is considered to be five days after the date the notice is sent , unless the notice recipient shows otherwise. The reasonable opportunity period for applicants pending verification of citizenship or immigration status aligns with the 90-day provisional eligibility period for applicants pending verification of other eligibility criteria, such that benefits provided may begin prospectively with respect to all applicants as early as the date of application.

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

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

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

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

For individuals who indicate on the application that they have breast or cervical cancer or HIV, a determination of eligibility will be made in accordance with the procedures described in STC 24. Persons who have not submitted verification of breast cancer, cervical cancer, or HIV diagnosis within 90 days of the eligibility determination will subsequently have their eligibility redetermined as if they did not have breast cancer, cervical cancer, or HIV.

26. **Eligibility Exclusions.** Notwithstanding the eligibility criteria outlined in this section or in Table A, the following individuals are excluded from this demonstration. Payments or expenditures related to uncompensated care for such individuals as defined in STC 50(b), and for DSHP as described in STC 50(a), however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP).

Individuals 65 years and older (unless a parent or caretaker relative of a child 18 years old or younger)
Individuals who are eligible based on institutional status
Participants in Program of All-Inclusive Care of the Elderly (PACE)
Refugees served through the Refugees Resettlement Program

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

Table A. MassHealth State Plan Base Populations¹ (See STC 68(f) for terminology)

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
AFDC-Poverty Level infants	< Age 1: 0 through 185%	Title XIX	<u>Base Families</u>	Standard	
Medicaid Expansion infants	< Age 1: 185.1 through 200%	<ul style="list-style-type: none"> Title XIX if insured at the time of application Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted 	<u>1902(r)(2) Children</u> <u>1902(r)(2) XXI RO</u>	Standard	
AFDC-Poverty Level Children and Independent Foster Care Adolescents	<ul style="list-style-type: none"> Age 1 - 5: 0 through 133% Age 6 - 17: 0 through 114% Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets Former Foster Care Adolescents until the age of 26 without regard to income or assets (effective January 	Title XIX	<u>Base Families</u>	Standard	

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

	1, 2014)				
AFDC-Poverty Level Children	<ul style="list-style-type: none"> Age 6 - 17: 114.1% through 133% 	<ul style="list-style-type: none"> Title XIX if insured at the time of application Title XXI if uninsured at the time of application 	<u>Base Familles</u>	Standard	
Medicaid Expansion Children I	<ul style="list-style-type: none"> Age 18: 0 through 133% 	<ul style="list-style-type: none"> Funded through title XIX if title XXI is exhausted 	<u>Base Familles</u> <u>XXIRO</u>		

Table A. MassHealth State Plan Base Populations (continued)*

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	<ul style="list-style-type: none"> Title XIX if insured at the time of application Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted 	<u>1902(r)(2) Children</u> <u>1902(r)(2) XXI RO</u>	Standard	
Medicaid Expansion Children II (effective January 1, 2014)	Ages 19 and 20: 133.1 through 150%	Title XIX	<u>1902(r)(2) Children</u>	Standard	
CHIP Unborn Children	0 through 200%	Title XXI	<u>n/a</u>	Standard	
Pregnant women	0 through 185%	Title XIX	<u>Base Families</u>	Standard	
Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance	0 through 133%	Title XIX	<u>Base Families</u>	Standard	
Disabled children under age 19	0 through 150%	Title XIX	<u>Base Disabled</u>	Standard	
Disabled adults ages 19 through 64	0 through 114%	Title XIX	<u>Base Disabled</u>	Standard	
Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	<u>Base Disabled</u>	CommonHealth	Must spend-down to medically needy income standard to become eligible as medically needy
Pregnant women	185.1 through 200%	Title XIX	<u>1902(r)(2) Children</u>	Standard	

Table A. MassHealth State Plan Base Populations (continued)*

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
“Non-qualified Aliens” or “Protected Aliens”	Otherwise eligible for Medicaid under the State Plan	Title XIX	<u>Base Families</u> <u>Base Disabled</u> <u>1902(r)(2) Children</u> <u>1902(r)(2) Disabled</u> <u>New Adult Group (New Adult Group coverage began January 1, 2014)</u>	Limited	Member eligible for emergency services only under the state Plan and the demonstration. Members who meet the definition and are determined to have a disability are included in the Base Disabled EG Members who are determined eligible via 1902(r)2 criteria are included in the 1902(r)(2) EG
Disabled adults ages 19 through 64	114.1 through 133%	Title XIX	<u>1902(r)(2) Disabled</u>	Standard	
Individuals eligible under the BCCTP with income above 133% through 250% FPL.	>133 through 250%	Title XIX	<u>BCCTP</u>	Standard	
Children eligible under TEFRA section 134, SSA section 1902(e)(3) and 42 U.S.C. 1396a(e)(3) (Kaileigh Mulligan kids)	<ul style="list-style-type: none"> • Age 0 – 17 • Require hospital or nursing facility level of care • Income < or = to \$72.81, or deductible • \$0 through \$2,000 in assets 	Title XIX	<u>Base Disabled</u>	Standard	Income and assets of their parents are not considered in determination of eligibility
Children receiving title IV-E adoption assistance	<ul style="list-style-type: none"> • Age 0 through 18 	Title XIX	<u>Base Families</u>	Standard	Children placed in subsidized adoption under title IV-E of the Social Security Act

Table A. MassHealth State Plan Base Populations (continued)*

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Special Home and Community-Based Waiver (HCBW) Group (individuals who without the HCBW would be eligible for Medicaid if in an institution) under age 65	<ul style="list-style-type: none"> • 0 through 300% SSI Federal Benefits Rate • \$0 through \$2,000 in assets 	Title XIX	<u>Base Disabled</u>	Standard	All other participants under age 65 in a HCBW are reflected in other Base Eligibility Groups in this chart.
Affordable Care Act New Adult Group (effective January 1, 2014)	<ul style="list-style-type: none"> • Ages 19 and 20: 0 through 133% • Individuals with HIV or breast or cervical cancer: 0 through 133% • Individuals receiving services or on a waiting list to receive services through the Department of Mental Health: 0 through 133% • Adults ages 21-64: 0 through 133% 	Title XIX	New Adult Group	Standard (Alternative Benefit Plan) CarePlus (Alternative Benefit Plan)	Ages 19 and 20 treated as children and entitled to EPSDT Individuals exempt from mandatory enrollment in an Alternative Benefit Plan may enroll in Standard

Table A. MassHealth Demonstration Expansion Populations *

Groups with a Categorical Link Made Eligible through the Demonstration (“Hypotheticals”)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Higher income children with disabilities	<ul style="list-style-type: none"> • < Age 1: 200.1 through 300% • Ages 1 - 18: 150.1 through 300% 	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI via the separate XXI program (Funded through title XIX if title XXI is exhausted) 	<p align="center"><u>CommonHealth</u></p> <p align="center"><u>CommonHealth XXI</u></p>	CommonHealth	The CommonHealth program existed prior to the separate XXI Children’s Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI state plan and as authorized under this 1115 demonstration. Certain children derive eligibility from both the authority granted under this demonstration <u>and</u> the separate XXI program.
Higher income children with disabilities ages 0 through 18	Above 300%	Title XIX	<u>CommonHealth</u>	CommonHealth	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL
Higher income adults with disabilities ages 19 through 64 working 40 hours a month or more	Above 133% Above 150% for 19- and 20-year olds)	Title XIX	<u>CommonHealth</u>	CommonHealth (“working”)	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

Table A. MassHealth Demonstration Expansion Populations (See STC 68(f) for terminology)

Populations Made Eligible through the Demonstration	Federal Poverty Level (FPL) and other qualifying criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	Massachusetts Demonstration Program	Additional comments
<p>Children ages 1 through 18 (Non-disabled)</p> <p>Children less than age 1</p>	<p>150.1 through 200</p> <p>Above 200 through 300% (effective January 1, 2014)</p> <p>Above 200 through 300% (effective January 1, 2014)</p>	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI via the separate XXI program if uninsured <p>(Funded through title XIX if title XXI is exhausted)</p>	<p align="center"><u>e-Family Assistance</u></p> <p align="center"><u>Fam Assist XXI</u> (if XXI is exhausted)</p>	<p>Family Assistance</p> <ul style="list-style-type: none"> • Premium Assistance • Direct Coverage <p>The premium assistance payments and FFP will be based on the children’s eligibility. Parents are covered incidental to the child. No additional wrap other than dental is provided to ESI.</p>	<p>Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children’s Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration <u>and</u> the separate XXI program.</p> <p>Effective January 1, 2014, children ages 0 through 18 from 200-300% FPL who are insured at the time of application are eligible under the 1115 demonstration.</p> <p>Children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration and the XXI program.</p>
<p>Adults under the age of 65 who are not otherwise eligible for medical assistance who work for a small employer and purchase ESI that meets basic benefit level (BBL) standards</p>	<p>133.1 through 300%</p>	<p>Title XIX</p>	<p align="center"><u>SEB</u></p>	<p>Small Business Employee Premium Assistance</p>	<p>Individuals must not be eligible for any other MassHealth coverage or for APTCs.</p> <p>No additional wraparound benefits are provided.</p> <p>Individuals whose spouse or children are receiving MassHealth premium assistance for a policy that is available to the individual are not entitled to this benefit.</p>

Table A. MassHealth Demonstration Expansion Populations (continued)*

Populations Made Eligible through the Demonstration	Federal Poverty Level (FPL) and other qualifying criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	Massachusetts Demonstration Program	Additional comments
Individuals with HIV not otherwise eligible for medical assistance with income above 133% through 200% FPL.	Above 133 to 200%	Title XIX	<u>e-HIV/FA</u>	Family Assistance	Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.
Individuals who receive Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children	N/A	Title XIX	<u>TANF/EAEDC</u>	MassHealth	Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not an income determination.
Provisional Eligibility	Self Attested income level to qualify for other group, pending verification	Title XIX	<u>Provisional Eligibility</u>	MassHealth	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority in accordance with STC 24.
End of Month Coverage Beneficiaries determined eligible for subsidized Qualified Health Plan (QHP) coverage through the Massachusetts Health Connector but not enrolled in a QHP	Ineligible for MassHealth and Eligible for QHP up to 400% FPL	Title XIX	<u>End of Month Coverage</u>	N/A	Effective January 1, 2014, expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP, during the period specified in STC 28.
Individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration by qualified hospitals that elect to do so.	HIV-Family Assistance – 133.1 through 200 BCCPT – above 133.1 through 250	Title XIX	<u>Presumptively Eligible</u>	Family Assistance Standard	

V. DEMONSTRATION PROGRAMS AND BENEFITS

28. **End of Month Coverage for Members Eligible for Subsidized QHP Coverage through the Massachusetts Health Connector.** When a MassHealth member's enrollment is being terminated due to a change in circumstance that makes the member ineligible for MassHealth but eligible for subsidized QHP coverage through the Connector, MassHealth will extend the member's last day of coverage to the end of the month before QHP coverage may feasibly become effective. If the termination otherwise would have been effective on or before the 15th of a given month, then MassHealth coverage will be extended to the end of that month. If the termination otherwise would have been effective on or after the 16th of a given month, then MassHealth coverage will be extended to the end of the following month.
29. **Temporary Authority: Transition to New Programs.** The Commonwealth will extend the eligibility of enrollees who needed a redetermination between October - December 2013 and January - December 2014 through 2015. The Commonwealth will use streamlined strategies to process redeterminations and changes in income based on the mitigation plan approved by CMS.
30. **Demonstration Program Benefits.** Massachusetts provides health care benefits through the following specific benefit programs. The benefit program for which an individual is eligible is based on the criteria outlined in Table A of section IV of the STCs. Table B in STC 37, provides a side-by-side analysis of the benefits offered through these MassHealth programs.
31. **MassHealth Standard.** Individuals enrolled in MassHealth Standard receive state plan services including for individuals under age 21, Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. In addition, individuals enrolled in Standard receive additional demonstration benefits specifically authorized in demonstration expenditure authorities.

MassHealth's Standard Alternative Benefit Plan (ABP) is for individuals in the New Adult Group who are ages 19-20, as well as individuals 21-64 who are HIV positive, have breast or cervical cancer or are receiving services from the Department of Mental Health or who are on a waiting list to receive such services. Individuals enrolled in the Standard ABP receive the same benefits offered in Standard and benefits are provided in the same manner as outlined below.

MassHealth Standard benefits will be provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished as described in STC 45.

MassHealth Standard benefits include, for individuals with incomes at or below 133 percent of FPL who are also eligible for Medicare, (1) payment of monthly Medicare Part B premiums, (2) payment of hospital insurance premiums under Medicare Part A; and, (3) payment of deductibles and co-insurance under Medicare Part A and B. The Commonwealth may establish eligibility for this coverage without applying an asset test. These benefits will begin on the first day of the month following the date of the

MassHealth eligibility determination. The benefits available under the MassHealth Standard ABP are effective as of January 1, 2014.

31A. MassHealth CarePlus. MassHealth's CarePlus ABP is for individuals in the New Adult Group ages 21-64 who are not otherwise eligible for MassHealth Standard ABP. CarePlus provides medical and behavioral health services, including diversionary behavioral health service and non-emergency medical transportation, but does not include long term services and supports. Benefits are provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished in coordination with STC 45. The benefits available under MassHealth CarePlus ABP are effective as of January 1, 2014.

32. **MassHealth Breast and Cervical Cancer Treatment Program (BCCTP).** The BCCTP is a health insurance program for individuals in need of treatment for breast or cervical cancer. This program offers MassHealth Standard benefits to individuals under 65 who do not otherwise qualify for MassHealth.
33. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under Standard; individuals under age 21 receive EPSDT services as well. In addition, individuals enrolled in CommonHealth receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished in coordination with STC 45. In addition, for CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth will also pay the cost of the monthly Medicare Part B premium. These benefits shall begin on the first day of the month following the date of the MassHealth eligibility determination. The Commonwealth may establish eligibility for this coverage without applying an asset test.
34. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under Standard. Among other things, individuals enrolled in Family Assistance receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. The Commonwealth may waive its requirement for children with access to ESI to enroll in ESI if the Commonwealth determines it is more cost effective to provide benefits under direct Family Assistance coverage than to provide premium assistance. There are two separate categories of eligibility under Family Assistance:
- a) **Family Assistance-HIV/AIDS.** As referenced in table A above, for persons with HIV/AIDS whose income is above 133 percent less than or equal to 200 percent of the FPL. Unlike other coverage types, persons with HIV who have access to ESI do not have to enroll in available ESI; however, if they choose to receive premium assistance, the Commonwealth will provide covered services that are not available from the ESI plan on a fee-for-service (FFS) basis.

b) **Family Assistance-Children.** As referenced in table A above, children can be enrolled in Family Assistance if their family’s income is above 150 percent and less than or equal to 300 percent FPL. Benefits are provided either through direct coverage or cost effective premium assistance. Direct coverage Family Assistance under the title XXI program is provided through an MCO or the PCC plan for children without access to ESI. Premium Assistance benefits are limited to premium assistance for ESI, to the extent that ESI is available to these children that is cost-effective, meets a basic benefit level (BBL), and for which the employer contributes at least 50 percent of the premium cost. Premium assistance may exceed the cost of child-only coverage and include family coverage if cost effective based on the child’s coverage. Direct coverage is provided for children with access to cost effective ESI that meets the BBL only during the provisional eligibility period and the time span while the Commonwealth is investigating availability of and enrolling the child in ESI.

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

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

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

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

Benefits	Standard/ Standard ABP	Common Health	Family Assistance	CarePlus
EPSDT	X	X		
Inpatient Acute Hospital	X	X	X	X
Adult Day Health	X	X		
Adult Foster Care**	X	X		
Ambulance (emergency)	X	X	X	X
Audiologist Services	X	X	X	X
Behavioral Health Services (mental health and substance abuse)	X	X	X	X
Chapter 766 Home	X	X	X	

Benefits	Standard/ Standard ABP	Common Health	Family Assistance	CarePlus
Assessment***				
Chiropractic Care	X	X	X	X
Chronic Disease and Rehabilitation Hospital Inpatient	X	X	X	X
Community Health Center (includes FQHC and RHC services)	X	X	X	X
Day Habilitation****	X	X		
Dental Services	X	X	X	X
Diversionary Behavioral Health Services	X	X	X	X
Durable Medical Equipment and Supplies	X	X	X	X
Early Intervention	X	X	X	
Intensive Early Intervention Services for Eligible Children with Autism Spectrum Disorder	X	X	X	
Family Planning	X	X	X	X
Hearing Aids	X	X	X	X
Home Health	X	X	X	X
Hospice	X	X	X	X
Laboratory/X-ray/ Imaging	X	X	X	X
Medically Necessary Non- emergency Transport	X	X		X
Nurse Midwife Services	X	X	X	X
Nurse Practitioner Services	X	X	X	X
Orthotic Services	X	X	X	X
Outpatient Hospital	X	X	X	X
Outpatient Surgery	X	X	X	X
Oxygen and Respiratory Therapy Equipment	X	X	X	X
Personal Care	X	X		
Pharmacy	X	X	X	X
Physician	X	X	X	X
Podiatry	X	X	X	X

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

38. Diversionary Behavioral Health Services. Diversionary behavioral health services are
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home and community-based mental health services furnished as clinically appropriate alternatives to and diversions from inpatient mental health services in more community-based, less structured environments. Diversionary services are also provided to support an individual's return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided on an outpatient basis in a non-24-hour setting or facility. Generally, 24-hour and non-24 hour diversionary behavioral health services are provided by free-standing (community-based) or hospital-based programs licensed by the Department of Mental Health or the Department of Public Health. Some of the 24 hour, service providers of Diversionary Behavioral Health Services meet the definition of an Institution for Mental Diseases (IMD). For those settings that are IMDs, the demonstration will only authorize expenditure authority for a two-year period, at which time the efficacy of such services when provided in IMDs will be reviewed, and a decision will be made as to whether to phase down such services through IMDs or consider extending for the remainder of the demonstration period. Please see STC 61 for additional information about the evaluation plan for diversionary behavioral health services provided in IMDs. Diversionary services are offered to provide interventions and stabilization to persons experiencing mental health or substance abuse crises in order to divert from acute inpatient hospitalization or to stabilize after discharge. These services do not include residential programs involving long-term residential stays. Any MassHealth member under the demonstration who is enrolled in managed care may be eligible to receive diversionary services. Managed care entities and the Prepaid Inpatient Health Plan (PIHP) for behavioral health services identify appropriate individuals to receive diversionary services. Managed care entities maintain a network of diversionary services and arrange, coordinate, and oversee the provision of medically necessary diversionary services, as described in Table C.

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

<u>Diversionary Behavioral Health Service</u>	<u>Setting</u>	<u>Definition of Service</u>
Community Crisis Stabilization	24-hour facility	Services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.
Community Support Program (CSP)	Non-24-hour facility	An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services

<u>Diversions Behavioral Health Service</u>	<u>Setting</u>	<u>Definition of Service</u>
		<p>to Covered Individuals with a long-standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.</p>
<p>Partial Hospitalization*</p>	<p>Non-24-hour facility</p>	<p>An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.</p>
<p>Acute Treatment Services for Substance Abuse</p>	<p>24-hour facility</p>	<p>24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These</p>

<u>Diversions Behavioral Health Service</u>	<u>Setting</u>	<u>Definition of Service</u>
		services may be provided in licensed freestanding or hospital-based programs.
Clinical Support Services for Substance Abuse	24-hour facility	24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.
Transitional Care Unit Services addressing the needs of children and adolescents, under age 19, in the custody of the Department of Children and Families (DCF), who need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care.	24-hour facility	A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu**, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.
Psychiatric Day Treatment*	Non-24-hour facility	Services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.
Intensive Outpatient Program	Non-24-hour	A clinically intensive service

Diversions Behavioral Health Service	Setting	Definition of Service
	facility	designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.
Structured Outpatient Addiction Program	Non-24-hour facility	Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.
Program of Assertive Community Treatment	Non-24-hour facility	A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and

Diversions Behavioral Health Service	Setting	Definition of Service
		provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.
Emergency Services Program*	Non-24-hour facility	Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.
Community Based Acute Treatment for Children and Adolescents	24-hour facility	Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (which is defined as one-on-one therapeutic monitoring as needed for individuals who may be at immediate risk for suicide or other self harming behavior); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.

Chart Notes:

* This service is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment.

** In this context, “therapeutic milieu” refers to a structured, sub-acute setting, in which clinical services (therapies) are provided at both the individual and group level, and in which the common social/interpersonal interactions between each patient, and all others who are present in the setting, are incorporated into the treatment approach.

39. Pediatric Asthma Pilot Program. This pilot program will utilize an integrated delivery system for preventive and treatment services through methodologies that may include a

payment such as a per member/per month (PMPM) payment to participating providers for asthma-related services, equipment and supports for management of pediatric asthma for high-risk patients, to improve health outcomes, reduce asthma-related emergency department utilization and asthma-related hospitalizations, and to reduce associated Medicaid costs. These methodologies are subject to CMS approval of the pilot program protocol. The CMS approved protocol is Attachment F to these STCs. The state must evaluate the degree to which such a payment and flexible use of funds enhances the effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower costs.

- a) Eligibility. The state must limit the pilot program to demonstration eligible children, age 2 through 18 at the time of enrollment in the pilot, who are enrolled in the Primary Care Clinician Plan panel of a participating practice site, and who have high-risk asthma. Children with high-risk asthma are those children who have, in the last 12 months prior to enrollment in the pilot, had an asthma-related inpatient hospitalization, observation stay, or emergency department visit or an oral corticosteroid prescription for asthma. The state must utilize Medicaid claims data to identify eligible children.
- b) Benefits. The benefits within a payment such as a PMPM may vary over the course of the pilot. Prior to enrolling beneficiaries in the Pediatric Asthma Program, CMS must approve the benefit package and any changes proposed to the benefit package over the course of the pilot through the protocol process outlined in subparagraph (g). For example, services include for Phase I: non-traditional services and supplies to mitigate environmental triggers of asthma and home visitation and care coordination services conducted by qualified Community Health Workers. In Phase II, the payment structure such as a PMPM, bundled, global, or episodic payment may be expanded to also include certain Medicaid State plan services with utilization that is particularly sensitive to uncontrolled asthma (i.e. treatment provided by physicians, nurse practitioners and hospitals, medical equipment such as a nebulizer, spacer, peak flow meter, etc.).
- c) Delivery System. Provider Participation in the pilot must be limited to primary care clinician sites that participate or enroll in the Primary Care Clinician Plan (PCCP). The practices must be responsible for supervision and coordination of the medical team, including Community Health Workers; delivery of asthma-related services paid for by the PMPM payment; as well as the PMPM cost of each beneficiary enrolled.

Provider participation in the pilot must be determined through a Request for Proposal (RFP) process. The state must prioritize participation by qualified practices that serve a high number of patients with high-risk asthma enrolled in PCCP and have the capacity to manage asthma in a coordinated manner. In addition, the state must seek to include qualified practices that are geographically dispersed across the state and represent a range of provider types, such as physician group practices, community health centers, and hospital outpatient departments, in order to explore a variety of infrastructure challenges.

- d) Infrastructure Support for Participating Provider Sites. To defray the costs of implementing the financial, legal and information technology system infrastructure required to manage a payment such as PMPM and coordination of patient care,

participating provider sites are eligible for up to \$10,000 per practice site for the sole purpose of infrastructure changes and interventions related to this Pediatric Asthma Pilot only. The amount of infrastructure support is variable up to this maximum depending on the provider's readiness, the state's review and finding of such readiness, and CMS' concurrence on the use of the proposed funding for the practice as per the protocol process outlined in subparagraph (g) and (h).

- e) Pilot Expansion. Following initial implementation and evaluation of programmatic outcomes, and subsequent CMS approval, the state may request CMS approval to implement a payment such as a PMPM, bundled, global or episodic payment and/or shared savings methodology component to the Pediatric Asthma Pilot. Examples of favorable outcomes include the prevention of asthma-related emergency department utilization, and asthma-related hospitalizations and improved patient outcomes.
- f) Extent of FFP in the Pilot. FFP for this pilot program is subject to the compliance with the protocols attached as Appendix F, as such protocols may be amended pursuant to subparagraph (g) below. The infrastructure support described in subparagraph (d) above must be provided through the Infrastructure and Capacity-Building fund as part of the Safety Net Care Pool outlined in STC 50(c). CMS will provide FFP at the applicable Federal Medical Assistance Percentage for services and supplies outlined in the approved benefit package pursuant to subparagraph (g)(1), subject to reimbursement amounts identified in the payment methodology outlined in subparagraph (g)(5), demonstration budget neutrality limits and any applicable SNCP limits.
- g) Required Protocols Prior to Claiming FFP. The state has met the following milestones which required CMS preapproval in order to enroll beneficiaries and claim FFP under this pilot program. These protocols/milestones are found in Attachment F.
 - 1) A description and listing of the program specific asthma-related benefit package that will be provided to the pilot participants with rationale for the inclusion of each benefit;
 - 2) Eligibility, qualifications and selection criteria for participating providers, including the RFP for preapproval;
 - 3) A plan outlining how this pilot may interact with other federal grants, such as for related research (e.g. NIH, HUD, etc.) and programmatic work (e.g. CHIPRA grant related to pediatric health care practices in multi-payer medical homes, etc.). This plan should ensure no duplication of federal funds and outline the state's coordination activities across the various federal support for related programmatic activities to address potential overlap in practice site selection, patient population, etc.
 - 4) A plan for the purchase and dissemination of supplies within the pilot specific benefit package, including procurement methods by the state and/or providers including volume discounts, etc.;
 - 5) A payment rate setting methodology outlining the PMPM payment for the pilot services and supplies, consideration of risk adjustment and the estimated/expected cost of the pilot;
 - 6) A payment methodology outlining cost and reconciliation for the infrastructure

- payments to participating provider sites, and the eligibility and reporting requirements associated with the infrastructure payments; and
- 7) An approved evaluation design for the pilot that is incorporated into the evaluation design required per STC 90. The objective of the evaluation is to determine the benefits and savings of the pilot as well as design viability and inform broader implementation of the design. The evaluation design must include an evaluation of programmatic outcomes for purposes of subparagraph (e). As part of the evaluation, the state at a minimum must include the following requirements:
- i. Collect baseline and post-intervention data on the service utilization and cost savings achieved through reduction in hospital services and related provider services for the population enrolled in the pilot. This data collection should include the quality measure on annual asthma-related emergency room visits outlined in the initial core set of children's health care quality measures authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA) beginning with a baseline set at the onset of the pilot, adjusted for the age range enrolled in the pilot program;
 - ii. A detailed analysis of how the pilot program affects the utilization of acute health services, such as asthma-related emergency department visits and hospitalizations by high risk pediatric asthma patients, and how the pilot program reduces or shifts Medicaid costs associated with treatment and management of pediatric asthma;
 - iii. An assessment of whether the cost projections for the provider payment were appropriate given the actual cost of rendering the benefits through the pilot program; and
 - iv. A detailed analysis of how the effects of the pilot interact with other related initiatives occurring in the state.
- h) Changes to the Pediatric Asthma Program and/or Amendments to the Protocols. If the state proposes to amend the pilot benefits, payment structure, delivery system or other issues pursuant to the protocols it must seek CMS approval to amend its protocols as outlined in subparagraph (g) and (i). An amendment to protocols is not subject to STC 7 regarding demonstration amendments. Should the state choose to design and plan for payments such as bundled, global or episodic payments or shared savings to participating providers, methodology documents must be preapproved by CMS prior to contract changes or implementation of the changes; any shared savings or payment methodologies must be consistent with CMS policy and guidelines, including any quality reporting guidelines.
- i) Reporting. The state must provide status updates on the pilot program within the quarterly and annual reports as required by STCs 60 and 62. At a minimum, reporting for the pilot program must provide an update on all pilot program related activities including:
- 1) Current and future state activities related to the required deliverables as described in subparagraph (g), including anticipated changes to the benefit package, delivery system or payment methodology;

- 2) Services and supplies provided to beneficiaries, community outreach activities, increases and decreases in beneficiary enrollment or provider enrollment, and any complaints regarding quality or service delivery;
- 3) Pediatric asthma pilot program payments to participating providers that occurred in the quarter. Infrastructure payments made to providers under this pilot will be reported pursuant to STCs 50(c) and 51(b);
- 4) Expenditure projections reflecting the expected pace of future provider payments; and
- 5) Progress on the evaluation of the pilot program as required in subparagraph (g), including a summary of the baseline and pilot outcome data from Medicaid claims data associated with enrollee utilization and associated cost of treatment, including prescriptions, and primary care, emergency department and hospitalization visits.

40. Intensive Early Intervention Services for Children with Autism Spectrum Disorder.

The state will provide medically necessary Applied Behavioral Analysis-based (ABA) treatment services to MassHealth eligible children as stipulated below. The early intervention services are highly structured, evidence based, individualized, person-centered treatment programs that address the core symptoms of autism spectrum disorder (ASD). -A waiting list is not allowable for this program. The approval of this program under this section 1115 authority does not preclude Massachusetts' obligation to furnish all medically necessary services to children aged 0 to age 21 under the State Plan EPSDT benefit pursuant to section 1905(r) of the Social Security Act.

- a) Eligibility. The state will limit eligibility to MassHealth eligible children, ages 0 through three years with a confirmed diagnosis of one of the following codes: Autism Spectrum Disorder code 299.00 or 299.01 according to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or a diagnosis of autism spectrum disorder in any updated version of this manual, and must be conferred by a physician or a licensed psychologist; have an Individualized Family Service Plan (IFSP) that identifies medically necessary ABA-based services; and who are not otherwise enrolled in the state's currently approved section 1915(c) HCBS waiver entitled "Children's Autism Spectrum Disorder Waiver," CMS base control number 40207, because the child has not been determined to meet institutional level of care requirements.
- b) Individualized Family Service Plan (IFSP). Massachusetts will utilize a universal IFSP form approved by the Massachusetts Department of Public Health that includes the elements required under Part C of the Individuals with Disabilities Education Act (IDEA) and Massachusetts Early Intervention Operational Standards. The form will utilize a child-centered and family-directed planning process intended to identify the strengths, capacities, preferences, needs, and desired outcomes for the child.

The IFSP is a written plan that is developed for each eligible infant and toddler with a disability according to the Part C regulations under the IDEA. The IFSP specifies the child's: service coordinator; present levels of development; and family resources, priorities, and concerns. It also includes measurable results or outcomes and the criteria,

procedures, and timelines used to determine the degree to which progress toward achieving the results or outcomes identified in the IFSP is being made. There is also a statement of the specific early intervention services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family to achieve the results or outcomes identified including: beginning date, length, duration, frequency, intensity, method of delivering, and location of the services. The IFSP will also include a statement that the ABA-based treatment will be provided in the natural environment for that child to the maximum extent appropriate, or a justification as to why the service will not be provided in the natural environment. The IFSP must specify the identification of medical or other services such as ABA-based treatment the child needs or is receiving through other sources, including title XIX. The plan will be reviewed and updated at least annually.

- c) Benefits. Participants are eligible to receive ABA-based services. All treatment must be evidence-based, and newer interventions for which there is no evidence of effectiveness may not be employed until such time as there is at least emerging evidence to fully support the intervention's appropriate usage and assure the health and safety of demonstration enrollees. There is no annual maximum benefit.

The following services will be provided as ABA-based treatment:

- 1) Assessment of child's functional skills across domains impacted by ASD;
- 2) Development of individualized treatment plan to teach new skills;
- 3) Direct child instruction to teach new skills;
- 4) Functional behavioral assessment and support plan to decrease problematic behavior and increase appropriate behavior when indicated;
- 5) Family training to assist family, extended family, and non-paid caregivers in generalization of skills into the child's natural routines and in management of behavior; and
- 6) Supervisory session to ensure consistency in instructional practices, data collection accuracy, and to make program adjustments as needed.

- d) Delivery System. MassHealth will provide ABA-based treatment services to children through the fee for service delivery system. Children who are enrolled in a contracted managed care organization (MCO) will receive the services as a fee for service "wrap" to the MassHealth covered services.

- e) Behavioral Supports and Coordination. Provider specifications for each service specified above are as follows:

- 1) Board-Certified Behavioral Analyst: hold a doctoral or master's degree and meet certification requirements of the Behavior Analyst Certification Board;
- 2) Supervising Clinician: hold a degree in psychology, education or related field, and any related state licensure for the discipline;
- 3) Therapist: hold a bachelor's degree; one year experience with children with autism is preferred; and
- 4) Specialty Associate: have one year experience providing care for a child on the autism spectrum.

- f) Provider Participation. All providers must participate in MassHealth. The Department of Public Health shall require that direct care personnel providing the ABA-based treatment will attain provisional certification prior to billing Medicaid for any direct services. Entities or individuals that have responsibility for IFSP development may not provide ABA-based treatment to a demonstration enrollee.
- g) Cost-Sharing. MassHealth cost sharing requirements will apply to children who are both eligible for MassHealth, and the ABA-based services. Cost-sharing requirements for MassHealth enrolled children who receive the ABA-based treatment will be the same as the cost-sharing requirements for all other section 1115 demonstration waiver participants as outlined in Attachment B.
- h) Payment. Before providing the services outlined in subparagraph (c) and claiming FFP under this component of the demonstration, the state must submit a protocol to CMS for CMS approval that outlines the methodology of the payment rate and the actual rates provided to demonstration participants outlined in subparagraph (c) which are provided by providers specified in subparagraphs (e) and (f). This deliverable will be future Attachment G.

Proposed rates and any proposed changes to such rates will be subject to public notice. Any changes to the payment protocol are subject to CMS approval as outlined above.

- i) Self Direction. Families of children who are eligible to receive the ABA-based services may participate in electing the evidence based intervention treatment model for their child. Parents or other legally responsible relatives will be given the opportunity to interview providers before making the selection of a particular treatment model or provider.
- j) Assurances. The state must meet the following requirements:
 - 1) Assure CMS that Part C grant funds will not be used as the non-federal share for Medicaid purposes;
 - 2) Comply with all other requirements of Part 303 of the IDEA, Early Intervention Program for Infants and Toddlers with Disabilities in accordance with the provision of the ABA-based treatment;
 - 3) Must not permit restraint or seclusion during the course of service delivery; and
 - 4) Assure that direct service workers accused of abuse or neglect will not provide services to MassHealth enrollees receiving ABA-based treatment until the state's investigation process is completed.
- k) Quality Strategy for ABA-Based Treatment Services. The state must implement an overall Quality Assurance and Improvement (QAI) strategy that assures the health and welfare of children receiving the ABA-based services. The strategy will be consistent with the general quality requirements for Medicaid home and community-based services (HCBS) through other sections of the Act such as sections 1915(c) and 1915(i).

Through an ongoing discovery, remediation and improvement process the state will monitor, at a minimum:

- 1) IFSP determinations and service delivery;
- 2) Provider qualifications;
- 3) Enrollee health and welfare;
- 4) Financial oversight between the State and Federal programs; and
- 5) Administrative oversight.

The state must also monitor such items as medical necessity determinations for ABA-based treatment, timeliness of service delivery, improvement and sustainability of functional abilities of enrolled children, effectiveness of treatment type, and staff training. The state will submit its QAI strategy for ABA-based treatment by July 31, 2014. During the time the demonstration is effective, the state assures CMS it will implement the strategy and update it as needed in part based on findings listed in the annual report described below.

- 1) Annual Report. The state shall provide CMS with a draft annual HCBS report as part of the annual report requirement for the demonstration as stipulated in STC 62. The first draft HCBS report will be due no later than October 1, 2014. The HCBS report will at a minimum include:
 - 1) An introduction;
 - 2) A description of each ABA-based treatment;
 - 3) An overarching QAI strategy that assures the health and welfare of enrollees receiving HCBS that addresses the: (a) enrollee's person-centered individual service plan development and monitoring, b) specific eligibility criteria for particular HCBS, c) provider qualifications and/or licensure, d) health and safety, d) financial oversight between State and Federal programs, and e) administrative oversight by the State Medicaid Agency;
 - 4) An update on services used by enrollees;
 - 5) The various treatment modalities employed by the state, including any emerging treatments, updated service models, opportunities for self-direction, etc.;
 - 6) Specific examples of how the services have been used to assist demonstration enrollees;
 - 7) A description of the intersection between demonstration ABA-based treatment and any other state programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures; and
 - 8) Other topics of mutual interest between CMS and the state related to the ABA-based treatment.

The annual report may also address workforce development, certification activity, self-direction, and capacity in the state to meet needs of the population receiving the services, and rebalancing goals related to HCBS. Additionally, the annual report will summarize the outcomes of the state's Quality Strategy for HCBS as outlined above. The state may also choose to provide CMS with any other information it believes pertinent to the provision of the ABA-based treatment services/HCBS and their inclusion in the demonstration, including innovative practices, cost-effectiveness, and short and long-

term outcomes in the annual report.

VI. DELIVERY SYSTEM

The MassHealth section 1115 demonstration provides benefits through multiple delivery systems and programs. A fundamental philosophy of MassHealth is that the Commonwealth will enable beneficiaries to take advantage of available and qualified employer-sponsored insurance (ESI) when cost effective. These circumstances include the availability of ESI, the employer's contribution level meeting a state-specified minimum, and its cost-effectiveness. MassHealth pays for medical benefits directly (direct coverage) only when no other source of payment is available and cost-effective. Beneficiaries are required, as a condition of eligibility under some coverage types, to obtain or maintain private health insurance when MassHealth determines it is cost effective to do so, with the premium assistance necessary to make it affordable for the beneficiary. All demonstration programs except MassHealth Limited have a premium assistance component.

41. Direct Coverage. MassHealth benefits provided through direct coverage are delivered both on a fee for service (FFS) and capitated basis under the demonstration. As described below in Table D, MassHealth may require beneficiaries eligible for direct coverage under Standard, Standard ABP, Family Assistance, CommonHealth, or CarePlus to enroll in managed care. Generally, these individuals can elect to receive services either through the statewide Primary Care Clinician (PCC) Plan or from a MassHealth-contracted managed care organization (MCO). Managed care enrollment is mandatory for CommonHealth members with no third party liability. In addition, children who are clients of the Departments of Children and Families (DCF) or Youth Services (DYS) who do not choose a managed care plan are required to enroll with the behavioral health contractor for behavioral health services and may choose to receive medical services on a fee-for-service basis.

Children eligible under TEFRA section 134 (Kaileigh Mulligan) and children receiving title IV-E adoption assistance may opt to enroll in managed care or receive health services via fee-for-service. Children who choose managed care may choose a managed care organization (MCO) or a PCC plan. Children who choose an MCO will receive their behavioral health services through the MCO. Children who choose the PCC Plan will receive their behavioral health services through the behavioral health contractor. Children who choose fee-for-service will be passively enrolled with the behavioral health contractor for behavioral health services, but have the ability to opt-out and receive behavioral health services through the fee-for-service provider network.

42. Managed Care Arrangements. MassHealth may implement, maintain, or modify (without amendment to the demonstration), and any managed care arrangements authorized under section 1932(a) of the Act or 42 CFR 438 et seq., including:

- a) **PCC Plan.** The PCC Plan is a primary care case management program administered by MassHealth. In the PCC Plan, members enroll with a PCC who provides most primary and preventive care and who is responsible for providing referrals for most specialty services. Members can access specialty services from any MassHealth provider, subject to PCC referral and other utilization management requirements. Members enrolled in the PCC Plan receive mental health and substance abuse services through a single Behavioral

Health Program (BHP) contractor, which is a Prepaid Inpatient Health Plan (PIHP). The PCC Plan members are guaranteed freedom of choice of provider for family planning services and are able to obtain these services from any participating Medicaid provider without consulting their PCC or obtaining MassHealth's prior approval.

- b) Enhanced Primary Care Clinician Payments. In accordance with 42 C.F.R. section 438.6(c)(5)(iv), MassHealth may establish enhanced fee-for-service rate payments or capitated rate payments to Primary Care Clinicians for coordination of the care delivered to their enrolled PCC plan members. MassHealth may also establish pay-for-performance incentives using capitated or other payment arrangements for achieving certain quality of care benchmarks, for demonstrating certain levels of improvement for selected Healthcare Effectiveness Data and Information Set (HEDIS) or other quality indicators, and for implementing practice infrastructure designed to support the delivery of high-quality health care services to enrolled members.
- c) Patient Centered Medical Home Initiative (PCMHI). The PCMHI is a multi-payer initiative to transform selected primary care practice sites into PCMHs by 2015. MassHealth is a dominant public payer in the PCMHI and is assuming the same responsibilities as other participating payers both for enrollees in its PCC Plan and those in Medicaid contracted MCOs. The PCMHI practices must meet reporting requirements on clinical and operational measures, in addition to certain benchmarks to indicated continued progress towards medical home transformation, such as obtaining National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medicaid Home (PPC®-PCMH™) Level One recognition. Any infrastructure support provided to Primary Care Clinicians who participate as PCMHI providers must be funded by the infrastructure and capacity-building component of the SNCP as referenced in STC 50(c). A formal evaluation of the PCMHI is also being conducted and should be included as relevant to the demonstration in draft evaluation design as per STC 90.
- d) MCO. MassHealth contracts with MCOs that provide comprehensive health coverage including behavioral health services to enrollees. MCO enrollees may receive family planning services from any provider without consulting their PCP or MCO and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in the MCO network, MassHealth reimburses the provider on a FFS basis and recoups the funds from the MCO. MassHealth CarePlus members must enroll in an MCO if two or more MCOs are available in the member's service area. If there are fewer than two MCOs available in the member's service area, MassHealth CarePlus members may enroll in the available MCO or in the PCC Plan. MassHealth Standard, CommonHealth and Family Assistance members who either choose or are assigned to a health plan may transfer to another available health plan in their geographic service area at any time for any reason, except that individuals receiving MassHealth CarePlus may transfer to another available health plan in their geographic service area for any reason, but the transfer will be effective on the first of the month following the request to transfer unless it is a transfer for cause which will be effective immediately.

43. **Exclusions from Managed Care Enrollment.** The following individuals may be excluded from enrollment in a MassHealth-contracted managed care plan:

- a) Individuals for whom MassHealth is a secondary payer (i.e., a member with other health insurance). For purposes of exclusion from managed care, “other health insurance” is defined as any medical coverage plan available to the member, including, but not limited to Medicare, CHAMPUS, or a private health plan. However, MassHealth requires children eligible for MassHealth Standard/Standard ABP and CommonHealth, for whom MassHealth is a secondary payer, to enroll with the behavioral health contractor for behavioral health services;
- b) Individuals receiving benefits during the hospital-determined presumptive eligibility period or the time-limited period while MassHealth investigates and verifies access to qualified and cost-effective private health insurance or the time-limited period while the member is enrolling in such insurance;
- c) Individuals receiving Limited coverage;
- d) Individuals receiving hospice care, or who are terminally ill as documented with a medical prognosis of a life expectancy of 6 months or less; and
- e) Participants in a Home and Community-Based Services Waiver who are not eligible for SSI and for whom MassHealth is not a secondary payer. MassHealth may permit such individuals to enroll in managed care, including the option to enroll with the behavioral health contractor for behavioral health services and receive their medical services on a fee-for-service basis.

44. **Contracts.**

- a) Managed Care Contracts. All contracts and modifications of existing contracts between the Commonwealth and MCOs must be prior approved by CMS. The Commonwealth will provide CMS with a minimum of 30 days to review and approve changes.
- b) Public Contracts. Contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index), unless the contractual payment rate is set at the same rate for both public and private providers. This requirement does not apply to contracts under the SNCP as outlined in STC 50 (a)(3), (c), (d) and (e).
- c) Selective Contracting. Procurement processes and the subsequent final contracts developed to implement selective contracting by the Commonwealth with any provider group shall be subject to CMS approval prior to implementation, except for contracts authorized pursuant to 42 C.F.R. section 431.54(d).

- d) Patient Centered Medical Home Initiative (PCMHI). Details regarding the PCHMI may be found in the Commonwealth’s PCC and MCO contracts.

45. MassHealth Premium Assistance. For most individuals eligible for MassHealth, the Commonwealth may require as a condition of receiving benefits, enrollment in available insurance coverage. In that case, Massachusetts provides a contribution through reimbursement or direct payment to the insurer, toward an employed individual’s share of the premium for a commercial plan which meets a basic benefit level (BBL). The Commonwealth has identified the features of a qualified health insurance product, including covered benefits, deductibles and co-payments, which constitute the BBL. Each commercial plan is measured against the BBL, and a determination is then made regarding the cost-effectiveness of providing premium assistance. For individuals eligible for premium assistance only through the SBE ESI program, this same test will apply.

If available and cost effective, the Commonwealth will provide premium assistance on behalf of individuals eligible for Standard or CommonHealth coverage, to assist them in the purchase of private health insurance coverage. The state will also provide coverage for additional services required to ensure that such individuals are receiving no less than the benefits they would receive through direct coverage under the state plan. This coverage will be furnished, at the state option, on either a FFS basis or through managed care arrangements. These individuals are not required to contribute more towards the cost of their private health insurance than they would otherwise pay for MassHealth Standard, or CommonHealth coverage. Cooperation with the Commonwealth to obtain or maintain available health insurance will be treated as a condition of eligibility for all of those in the family group, except those who are under the age of 21, or pregnant. Effective January 1, 2014, these premium assistance provisions also apply to individuals in the New Adult Group.

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

Table D. Delivery System and Coverage for MassHealth Demonstration Programs

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
<u>Standard/Standard ABP</u>					
Individuals with no third party liability (TPL)	MCO or PCC Plan**	x			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI	Premium assistance with wrap			x	10 days prior to date of application
Kaileigh Mulligan eligible children and children receiving title IV-E adoption assistance	Behavioral health is typically provided via BHP PIHP, although a FFS alternative must be available; all other services are offered via MCO, PCCP Plan or FFS.		x		Kaileigh Mulligan - may be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided.” Title IV-E adoption assistance -start date of adoption
Medically complex children in the care/custody of the DCF	Special Kids Special Care MCO		x		Start date of state custody
Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF	All services are offered via MCO, PCC Plan or FFS, with the exception of behavioral health which is provided via mandatory enrollment in BHP PIHP unless a child	x	x	x	Start date of state custody

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
	is enrolled in an MCO (in which case, behavioral health is provided through the MCO).				
Provisionally eligible pregnant women and children, for an up to 90-day period, before self-attested family income is verified	FFS			x	10 days prior to date of application if citizenship/immigration status is verified
Individuals in the Breast and Cervical Cancer Treatment Program	MCO or PCC Plan	X			10 days prior to date of application
<u>CommonHealth*</u>					
Individuals with no TPL	MCO or PCC Plan**	X			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for HIV/AIDS*</u>					
Individuals with no TPL	MCO or PCC Plan**	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Individuals with qualifying ESI	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for Children***</u>					
Individuals with no TPL	MCO or PCC Plan**	X			10 days prior to date of application
Individuals with qualifying ESI	Premium assistance with wrap			x	10 days prior to date of application
<u>CarePlus</u>					
Individuals with no TPL	MCO only (if there are two MCOs in the area)	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application
Individuals with qualifying ESI	Premium assistance with wrap			X	10 days prior to date of application
<u>Small Business Employee Premium Assistance</u>					
Individuals with qualifying ESI	Premium assistance for employees			N/A	First month's premium payment following determination of eligibility
<u>Limited</u>					
Individuals receiving emergency services only	FFS			x	10 days prior to date of application
<u>Home and Community-Based Waiver, under age 65</u>	Generally FFS, but also available through voluntary MCO or PCC Plan		x		May be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided.
Health Connector Subsidies	Premium assistance only	x			Start date of QHP/Health Connector benefits
<u>Chart Notes</u>					

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
*TPL wrap could include premium payments					
**FFS until member selects or is auto-assigned to MCO or PCC Plan; if fewer than two MCOs are available in a CarePlus member's service area, the member must enroll in the PCC Plan or MCO					
***Presumptive and time-limited during health insurance investigation					
****All retroactive eligibility is made on a FFS basis					

VII. COST SHARING

47. **Overview.** Cost-sharing imposed upon individuals enrolled in the demonstration and eligible under the state plan or in a “hypothetical” eligibility group is consistent with the provisions of the approved state plan except where waived in the demonstration expenditure authorities. Cost sharing for individuals eligible only through the demonstration varies across demonstration programs and by FPL, except that no co-payments are charged for any benefits rendered to children under age 19, individuals ages 19 or 20 or pregnant women. Additionally, no premium payments are required for any individual enrolled in the Demonstration whose gross income is less than 150 percent FPL. Please see Attachment B for a full description of cost-sharing under the demonstration for MassHealth-administered programs. The Commonwealth has the authority to change cost-sharing for the Small Business Employee Premium Assistance programs without amendment. Updates to the cost-sharing will be provided upon request and in the annual reports.

VIII. THE SAFETY NET CARE POOL (SNCP)

48. **Description.** The Safety Net Care Pool (SNCP) was established effective July 1, 2005 for the purpose of reducing the rate of uninsurance in the Commonwealth while providing residual provider funding for uncompensated care, and care for Medicaid FFS, Medicaid managed care, Commonwealth Care and low-income uninsured individuals, as well as infrastructure expenditures and access to certain state health programs related to vulnerable individuals, including low-income populations as described in Attachment E. As the Commonwealth has achieved significant progress in increasing access to health coverage, the SNCP has evolved to support delivery system transformation and infrastructure expenditures, both aimed at improving health care delivery systems and thereby improving access to effective, quality care. In DYs 21 and 22 Massachusetts is not currently authorized to make SNCP provider payments. During this demonstration period, the Commonwealth and CMS will collaborate to reach agreement on a redesigned SNCP structure for DYs 21 and 22 that ensures the Commonwealth can sustainably support delivery of care to low-income populations and align with system-wide transformation. If an amendment to the demonstration for restructured SNCP provider payments for DYs 21 and 22 is not approved, Massachusetts will resume making DSH payments in accordance with an approved State plan pursuant to section 1902(a)(13)(A)(iv) of the Social Security Act.

49. SNCP Operational Authority and Effective Date.

a) **Coordination of funding with Temporary Extension period.** For the period operating under temporary extension from July 1, 2014, through the period prior to the date of the approval letter, all SNCP expenditures were authorized up to the amount of the DSH allotment for SFY 2015, with the exception of Commonwealth Care Orderly Closeout and Temporary Coverage DSHPs which were funded through budget neutrality savings. The aggregate SNCP cap must be reduced by Commonwealth Care Orderly Closeout and Temporary Coverage DSHP expenditures for the temporary extension period to reflect this exception.

b) **Operation through June 30, 2017.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, the Commonwealth is currently only authorized to operate the SNCP through June 30, 2017, with the exception of the Health Connector Subsidies which are authorized through June 30, 2019. All STCs, waivers and expenditure authorities relating to the SNCP are effective for dates of service beginning on the date of the approval letter through June 30, 2017 unless otherwise provided in these STCs and reflected in Attachment E.

50. **Expenditures Authorized under the SNCP.** The Commonwealth is authorized to claim as allowable expenditures under the demonstration, to the extent permitted under the SNCP limits under STC 51, the following categories of payments and expenditures. The Commonwealth must identify the provider and the source of non-federal share for each component of the SNCP. Federally-approved payments and expenditures within these categories are specified in Attachment E. The Commonwealth must only claim expenditures at the regular FMAP for these programs.

a) Designated State Health Programs

- (1) Commonwealth Care Orderly Closeout. This authority expires on February 28, 2015. - The Commonwealth may claim as allowable expenditures under the demonstration to the extent permitted under the SNCP limits under STC 51. For dates of service January 1, 2014 through February 28, 2015, the Commonwealth may claim as allowable expenditures under the demonstration costs of an orderly closeout of the Commonwealth Care premium assistance program, as described in Attachment E, chart A. Allowable expenditures under this program will be subject to the aggregate SNCP limit described in STC 51.
- (2) Temporary Coverage. This authority expires on February 28, 2015. For dates of service from January 1, 2014 through February 28, 2015, the Commonwealth may claim as allowable expenditures under the demonstration, for a state-funded program to ensure temporary Fee for Service (FFS) state operated coverage for individuals who are not able to receive a full eligibility determination for MassHealth or Marketplace coverage. The Commonwealth assures that no federal funds will be claimed for temporary coverage program expenditures for individuals whose enrollment in other coverage options has become effective or whose income is ultimately found to be higher than 400 percent of the federal poverty level (FPL) and are not eligible for MassHealth coverage during the period the expenditure authorities are in effect. Massachusetts also assures that its reconciliation process for the state transition program is auditable. Allowable expenditures under this program will be subject to the aggregate SNCP limit described in STC 51.
- (3) Other State-Funded Programs. The Commonwealth may claim as allowable expenditures under the demonstration expenditures for designated programs that provide or support the provision of health services and initiatives that promote cost containment and that are otherwise state funded, as specified in Attachment E

of the STCs, for dates of service beginning as of the date of the approval letter through June 30, 2017. Allowable expenditures under this program will be subject to the DSHP limit described in STC 51.

- (4) Health Connector Subsidies. For dates of service January 1, 2014 through June 30, 2019, the Commonwealth may claim as allowable expenditures under the demonstration Health Connector subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for individuals with incomes above 133 percent of the FPL through 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 300 percent of the FPL. Federal financial participation for the premium assistance portion of Health Connector subsidies for citizens and eligible qualified non-citizens will be provided through the Designated State Health Programs authority under the SNCP pursuant to this STC. Allowable expenditures for Health Connector subsidies will not be subject to the DSHP cap and aggregate SNCP limit described in STC 51.
- b) Providers. For dates of service beginning July 1, 2014, as described in Attachment E, the Commonwealth may claim as an allowable expenditure under the demonstration to the extent permitted under the SNCP limits under STC 51, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, Medicaid managed care, and low-income uninsured individuals. The Commonwealth may also claim as an allowable expenditure payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).
- c) Infrastructure and capacity-building. The Commonwealth may claim as allowable expenditures under the demonstration to the extent permitted under the SNCP limits under STC 51 expenditures that support capacity-building and infrastructure for the improvement or continuation of health care services that benefit the uninsured, underinsured, MassHealth, demonstration and SNCP populations. Infrastructure and capacity-building funding may also support the improvement of health care services that benefit the demonstration populations as outlined in STCs 39 and 42(c). Activities related to Delivery System Transformation Initiatives are prohibited from also being claimed as infrastructure and capacity-building. In the annual report as required by STC 62, the Commonwealth must provide the actual amount, purpose and the entity each associated payment was made to for this component of the SNCP.
- d) Delivery System Transformation Initiatives (DSTI). The Commonwealth may claim as allowable expenditures under the demonstration, to the extent permitted under the SNCP limits under STC 51, incentive payments to providers for the development, implementation, and improvement of programs that support hospitals' efforts to enhance

access to health care, improve the quality of care and the health of the patients and families they serve and build the capacity to participate in payment reform strategies and models. Massachusetts must use an independent assessor to evaluate DSTI hospital Semi-Annual and Annual reports and determine whether the state and hospitals have achieved the specified metrics and measures. FFP at the administrative match rate is available for the independent assessor.

- 1) Eligibility. The program of activity funded by the DSTI shall be based in public and private acute hospitals, with a high, documented Medicaid patient volume, that are directly responsive to the needs and characteristics of the populations and communities. Therefore, providers eligible for incentive payments are defined as public or private acute hospitals with a high Medicaid payer mix and a low commercial payer mix based on the 2009 cost report data . The hospitals eligible for incentive payments, over this demonstration period, based on this criterion, are listed in Attachment I.
- 2) Master DSTI Plan. The Commonwealth must submit to CMS for approval a “master” DSTI plan (future attachment J). The master plan must:
 - i. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by hospitals;
 - ii. Specify the DSTI categories consistent with subparagraph (4) below, and detail the associated projects, population-focused objectives and evaluation metrics from which each eligible hospital will select to create its own plan;
 - iii. Detail the requirements of the hospital-specific plans discussed in subparagraph (3) and STC 52; and
 - iv. Specify all requirements for the DSTI plans and funding protocol pursuant to STC 52.
- 3) Hospital-specific Plans. Upon CMS approval of the Commonwealth’s master DSTI plan, each participating hospital must submit an individual DSTI plan approved by the state and CMS that identifies the projects, population-focused objectives, and specific metrics adopted from the master DSTI plan and meets all requirements pursuant to STC 52. CMS shall approve each hospital’s DSTI plan following the state review process pursuant to STC 52(a)(6), provided that the plan(s) meet all requirements of the approved master DSTI plan outlined in STC 50 and STC 52 in addition the requirements outlined for the hospital specific DSTI plans pursuant to STC 52(b) and the approved DSTI payment and funding protocol pursuant to STC 52 (c).

Participating hospitals must implement new, or significantly enhance existing health care initiatives. The hospital-specific DSTI plans must address all four categories, as outlined in subparagraph (4) below, but each hospital is not required to select all projects within a given category. Each individual hospital DSTI plan must include a minimum number of projects selected within each category as

outlined in the master DSTI plan and report on progress to receive DSTI funding. Eligibility for DSTI payments will be based on successfully meeting metrics associated with approved projects as outlined in subparagraph (8) and the submission of required progress reports outlined in STC 53(d)(1).

- 4) **DSTI Categories and Projects.** Each participating hospital must select a minimum number of projects from each category as outlined in the master DSTI plan. Additionally, the projects must be consistent with the overarching approach of improving health care through the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The selected projects will be detailed in the hospital-specific plans described in subparagraph (3) and STC 52. Each project, depending on the purpose and scope of the project, may include a mix of process-oriented metrics to measure progress in the development and implementation of infrastructure and outcome metrics to measure the impact of the investment. Metrics are further discussed in subparagraph (5) and STC 52.

There are four categories for which funding authority is available under the DSTI, each of which has explicit connection to the achievement of the Three Part Aim mentioned in the preceding paragraph:

Category 1: Development of a fully integrated delivery system: This category includes investments in projects that are the foundation of delivery system change to encompass the concepts of the patient-centered medical home (PCMH) model to increase delivery system efficiency and capacity. Examples include:

- i. Investments in communication systems to improve data exchange with medical home sites
- ii. Integration of physical and behavioral health care
- iii. Development of integrated care networks across the continuum of care
- iv. Investment in patient care redesign efforts, such as patient navigators, alternative delivery sites, alternative office hours, etc.

Category 2: Improved Health Outcomes and Quality: This category includes development, implementation and expansion of innovative care models which have the potential to make significant demonstrated improvements in patient experience, cost and care management. Examples include:

- i. Implementation of Enterprise-wide Care Management or Chronic Care Management initiatives, which may include implementation and use of disease management registries
- ii. Improvement of care transitions, and coordination of care across inpatient, outpatient, post-acute care, and home care settings
- iii. Adoption of Process Improvement Methodologies to improve safety, quality, and efficiency

Category 3: Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments that promote system sustainability. Examples include:

- i. Enhancement of Performance Improvement and Reporting Capabilities
- ii. Development of enhanced infrastructure and operating and systems capabilities that would support new integrated care networks and alternative payment models to manage within new delivery and payment models
- iii. Development of risk stratification capabilities/functionalities

Category 4: Population-Focused Improvements. This category involves evaluating the investments and system changes described in categories 1, 2 and 3 through population-focused objectives. Metrics must evaluate the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers. Metrics must also evaluate the impact of the payment redesign and infrastructure investments to improve areas such as cost efficiency, systems of care, and coordination of care in community settings. All hospitals must report on metrics selected from a nationally validated or where applicable, a state validated common set of metrics defined in the master DSTI plan.

- 5) **DSTI Metrics and Evaluation.** Each eligible provider must develop process-oriented and outcome metrics for each of the Categories 1, 2 and 3 that demonstrate clear project goals and objectives to achieve systematic progress. Examples of such project metrics may include: identification and purchase of system, programming of system, going live on a system, contracting with a payer using a bundled payment system, enrollment of a defined percentage of patients to a Medical Home model, increase by a defined amount the number of primary care clinics using a Care Management model, improve by a defined percentage patients with self-management goals, increase by a defined amount the number of patients that have an assigned care manager team, etc.

Metrics related to Category 4 shall recognize that the population-focused objectives/projects do not guarantee outcomes, but may impact outcomes. The objectives/projects must result in learning, adaptation and progress toward the desired outcome. These metrics must quantitatively measure the impact of the projects in Categories 1, 2, and 3 (e.g. disease measurements, ER admissions, cost management, etc.) on each participating provider's patient population.

- 6) **Funding At Risk for Outcomes and Quality Improvement:** The percentage of DSTI funding at risk for improved performance on validated outcome or quality measures will gradually increase from 0 percent in SFY 2015 to 10 percent in SFY 2016 to 20 percent in SFY 2017 (averaging to 10 percent total over the three year period). This accountability structure is on a provider-specific basis. In addition, CMS will retain the existing "pass/fail" funding accountability for metrics associated with project activities (structural and process). Outcome measures focus on assessing progress on health outcomes that result from the structural and process modifications or improvements. Examples include impacts on morbidity, mortality, or readmissions. The specific outcome and quality measures will be defined in the approved Master DSTI Plan and hospital-specific plans described in STC 52. Examples of approvable metrics for outcome measures include but are not limited to:

- i. Agency for Healthcare Research and Quality (AHRQ) inpatient quality indicators and pediatric quality indicators
- ii. National Quality Forum
- iii. CMS Adult or Child Core Measures
- iv. CMS Inpatient Quality Reporting (CMS-IQR)/Joint Commission
- v. The U.S. Preventive Services Task Force (USPSTF) Preventive Measures
- vi. AHRQ Preventive Quality Indicators
- vii. National Quality Forum (NQF) 0028 – Preventive Care and Screening
- viii. NQF 0712 - Screening for clinical depression
- ix. Transition of Care Measure CTM-3
- x. NQF 0554: Medication Reconciliation Post-Discharge (MRP)
- xi. NQF 0441 – Assessed for rehabilitation
- xii. NQF 1604 – Total Cost of Care Population Based PMPM Index
- xiii. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- xiv. National Committee for Quality Assurance (NCQA)
- xv. Massachusetts Patient-Centered Medical Home Initiative Measures

7) Aggregate DSTI Outcome and Quality Improvement Accountability. Overall DSTI project funding is available up to the amounts specified in the special terms and conditions and Attachment E. As a general matter, DSTI funding is subject to the provider meeting the specific metric in the approved Master DSTI Plan. In addition, pool wide achievement of performance goals and targets must be achieved or maintained for full access to the funding level specified in the STCs, Attachment E and the DSTI Master Plan. Performance goals and targets for the DSTI providers will be defined in the Master DSTI Plan. The performance goals and targets will be based on the four domains described above. In DY 20 (SFY 2017) (the third year of the renewal period), the DSTI hospitals must show improvement relative to DY 18 (SFY 2015) performance baselines. If the DSTI providers do not meet the required aggregate performance goals as specified by the DSTI Master Plan by the end of year three, the DSTI pool will be subject to a five percent reduction in available funding. In other words, if the DSTI hospitals do not demonstrate the aggregate performance improvements as specified in the DSTI Master Plan, five percent of the DY 20 DSTI funding will be withheld.

This reduction, if applicable, will be taken at the end of the three year period.

The five percent reduction is an aggregate pool wide penalty based on three years of performance. It is not an additional penalty imposed on an individual provider for not meeting a specific metric. CMS will work with the Commonwealth to assure that any reduction penalty is equitable.

8) DSTI Payments. DSTI payments for each participating provider are contingent on that provider meeting project metrics as defined in the approved hospital-specific plans. As further discussed in subparagraph (9) below, the master DSTI plan and payment and funding protocol, as required by STC 52, includes an incentive payment formula. Payment cycles to providers are described in the DSTI funding

protocol and will be made at a minimum on a semi-annual basis contingent upon providers meeting the associated metrics. The actual metrics for incentive payments and the amount of incentive payments disbursed in a given year will be outlined pursuant to the approved master DSTI plan, hospital-specific plans and funding protocol requirements outlined in STC 52 and the reporting requirements outlined in STC 53. In DY18, approval of the hospital-specific plans will be considered an appropriate metric for the first incentive payment, and will equal up to 25 percent of the DY 18 total annual amount of DSTI funding a hospital is eligible for based upon incentive payments.

DSTI payments are not direct reimbursement for expenditures or payments for services. DSTI payments are intended to support and reward hospital systems for improvements in their delivery systems and payment models that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The payments are not direct reimbursement for expenditures incurred by hospitals in implementing reforms. The DSTI payments are not reimbursement for health care services that are recognized under these STCs or under the state plan.

DSTI payments should not be considered patient care revenue and will not be offset against other Medicaid reimbursements to hospital systems, including payments funded through approved intergovernmental transfers, or approved certified public expenditures incurred by government owned or operated hospital systems and their affiliated government entity providers for health care services, infrastructure and capacity-building, administrative activities, or other non-DSTI payment types authorized under these STCs and/or under the state plan.

- 9) Distribution of DSTI Funds among Hospitals: Attachment I specifies the hospitals eligible for DSTI over the demonstration approval period and outlines available DSTI funds for participating providers to earn through DSTI incentive payments for SFY 2015 - 2017.

The master DSTI plan, and payment and funding protocol, as outlined in STC 52, must specify the DSTI incentive payment formula and denote the total annual amount of DSTI incentive payments each participating hospital may be eligible for based upon the projects and metrics it selects. The incentive payment formula must identify per metric the following: (1) the annual base amount of funding per metric associated with the each category pursuant to STC 50(d)(4); (2) increases to that base amount associated with a hospital's proportional annual DSTI allowance; and (3) a rationale for any percentage adjustments made to a hospital's calculated DSTI allowance to account for factors such as differences in quality infrastructure, differences in external supports for improvements, and differences in patient populations to be identified in the master DSTI plan.

- 10) FFP. FFP is not available for DSTI payments to a participating provider until the DSTI master plan, the individual provider's plan and the funding protocol outlined

in STC 52 are approved by CMS. DSTI payments to a particular provider are contingent upon whether that participating provider meets project metrics as defined in its hospital-specific plan, and are subject to legislative appropriation and availability of funds. FFP is available only for DSTI payments that are made in accordance with the master DSTI plan and the applicable hospital-specific plan.

- e) Cambridge Health Alliance (CHA) Public Hospital Transformation and Incentive Initiatives. CHA is the Commonwealth's only public acute hospital and has the highest concentration of patients participating in MassHealth demonstration programs of any acute hospital in the Commonwealth. Through June 30, 2017, CHA will implement behavioral health integration initiatives as well as other approved initiatives. CHA identified that integrating primary care and behavioral health will help address the significant health disparities, and additional initiatives will support CHA's ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety-net populations it serves. Details regarding the Metrics and Evaluation of the initiatives will be outlined in future Attachment K. Unless otherwise noted in Attachment K, CHA's Public Hospital Transformation and Incentive Initiatives must comply with DSTI requirements, including carry-forward and reclamation provisions, as outlined in STC 52. Reflecting the size of the federal commitment to CHA and CHA's emphasis on short-term delivery system transformation, the percentage of CHA Public Hospital Incentive Initiative specific funding at risk for outcome measures goes from 0 percent in SFY 2015 to 15 percent in SFY 2016 to 30 percent in SFY 2017 (averaging 15 percent over the three year period). In DY18, CMS approval of CHA's initiatives will be considered an appropriate metric for the first incentive payment, and will equal up to 25 percent of the DY 18 total annual amount of Public Hospital Transformation and Incentive Initiatives funding that CHA is eligible for based upon incentive payments. Attachment E specifies the total allotment for CHA's Public Hospital Transformation and Incentive Initiatives.

CHA's Public Hospital Transformation and Incentive Initiative payments are not direct reimbursement for expenditures or payments for services. Public Hospital Transformation and Incentive Initiative payments are intended to support and reward the hospital system for improvements in its delivery systems and payment models that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The payments are not direct reimbursement for expenditures incurred by the hospital in implementing reforms. The Public Hospital Transformation and Incentive Initiative payments are not reimbursement for health care services that are recognized under these STCs or under the state plan.

Public Hospital Transformation and Incentive Initiative payments should not be considered patient care revenue and will not be offset against other Medicaid reimbursements to hospital systems, including payments funded through approved intergovernmental transfers, or approved certified public expenditures incurred by government owned or operated hospital systems and their affiliated government entity providers for health care services, infrastructure and capacity-building, administrative

activities, or other non-Public Hospital Transformation and Incentive Initiative payment types authorized under these STCs and/or under the state plan.

CMS Approval of CHA's Public Hospital Transformation and Incentive Initiatives Protocols and Plans. CMS and the state agree to the targeted approval period of 90 calendar days after the date of the approval letter. However, if CMS determines that a protocol or plan is not ready for approval on the target date, CMS will notify the state of its determination.

51. Expenditure Limits under the SNCP.

- a) Aggregate SNCP Cap. From the date of the approval letter through June 30, 2017 (SNCP extension period), the SNCP will be subject to an aggregate cap of \$4.635 billion, as well as the overall budget neutrality limit established in section XI of the STCs, provided, however, that allowable expenditures for Health Connector subsidies will not be subject to the aggregate SNCP cap or DSHP cap. Because the aggregate SNCP cap is based in part on an amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment, any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate SNCP cap, and a corresponding change to the provider cap as described in subparagraph (c). Such a change shall be reflected in STCs 51(a) and 51(c), and shall not require a demonstration amendment. The aggregate SNCP cap of \$4.635 billion is based on an annual DSH allotment of \$659,573,317 (total computable), the Commonwealth's projected DSH allotment for SFY15, and budget neutrality savings. With the exception of Health Connector Subsidies DSHP authority, the SNCP is extended for DYs 18-20 while CMS and the state transform the structure of the SNCP. The SNCP authority for Health Connector Subsidies DSHP extends through DY22.

For the period operating under temporary extension from July 1, 2014, through the period prior to the date of the approval letter, all SNCP expenditures were authorized up to the amount of the DSH allotment for SFY 2015, with the exception of Commonwealth Care Orderly Closeout and Temporary Coverage DSHPs which were funded through budget neutrality savings. The aggregate SNCP cap must be reduced by Commonwealth Care Orderly Closeout and Temporary Coverage expenditures for the temporary extension period to reflect this exception.

- b) Infrastructure Cap. The Commonwealth may expend an amount equal to no more than five percent of the aggregate SNCP cap over the SNCP extension period for infrastructure and capacity building, as described in STC 50(c). No FFP will be available to reimburse the Commonwealth for infrastructure and capacity-building until the Commonwealth notifies CMS and obtains subsequent CMS approval, of the specific activities that will be undertaken to improve the delivery of health care to the uninsured, underinsured or SNCP populations. No demonstration amendment is required for CMS approval of the specific activities for infrastructure and capacity-building. The Commonwealth must update Attachment E to reflect these activities; no demonstration amendment is required. Progress reports on all such activities must be included in the

quarterly and annual reports outlined in STCs 53,60 and 62, respectively. Infrastructure projects for which FFP is claimed under this expenditure authority are not eligible for DSTI incentive payments.

- c) Provider Cap. The Commonwealth may expend an amount for purposes specified in STC 50(b) equal to no more than the cumulative amount of the Commonwealth's annual DSH allotments for the SNCP extension period. Any change in the Commonwealth's federal DSH allotment that would have applied for the SNCP extension period absent the Demonstration shall result in an equal change to the provider cap. Such change shall not require a demonstration amendment. The provider cap is based on an annual DSH allotment of \$659,573,317 (total computable), the Commonwealth's projected annual DSH allotment for SFY 2015.
- d) DSHP Cap. Expenditure authority for DSHP is limited to \$385 million for SFY 2015, \$257 million for SFY 2016 and \$129 million for SFY 2017 through June 30, 2017. These limits do not apply to expenditure authority for the Commonwealth Care Orderly Closeout and Temporary Coverage DSHPs, as further described in Attachment E, chart A. Health Connector Subsidies are not subject to the DSHP cap. Prior CMS approval is required to make changes to Chart C of Attachment E. No demonstration amendment is required for CMS approval of updates to Chart C of Attachment E to include additional DSHP programs.
- e) Budget Neutrality Reconciliation. The Commonwealth is bound by the budget neutrality agreement described in section XI of the STCs. The Commonwealth agrees to reduce spending in the SNCP to comply with budget neutrality in the event that expenditures under the demonstration exceed the budget neutrality ceiling outlined in section XI, STC 84.
- f) Transition to Cost for Uncompensated Care Effective July 1, 2014. The SNCP payments pursuant to STC 50(b) support providers for furnishing uncompensated care. Prior to July 1, 2014, these payments were not limited to the documented cost of providing such care. During the 2011-2014 extension period, CMS and the Commonwealth worked to develop a cost limit protocol, approved by CMS on December 17, 2013 and included as Attachment H to the STCs. This protocol will ensure that beginning on July 1, 2014 all provider payments for uncompensated care pursuant to STC 50(b) will be limited on a provider-specific basis to the cost of providing Medicaid state plan services and any other additional allowable uncompensated costs of care provided to Medicaid eligible individuals and uninsured individuals, less payment received by or on behalf of such individuals for such services. The DSH audit rule definition of allowable inpatient and outpatient services and allowable uninsured costs and revenues served as the initial framework for discussions on the cost protocol. Any additional costs to be included as allowable as uncompensated were identified and included in the resulting approved cost limit protocol.

52. DSTI Plan and Funding Protocol. The state must meet the following milestones before it can claim FFP for DSTI funding:

- a) Commonwealth Master DSTI Plan. The Commonwealth must have an overarching master DSTI plan in place that has been approved by CMS. The master plan is affixed to the STCs in Attachment J. The master plan must at a minimum include:
- 1) Identification of community needs, health care challenges, the delivery system, payment reform, and population-focused improvements that DSTI will address in addition to baseline data to justify assumptions;
 - 2) Identification of the projects and objectives that fall within the four categories, as outlined in STC 50(d)(4), from which each participating hospital will develop its hospital-specific DSTI plan, and identify the minimum level of projects and population-focused objectives that each hospital must select;
 - 3) In coordination with subparagraph (a)(2) above, identification of the metrics and data sources for specific projects and population-focused objectives that each participating hospital will utilize in developing a hospital-specific DSTI plan to ensure that all hospitals adhere to a uniform progress reporting requirement;
 - 4) With regard to Category 3, the state must also identify its actions and timelines for driving payment reform;
 - 5) Guidelines requiring hospitals to develop individual hospital DSTI plans as outlined in STC 50(d)(3) and STC 52(b);
 - 6) A state review process and criteria to evaluate each hospital's individual DSTI plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
 - 7) A reporting protocol outlining the requirements, process and timeline for a hospital to submit its interim progress on DSTI plan metrics and for the state to provide CMS with information documenting progress;
 - 8) A state review process and timeline to evaluate hospital progress on its DSTI plan metrics and assure a hospital has met its approved metrics prior to the release of associated DSTI funds;
 - 9) A process that allows for hospital plan modification and an identification of under what circumstances a modification plan may be considered including for carry-forward/reclamation, pending state and CMS approval; and
 - 10) A state process of developing an evaluation of DSTI as a component of the draft evaluation design as required by STC 90. When developing the master DSTI plan, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XII of the STCs. The state

must select a preferred research plan for the applicable research question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, DSTI master plan must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating provider chooses not to undertake that project. The intent of this data set is to enable cross provider comparison even if the provider did not elect the intervention.

- b) Hospital DSTI Plans. At a minimum, the individual hospital DSTI plans should include the following, in addition to the requirements pursuant to STCs 52(b) and 53(d).
- 1) A background section on the hospital system(s) covered by the DSTI plan that includes an overview of the patients served by the hospital;
 - 2) An executive summary for the DSTI plan that summarizes the high-level challenges the DSTI plan is intended to address and the target goals and objectives included in the plan for the demonstration approval period including an explanation of the hospital's achievements and challenges in the SFY 2012-2014 demonstration approval period;
 - 3) Sections on each of the four categories as specified in the STC 50(d)(4), and include:
 - A. For Categories 1, 2 and 3 –
 - i. Each hospital must select a minimum number of projects, with associated metrics, milestones and data sources in accordance with the master DSTI plan.
 - ii. For each project selected, the hospital at a minimum must include:
 - (1) A description of the goal(s) of the project, which describes the challenges of the hospital system and the major delivery or payment redesign system solution identified to address those challenges by implementing the particular project;
 - (2) A description of the target goal over the demonstration approval period and metrics associated with the project and the significance of that goal to the hospital system and its patients;
 - (3) A narrative on the hospital's rationale for selecting the project, milestones, and metrics based on relevancy to the hospital system's population and circumstances, community need, and hospital system priority and starting point with baseline data;
 - (4) A narrative describing how this project supports, reinforces, enables and is related to other projects and interventions within the hospital system plan; and
 - (5) Any other hospital reporting guidelines stipulated in the master DSTI Plan.

- B. In addition to requirements addressed in the above subparagraph (i), Category 2 must also include:
 - i. A description of how the selected project can refine innovations, test new ways of meeting the needs of target populations and disseminate findings in order to spread promising practices.

- C. Category 4 – Population-Focused Improvements
 - i. Projects within this category must focus on evaluation of the population-focused improvements associated with Categories 1, 2 and 3 projects and associated incentive payments. Each hospital must select a minimum number of projects in accordance with the master DSTI plan. All hospitals will select metrics from a common set defined in the master DSTI plan.

- c) DSTI Payment and Funding Protocol. The state must develop and submit in conjunction or as part of the master DSTI plan, an incentive payment methodology for each of the four categories to determine an annual maximum budget for each participating provider. The state also must identify an allowable non-federal share for the DSTI pool, which must be approved by CMS. The following principles must also be incorporated into the funding protocol contained in Attachment J:
 - 1) Each hospital will be individually responsible for progress towards and achievement of its metrics to receive its potential incentive funding related to any metric from DSTI.
 - 2) In order to receive incentive funding related to any metric, the hospital must submit all required reporting as described in STC 53(d).
 - 3) Funding Allocation Guidelines. The master DSTI plan must specify a formula for determining incentive payment amounts. Hospital-specific DSTI plan submissions must use this formula to specify the hospital-specific incentive payment amounts associated with the achievement of approved transformation metrics for approval by the Commonwealth and CMS pursuant to STC 52(a)(6). Category metrics will have a base value. Each category may have a different base value but metrics within categories will be based on a starting dollar point. Given the varied nature of the projects and hospital systems, the total incentive payment amounts available to an individual hospital for each category depend upon the size of the hospital, total projects and metrics selected in the hospital specific DSTI. The submission must describe how the factors affect each hospital's maximum allowable payment.
 - 4) Carry-Forward/Reclamation. The master plan/protocol must describe the ability of a hospital to earn payment for any missed metric within a defined time period. Carry-forward/reclamation of incentive payments is only available to the hospital associated with a given incentive payment and is not available for redistribution to

other hospitals. Carry-forward/reclamation is limited to this demonstration approval period ending June 30, 2017.

- i. If a participating hospital system does not fully achieve a metric that was specified in its plan for completion in a particular year, the payment associated with that metric may be rolled over for 12 months and be available if the hospital meets the missed metric in addition to the metric associated with the year in which the payment is made.
- ii. In the case of a participating hospital that is close to meeting a metric in a particular year, the hospital may be granted a grace period to the reporting deadline set for a particular payment cycle by which to meet a metric associated with the incentive payment if it has an approved plan modification pursuant to STC 52(a)(9) above. The allowable time period for such a grace period may vary based on the type and scope of the project associated with such metric and may be up to 180 days. The plan modification must be approved by the Commonwealth and CMS 30 days prior to the deadline of the incentive payment reporting pursuant to STCs 50 and 52(c) and 53(d). The plan modification must outline how the hospital plans to meet the metric within the given grace period. The process for hospital plan modification, including the modification requirements, deadline by which a hospital must submit a requested modification and the Commonwealth and CMS approval process will be outlined within the master DSTI plan pursuant to STC 52(a)(9).
- iii. Projects that focus primarily on infrastructure will have further limited rollover ability as defined in the master DSTI plan.

- d) CMS Approval of DSTI Funding Protocols and Master and Hospital-Specific Plans. CMS and the state agree to the targeted approval period of 90 calendar days after the date of the approval letter. However, if CMS determines that a protocol or plan is not ready for approval on the target date, CMS will notify the state of its determination.

53. SNCP Additional Reporting Requirements. All SNCP expenditures must be reported as specified in section X, STC 66. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

- a) Charts A – B of Attachment E. The Commonwealth must submit to CMS for approval, updates to Charts A – B of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Years (SFYs) 2015-2017, and where applicable for SFY 2018-2019 and identify the non-federal share for each line item, no later than 45 business days after enactment of the State budget for each SFY. CMS shall approve the Commonwealth's projected SNCP payments and expenditures within 30 business days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 51.

Before it can claim FFP, the Commonwealth must notify CMS and receive CMS approval, for any SNCP payments and expenditures outlined in Charts A-B of Attachment E that are in excess of the approved projected SNCP payments and

expenditures by a variance greater than 10 percent. Any variance in SNCP payments and expenditures must adhere to the SNCP expenditure limits pursuant to STC 51. The Commonwealth must submit to CMS for approval updates to Charts A – B that include these variations in projected SNCP payments and expenditures. CMS shall approve the Commonwealth’s revised projected SNCP payments and expenditures within 30 business days of the Commonwealth’s submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 51.

The Commonwealth must submit to CMS for approval updates to Charts A – B of Attachment E that reflect actual payments and expenditures for each SFY, within 180 calendar days after the close of the SFY. CMS shall approve the Commonwealth’s actual SNCP expenditures within 45 business days of the Commonwealth’s submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in STC 51.

The Commonwealth must submit to CMS for approval further updates to any or all of these charts as part of the quarterly operational report and at such other times as may be required to reflect projected or actual changes in SNCP payments and expenditures. CMS must approve the Commonwealth’s updated charts within 45 business days of the Commonwealth’s submission of the update, provided that all SNCP payments and expenditures are within the applicable limits specified in STC 51.

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

- b) DSHP. The Commonwealth must submit to CMS for approval a table of projected DSHP spending for other state-funded health program expenditures authorized pursuant to STC 50(a)(3), by approved program, no later than 45 business days after enactment of the state budget for each SFY. CMS must approve the Commonwealth’s projected DSHP expenditures within 30 business days of the Commonwealth’s submission of the update, provided that all DSHP projections are within the applicable SNCP limits specified in STC 51(d).

The Commonwealth must submit to CMS for approval an update to the table of projected DSHP spending that reflects actual DSHP expenditures for each SFY, within 180 calendar days after the close of the SFY. CMS must approve the Commonwealth’s actual DSHP expenditures within 45 business days of the Commonwealth’s submission of the update, provided that all DSHP expenditures are within applicable limits.

The Commonwealth may submit to CMS for approval further updates to the table of projected DSHP spending by approved program at such other times as may be required to reflect projected or actual changes in DSHP expenditures. CMS must approve the Commonwealth’s updated charts within 45 business days of the Commonwealth’s submission of the update, provided that all DSHP expenditures are within applicable limits.

No demonstration amendment is required to update the table of projected DSHP spending by approved program within the expenditure limits specified in STC 51(d). Prior CMS approval is required to make changes to Chart C of Attachment E. No demonstration amendment is required in order to add to the list of DSHP programs in Chart C of Attachment E as long as the additional programs are approved by CMS and are within the expenditure limits for that demonstration year.

- c) Additional DSHP Reporting for Connector Care. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 62. This data must, at a minimum, include:
- 1) The number of individuals served by the program;
 - 2) The size of the subsidies; and
 - 3) A comparison of projected costs with actual costs.
- d) DSTI Reporting. The participating providers and the state must report the following:
- 1) Hospital Reporting. The reporting protocol within the master DSTI plan outlines the hospitals' reporting requirements, process and timelines and must be consistent with the following principles:
 - i. Hospital Reporting for Payment. Participating providers seeking payment under DSTI must submit reports to the state demonstrating progress, measured by Category specific metrics. The reports must include the incentive payment amount being requested for the progress achieved in accordance with the payment mechanisms outlined in the master DSTI plan. The required hospital reporting requirements, process and timeline are pursuant to the reporting protocol, state review process and funding protocol as outlined in STC 52(a)(7) and STC 52(a)(8) and STC 52(c) and must be consistent with the following principles:
 1. The hospital reports must be submitted using the standardized reporting form approved by the state and CMS;
 2. The state must use this documentation in support of DSTI claims made on the MBES/CBES 64.9 Waiver form.
 - ii. Hospital System Annual Report. Hospital systems must submit an annual report, based on the timeline approved in the reporting protocol component of the master DSTI plan. The reports must at a minimum:
 1. Be submitted using a standardized reporting form approved by the state and CMS;
 2. Provide information included in the semi-annual reports, including data on the progress made for all milestones; and
 3. Provide a narrative description of the progress made, lessons learned, challenges faced and other pertinent findings.
 - iii. Documentation. The hospital system must have available for review by the state or CMS, upon request, all supporting data and back-up documentation.

- 2) Commonwealth Reporting. STCs 60 and 62 require DSTI reporting as a component of the quarterly operational reports and annual reports. The DSTI reporting must at a minimum include:
 - i. All DSTI payments made to specific hospitals that occurred in the quarter;
 - ii. Expenditure projections reflecting the expected pace of future disbursements for each participating hospital;
 - iii. An assessment by summarizing each hospital's DSTI activities during the given period; and
 - iv. Evaluation activities and interim findings of the evaluation design pursuant to STC 90.

- e) ICB Reporting. STCs 60 and 62 require ICB reporting as a component of the quarterly operational reports and annual reports. The ICB reporting must at a minimum include:
 - 1) The applicant organization, project type, and funding awarded to the organization under ICB;
 - 2) Description of project activities and outcomes that occurred during the reporting period for each applicant organization;
 - 3) The amount of ICB payments that were made to the eligible hospital organization during the reporting period;
 - 4) Evaluation activities and interim findings of the evaluation design pursuant to STC 90.

54. Safety Net Care Pool Financing Report. The state must commission a report from a non-governmental entity that is independent of provider interests on Medicaid provider payments made under the SNCP. The intent of the SNCP Financing report and the subsequent Sustainability and Delivery System Transformation Report is to recommend a strategic platform for the Commonwealth and CMS to work from regarding payments that sustainably support and align with system-wide transformation. The report must evaluate the use of SNCP funding for the period of July 1, 2012 through June 30, 2015. The subject of the report (and the hypothesis test for the SNCP component of the demonstration evaluation) must focus on the effect, adequacy, and accountability of SNCP payments on provider financing. This evaluation must include all payment types under the SNCP, including uncompensated care payments, Delivery System Transformation Initiative and Infrastructure Capacity Building grants. Expenditures for the creation of the report will be considered a Medicaid administrative expenditure and eligible for FFP at the usual matching rate for administrative expenditures.

The draft report is due to CMS on October 1, 2015. The final report must be submitted to CMS no later than February 1, 2016. The Commonwealth must include updates on the status of the draft and final reports in each quarterly report.

The report must include the following criteria:

- a) The report must include a detailed description and analysis of the Medicaid payments to providers under the SNCP (all types) and financing system for the period of July 1, 2012 through June 30, 2015. The report must also include how the state funds the various

payments and how payments to providers correspond to amounts reported on the CMS-64. The report must note any gaps in payment as well as overages in the current funding structure.

- b) A detailed analysis of uncompensated care payments for each provider type that are attributable to each of the following:
 - i. Uninsured individuals
 - ii. Medicaid beneficiaries
- c) For the amount of pool payments attributable to Medicaid beneficiaries, for each provider type, comparison of the funds that are attributable, in aggregate and by age-band to the following:
 - i. Managed Care shortfall; and
 - ii. Fee-for-service shortfall.
- d) The total amount of uncompensated care that is provided by each provider type to each of the following: unqualified aliens, qualified aliens subject to a 5-year ban. This analysis must include use of age-banding as determined appropriate.
- e) An analysis of factors that contribute to the necessity of payments for uninsured individuals and Medicaid beneficiaries, including the following:
 - i. The number of uninsured individuals in the state;
 - ii. The number of Medicaid beneficiaries, including the growth of beneficiaries under Massachusetts health reform and the Affordable Care Act; and
 - iii. Factors that impact access to coverage. At a minimum, these must include geographic location, state of residency or homelessness rates.
- f) An analysis of the findings and conclusions drawn from the factors that contribute to the Medicaid shortfall, uncompensated care, and the necessity of uncompensated care payments overall as well, including the causal and solution role of FFS payment rates and managed care contracting requirements.
- g) Amount of DSTI payments made to participating providers by project.
- h) Analysis of measureable project outcomes achieved by participating provider per project

55. Sustainability and Delivery System Transformation Report: In the interest of supporting Massachusetts in attaining its payment reform goals, CMS requires that Massachusetts submit a second, broader report subsequent to the SNCP Financing report that lays out alternative pathways toward a sustainable and equitable Massachusetts' Medicaid financing system based on a coordinated and integrated care delivery system. The Sustainability and Delivery System Transformation Report will also identify reforms or alternatives to the Massachusetts Medicaid SNCP financing system.

The Sustainability and Delivery System Transformation Report will inform the Commonwealth and CMS' collaborative discussions regarding payment reform and a sustainable health care system in the Commonwealth and where CMS can be supportive regarding those goals. The report must assess the appropriate role the SNCP relative to conventional Medicaid payments, other revenue sources and provider costs, including both operational costs and costs associated with community benefit, research, and medical education. Expenditures for the creation of the report will be considered a Medicaid administrative expenditure and eligible for FFP at the usual matching rate for administrative expenditures. The draft report is due to CMS on March 1, 2016. The final report must be submitted to CMS no later than June 30, 2016. The Commonwealth must include updates on the status of the draft and final reports in each quarterly report.

IX. GENERAL REPORTING REQUIREMENTS

56. **General Financial Reporting Requirements.** The state must comply with all general financial requirements under title XIX of the Social Security Act in section X of the STCs.
57. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 C.F.R section 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.
58. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section XI of the STCs, including the submission of corrected budget neutrality data upon request.
59. **Bi-Monthly Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit packages, activities related to the Safety Net Care Pool, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes to payment rates, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the State is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.
60. **Quarterly Operational Reports.** The Commonwealth must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the Commonwealth's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but

are not limited to:

- a) Updated budget neutrality monitoring spreadsheets;
- b) Events occurring during the quarter or anticipated to occur in the near future that effect health care delivery including approval and contracting with new plans, benefits, enrollment, grievances, quality of care, access, proposed changes to payment rates, health plan financial performance that is relevant to the demonstration, payment reform initiatives or delivery system reforms impacting demonstration population and/or undertaken in relation to the SNCP including ICB grant programs, updates on activities related to the pediatric bundled payment pilot program, pertinent legislative activity, and other operational issues;
- c) Action plans for addressing any policy and administrative issues identified;
- d) Quarterly enrollment reports that include the member months for each demonstration population;
- e) Updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act;
- f) Activities and planning related to payments made under the Safety Net Care Pool pursuant to reporting requirements outlined in section VIII of the STCs;
- g) Updates on data related to the provisional eligibility authority.
 - 1) Total number of Medicaid/CHIP applicants for the specified quarter
 - 2) Total number Medicaid/CHIP applicants with identified income inconsistencies for the specified quarter
 - 3) Average number of days to resolve inconsistency
 - 4) Number of Medicaid CHIP applicants disenrolled due to income ineligibility identified
 - 5) Basis for ineligibility
 - 6) Quality of initial data
 - 7) Expenditures for ineligible individuals
- h) Evaluation activities and interim findings.

61. Special Reporting Requirements. The Commonwealth must submit information regarding the effectiveness of the diversionary behavioral health services delivered in facilities that meet the definition of an IMD. CMS will provide evaluation criteria and measures to be reported on by the state on a semi-annual basis regarding the efficacy of the diversionary behavioral health services delivered in IMDs in the demonstration during the two year approval period of those diversionary behavioral health services. The Commonwealth must also report on the efficacy of safety net care pool payments made to IMD providers.

62. Annual Report. The Commonwealth must submit a draft annual report documenting

accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 60 in addition to the annual HCBS report as stipulated in STC 40(k)(l). The Commonwealth must submit the draft annual report no later than October 1st of each year. Within 60 business days of receipt of comments from CMS, a final annual report shall be submitted.

63. **Transition Plan for Temporary Coverage and Commonwealth Care Orderly Closeout Designated State Health Program (DSHP) Coverage.** On or before November 14, 2014, the Commonwealth must submit a transition plan for how it will provide outreach and notices to individuals currently receiving benefits through the Temporary Coverage and Commonwealth Care Orderly Closeout DSHPs so that the individuals can be successfully enrolled into the appropriate coverage vehicle. Massachusetts expects to have a functioning eligibility system in place by the beginning of the Marketplace open enrollment period for coverage year 2015. Therefore, enrollment in Medicaid and the Marketplace is expected to replace enrollment into Temporary Coverage DSHP on November 15, 2014. In no event, shall the Temporary Coverage or Commonwealth Care Transitional DSHP coverage continue past the Marketplace open enrollment period for coverage year 2015.

The transition plan must include a detailed description of the following:

- a) the business workflow the Commonwealth will use to conduct the full eligibility determinations for the individuals;
- b) the outreach and noticing strategies the Commonwealth will employ to educate individuals of the steps they must take to secure Medicaid or Marketplace coverage;
- c) the process by which the Commonwealth will contact individuals who do not respond to the outreach strategies;
- d) the performance data the Commonwealth will use to track individuals who reapply for coverage; and
- e) the schedule by which the Commonwealth expects to have individuals successfully enrolled into the appropriate coverage vehicle.

On a biweekly basis, the Commonwealth must provide an update on its progress in implementing the transition plan, including the number of individuals enrolled in the Temporary Coverage and Commonwealth Care Orderly Closeout DSHPs and the Commonwealth's success in moving the individuals into the appropriate coverage vehicle.

64. **Final Report.** Within 120 calendar days following the end of the demonstration, the Commonwealth must submit a draft final report to CMS for comments. The Commonwealth must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

65. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section XI of the STCs.
66. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a) **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00030/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.
 - b) **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - c) **Pharmacy Rebates.** When claiming these expenditures the Commonwealth may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf>). The Commonwealth must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

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

the same matching rate as the original associated prescription drug expenditures.

- d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the Commonwealth under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64Narr by demonstration year.
- e) Demonstration year reporting. Notwithstanding the two-year filing rule, the Commonwealth may report adjustments to particular demonstration years as described below:
- i. Beginning July 1, 2005 (SFY 2006/ DY, 9) all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, and separate schedules will be completed for demonstration years 6, 7, 8, and 9.
 - ii. Beginning July 1, 2006 (SFY 2007/ DY 10), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-7 will be reported as demonstration year 7, and separate schedules will be completed for demonstration years 8, 9, and 10.
 - iii. Beginning July 1, 2007 (SFY 2008/ DY 11), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, and separate schedules will be completed for demonstration years 9, 10, and 11.
 - iv. Beginning July 1, 2008 (SFY 2009/ DY 12), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-10 will be reported as demonstration year 10, and separate schedules will be completed for demonstration years 11 and 12. Demonstration year 12 includes dates of service from July 1, 2008, through June 30, 2009.
 - v. Beginning July 1, 2009 (SFY 2010/ DY 13), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration year 11, and separate schedules will be completed for demonstration years 12 and 13 and 14. Demonstration year 13 includes dates of service from July 1, 2009, through June 30, 2010.
 - vi. Beginning July 1, 2010 (SFY 2011/ DY 14), all expenditures and adjustments for

demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration year 11, and separate schedules will be completed for demonstration years 12 and 13 and 14. Demonstration year 14 includes dates of service from July 1, 2010, through June 30, 2011.

vii. Beginning July 1, 2011 (SFY 2012/ DY 15), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration 11, all expenditures and adjustments for demonstration years 12-14 will be reported as demonstration year 14 and separate schedules will be completed for demonstration years 15 and 16 and 17. All expenditures and adjustments for dates of service beginning July 1, 2011, will be reported on separate schedules corresponding with the appropriate demonstration year.

viii. Beginning October 1, 2013, all expenditures and adjustments for demonstration years 1-11 previously reported in sections i.-vi. will be reported as demonstration year 11. All expenditures and adjustments for demonstration years 12-14 will be reported so that quarters with the same American Recovery and Reinvestment Act reimbursement rates are consolidated; e.g., reports QE 09/09 through QE 12/10, all of which have the ARRA rate of 11.59 percent, will be consolidated into one report. For the quarters ending 6/09, 3/11 and 6/11 that have ARRA rates that are not the same as another quarter, they will continue to be reported on separate schedules. Separate schedules will be completed for dates of service after July 1, 2011 for expenditures and adjustments for demonstration years 15, 16, and 17.

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

- 1) **Base Families:** Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only)
- 2) **Base Disabled:** Eligible individuals with disabilities enrolled in Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only)
- 3) **1902(r)(2) Children:** Medicaid expansion children and pregnant women who are enrolled in MassHealth Standard, as well as eligible

children and pregnant women enrolled in MassHealth Limited (emergency services only)

- 4) **1902(r)(2) Disabled:** Eligible individuals with disabilities enrolled in Standard with income between 114.1 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency services only)
- 5) **BCCTP:** Individuals eligible under the Breast and Cervical Cancer Treatment Program who are enrolled in Standard
- 6) **CommonHealth:** Higher income working adults and children with disabilities enrolled in CommonHealth
- 7) **e-Family Assistance:** Eligible children receiving premium assistance or direct coverage through 200 percent of the FPL enrolled in Family Assistance.
- 8) **Base Fam XXI RO:** Title XXI-eligible AFDC children enrolled in Standard after allotment is exhausted
- 9) **1902 (r)(2) XXI RO:** Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted
- 10) **CommonHealth XXI:** Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted
- 11) **Fam Assist XXI:** Title XXI-eligible children through 200 percent of the FPL eligible for Family Assistance under the demonstration after the allotment is exhausted
- 12) **e-HIV/FA:** Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance
- 13) **SBE:** Subsidies or reimbursement for ESI made to eligible individuals
- 14) **SNCP-HSNTF:** Expenditures authorized under the demonstration for payments held to the provider sub-cap to support uncompensated care
- 15) **SNCP-DSHP:** Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP)
- 16) **SNCP-DSTI:** Expenditures authorized under the demonstration for

Delivery System Transformation Initiatives (DSTI)

- 17) **SNCP-OTHER:** All other expenditures authorized under the SNCP
- 18) **Asthma:** All expenditures authorized through the pediatric asthma bundled pilot program
- 19) **Autism:** All expenditures authorized for early intervention services for children with autism
- 20) **New Adult Group :** Report for all expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119
- 21) **Marketplace Subsidy:** Expenditures for subsidies described in STC 49(b)
- 22) **Provisional Eligibility:** Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority
- 23) **TANF/EAEDC:** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children.
- 24) **End of Month Coverage:** Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.
- 25) **DSHP- Temporary Coverage:** Expenditures for costs incurred for the period January 1, 2014 through February 28, 2015, by a state-funded program to ensure temporary (FFS) state operated coverage for individuals who are not able to receive a full eligibility determination for MassHealth or Marketplace coverage.
- 26) **DSHP - CommCare Orderly Closeout:** Expenditures for costs incurred for the period January 1, 2014 through February 28 2015 by a state-funded program for an orderly closeout of the Commonwealth Care premium assistance program, as described in Attachment E, Chart A of the Special Terms and Conditions (STCs).

67. Reporting Expenditures under the Demonstration for Groups that are Eligible First under the Separate Title XXI Program. The Commonwealth is entitled to claim title XXI funds for expenditures for certain children that are also eligible under this title XIX

demonstration included within the Base Families EG, the 1902(r)(2) Children EG, the CommonHealth EG and the Family Assistance EG. These groups are included in the Commonwealth's title XXI state plan and therefore can be funded through the separate title XXI program up to the amount of its title XXI allotment (including any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual. If the title XXI allotment has been exhausted, including any reallocations or redistributions, these children are then eligible under this title XIX demonstration and the following reporting requirements for these EGs under the title XIX demonstration apply:

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

- a) Exhaustion of Title XXI Funds. If the Commonwealth has exhausted title XXI funds, expenditures for these optional targeted low-income children may be claimed as title XIX expenditures as approved in the Medicaid state plan. The Commonwealth shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 66 (Reporting Expenditures Under the Demonstration).
- b) Exhaustion of Title XXI Funds Notification. The Commonwealth must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures.
- c) If the Commonwealth chooses to claim expenditures for **Base Families XXI RO, 1902(r)(2) RO, and CommonHealth XXI** groups under title XIX, the expenditures and caseload attributable to these EGs will:
 - i. Count toward the budget neutrality expenditure limit calculated under section XI, STC 84 (Budget Neutrality Annual Expenditure Limit); and
 - ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 84, so that the Commonwealth is not at risk for caseload while claiming title XIX federal matching funds when title XXI funds are exhausted.
- d) If the Commonwealth chooses to claim expenditures for **Fam Assist XXI** under title XIX, the expenditures and caseload attributable to this EG will be considered expenditures subject to the budget neutrality agreement as defined in STC 84. The Commonwealth is at risk for both caseload and expenditures while claiming Title XIX federal matching funds for this population when title XXI funds are exhausted.

68. Expenditures Subject to the Budget Neutrality Agreement. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in section IV of the STCs, except where specifically exempted. All

expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

69. **Premium Collection Adjustment.** The Commonwealth must include demonstration premium collections as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis on the CMS-64 Summary Sheet and on the budget neutrality monitoring workbook submitted on a quarterly basis.
70. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the Commonwealth must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
71. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the Commonwealth made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.
72. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:
- a) For the purpose of calculating the budget neutrality agreement and for other purposes, the Commonwealth must provide to CMS, as part of the quarterly report required under STC 58, the actual number of eligible member months for the EGs 1-12 and EGs 20 - 22 and 25 defined in STC 66(f). The Commonwealth must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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

- b) The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

73. **Cost Settlement.**

- a) **Interim Reconciliation–** Within 12 months of the provider’s cost report filing for each reporting year, the Commonwealth must validate cost data using the CMS-approved cost review protocol, developed jointly by Massachusetts and CMS. Interim Reconciliation

will be based on the results of the Commonwealth's review. Any increasing or decreasing adjustment identified as a result of the settlement must be reported to CMS as an adjustment to reported expenditures and reported through the CMS-64 process.

- b) Final Reconciliation – For each provider subject to cost settlement, the Commonwealth must complete final settlement within 12 months after the provider's final and audited (as applicable) cost report become available. The Commonwealth must submit cost and payment information for that demonstration year as required by the CMS-approved cost limit protocol. Any increasing or decreasing adjustment identified as a result of the settlement must be reported to CMS as an adjustment to reported expenditures and reported through the CMS-64 process. CMS will complete its review of the costs reported using the protocol tool and send concurrence or share its findings with the Commonwealth within 120 calendar days of receipt.

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

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

- a) Administrative costs, including those associated with the administration of the demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c) Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period, including expenditures under the Safety Net Care Pool.

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

non-federal share of funding are subject to CMS approval.

- a) The CMS may review at any time the sources of the non-federal share of funding for the demonstration. The Commonwealth agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c) The Commonwealth assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

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

- a) Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
- b) To the extent, the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies as allowable under 42 C.F.R. § 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;
- d) The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from state or local monies and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the Commonwealth any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with

governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

78. **Monitoring the Demonstration.** The Commonwealth will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.
79. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

80. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning July 1, 2014.
81. **Limit on Title XIX Funding.** Massachusetts will be subject to a limit on the amount of federal title XIX funding that the Commonwealth may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual DSH allotment that would have applied to the Commonwealth absent the demonstration (DSH allotment). Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the Commonwealth using the procedures described in section X, STC 66. The data supplied by the Commonwealth to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Commonwealth's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.
82. **Risk.** Massachusetts shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Massachusetts will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Massachusetts at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.
83. **Expenditures Excluded From Budget Neutrality Test.** Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:
- a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on behalf of enrollees under age 65 who are institutionalized in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded, or a state psychiatric hospital for other than a short-term rehabilitative stay;

- b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient, and home and community-based waiver services, except pursuant to STC 40;
 - i. *Exception.* Hospice services provided to individuals in the MassHealth Basic and Essential programs are subject to the budget neutrality test.
- c) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement; and
- d) Allowable administrative expenditures.

84. **Budget Neutrality Annual Expenditure Limit.** For each DY, two annual limits are calculated.

- a) Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the Commonwealth under section X, STC 72 for each EG, including the hypothetical populations, times the appropriate estimated per member/per month (PMPM) costs from the table in subparagraph (v) below;
 - ii. Starting in SFY 2006, actual expenditures for the CommonHealth EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline CommonHealth costs, or actual CommonHealth per member per most cost experience for SFYs 2015-2017;
 - iii. The amount of actual expenditures included will be the lower of the trended baseline costs, or actual per member per most cost experience for each eligibility group in SFYs 2015-2017;
 - iv. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior demonstration periods are provided in Attachment D; and
 - v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Group (EG)	Trend Rate	DY 18 PMPM (SFY 2015)	DY 19 PMPM (SFY 2016)	DY 20 PMPM (SFY 2017)	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)
Mandatory and Optional State Plan Groups						
<u>Base Families</u>	5.2 percent	\$655.57	\$689.66	\$725.53	\$763.25	\$802.94
<u>Base Disabled</u>	4.8 percent	\$1,442.34	\$1,511.57	\$1,584.13	\$1,660.17	\$1,739.86
<u>BCCTP</u>	5.3 percent	\$4,290.46	\$4,517.85	\$4,757.30	\$5,009.44	\$5,274.94
<u>1902(r)2 Children</u>	4.6 percent	\$526.70	\$550.93	\$576.27	\$602.78	\$630.51
<u>1902(r)2 Disabled</u>	4.8 percent	\$1,129.30	\$1,183.51	\$1,240.32	\$1,299.85	\$1,362.25
Hypothetical Populations*						
<u>CommonHealth</u>	4.8 percent	\$671.10	\$711.36	\$754.04	\$799.29	\$847.24

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

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

Eligibility Group (EG)	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM
<u>New Adult Group</u>	5.3 percent	\$485.67	\$511.42	\$538.52	\$567.06	\$597.12

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

c. The Supplemental Budget Neutrality Test is calculated by taking the PMPM cost projection for the New Adult Group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap is obtained by multiplying total computable Supplemental Cap by the Composite Federal Share described in STC 87.

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

e. If total FFP for the New Adult Group should exceed the federal share of the

Supplemental Budget Neutrality Test after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in STC 84.

- f. The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure limits. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the Commonwealth may receive for expenditures on behalf of demonstration populations as well as demonstration services described in Table B in STC 37 during the demonstration period.
- g. Limit B. The Commonwealth's annual DSH allotment.
- h. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) adjustment:
 - i. The Commonwealth must present to CMS for approval a draft evaluation plan outlining the methodology to track the following:
 - 1) Baseline measurement of EPSDT service utilization prior to the EPSDT court-ordered remedial plan in *Rosie D. v Romney* (the Order) final judgment and final remedial plan established on July 16, 2007;
 - 2) Increase, following entry of the Order, in utilization of :
 - a) EPSDT screenings;
 - b) Standardized behavioral health assessments utilizing the Child and Adolescent Needs and Strengths (CANS), or other standardized assessment tool in accordance with the Order; and
 - c) State plan services available prior to the entry of the Court Order.
 - 3) Cost and utilization of services contained in State Plan amendments submitted by the Commonwealth in accordance with the Order and approved by CMS; and
 - 4) Methodology for tracking and identifying new EPSDT services for purposes of budget monitoring.
 - ii. The draft evaluation plan with an appropriate methodology to track new EPSDT expenditures must be approved by CMS through the amendment process described in STC 7. Once an appropriate methodology to track new EPSDT expenditures is approved by CMS, these projected expenditures will be included in the expenditure limit for the Commonwealth, with an effective date beginning with the start of the new EPSDT expenditures, and reconciled to actual expenditure experience.

86. 1115A Duals Demonstration Savings. When Massachusetts' section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the Duals

Demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the Duals Demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal. This evaluation of estimated and certified amounts of actual title XIX savings will reflect addendums and amendments to the 1115A Duals Demonstration contract and adjustment to the MassHealth Component of the capitation rate, including interim and final risk corridor settlements.

A. 1115A Duals Demo Rate Year/ Demo Year	B. MassHealth Component of the Capitation Rate (hypothetical)	C. Medicaid Savings Percentage Applied Per Contract (average)	D. Savings Per Month (B*C)	E. Member Months of MMEs who participated in 1115A Duals Demonstration and 1115(a) Demonstration (hypothetical)	F. Risk Corridor Payment/ (Recoupme nt)	G. Amount subtracted from 1115(a) BN savings/ margin (D*E)
CCY 2013/ DY 1	\$1,000 PMPM	0%	\$0 PMPM	1,000	\$15,000	[\$0 PMPM * 1,000 = \$0 =
CCY 2014 Jan. – March 2014/ DY 1	\$1,000 PMPM	0%	\$0 PMPM	1,000	\$15,000	[\$0 PMPM * 1,000 = \$0 =
CCY 2014 April to Dec. 2014/ DY 1	\$1,000 PMPM	1%	\$10 PMPM	1,000	\$15,000	\$10 PMPM * 1,000 = \$10,000=
CCY 2015/ DY 2	\$1,000 PMPM	1.5%	\$15 PMPM	1,000	\$10,000	\$15 PMPM * 1,000 = \$= 5,000
CCY 2016/ DY 3	\$1,000 PMPM	>4% (Per the Duals Demonstra tion contract, the savings percentage applied to	\$40 PMPM	1,000		[\$40 PMPM * 1,000 = =

		DY 3 will be finalized following the close of DY 1 to reflect DY 1 actual payments.)			
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Specifically, OACT will estimate and certify actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration following the methodology below.

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

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

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

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

- Number of unduplicated Medicare-Medicaid enrollees served under the 1115A duals demonstration = [Insert number]
- Number of member months = [Insert number]

- PMPM savings per dual beneficiary enrolled from the 1115A duals demonstration = [Insert number]”

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

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

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

Demonstration Year	Cumulative Target Definition	Percentage
DY 18	Cumulative budget neutrality limit plus:	2.0percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 18 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 18 through 21	Cumulative budget neutrality limit plus:	.5 percent
DY 18 through 22	Cumulative budget neutrality limit plus:	0 percent

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

89. Exceeding Budget Neutrality. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 87, composite federal share ratio. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

90. **Submission of a Draft Evaluation Design Update.** The Commonwealth must submit to CMS for approval a draft evaluation design update no later than 120 calendar days after CMS' approval date of the renewal. The draft evaluation design update must build and improve upon the evaluation design that was approved by CMS for demonstration period ending on June 30, 2014.

At a minimum, the draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire health care reform demonstration set forth in section II of these STCs. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population, specific testable hypothesis, including those that focus on target populations for the demonstration and more generally on beneficiaries, providers, plans, market areas and public expenditures. The updated design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. It must discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the Commonwealth. The draft design must identify whether the Commonwealth will conduct the evaluation, or select an outside contractor for the evaluation.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results. Information from the external quality review organization (EQRO) may be considered for the purposes of evaluation, as appropriate.

The updated design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.
 - 1) The number of uninsured in the Commonwealth;
 - 2) The number of demonstration eligibles accessing ESI;
 - 3) Growth in the Commonwealth Care Program;
 - 4) Decrease in uncompensated care and supplemental payments to hospitals;
 - 5) The number of individuals accessing the Health Safety Net Trust Fund;
 - 6) The impact of DSTI payments to participating providers on the Commonwealth's

goals and objectives outlined in its master plan including:

- i. Were the participating hospitals able to show statistically significant improvements on measures within Categories 1-3 related to the goals of the three-part aim as discussed in STC 50 and pursuant to STC 52?
 - ii. Were the participating hospitals able to show improvements on measures within Category 4 related to the goals of the three-part aim as discussed in STC 50 and pursuant to STC 52?
 - iii. What is the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers?
 - iv. What is the impact of the payment redesign and infrastructure investments to improve cost efficiency?
 - v. What is the impact of DSTI on managing short and long term per-capita costs of health care?
 - vi. How did the amount paid in incentives compare with the amount of improvement achieved?
- 7) The benefits, savings, and design viability of the Pediatric Asthma Pilot Program;
 - 8) The benefits, cost and savings of providing early intervention services for demonstration eligible children with autism;
 - 9) The impact of utilization of Express Lane Eligibility procedures for parents and caretakers and childless adults; and
 - 10) Availability of access to primary care providers.
 - 11) The impact of the ICB grants that allow participating providers to advance the Commonwealth's goals in the following areas or other areas of focus where applicable:
 - i. Readiness for global payments;
 - ii. Medical Home Transformation ;
 - iii. Improving health outcomes and quality, e.g., redirecting ED use to CHCs and implementing improvements in care transition; and
 - iv. Outreach and Enrollment.
 - 12) The impact of SNCP funding and recommendations for reforms or alternatives to the Massachusetts' Medicaid financing system that sustains funding through regular provider payments. The impact of the Health Connector subsidy program on QHP enrollment trends addressing the following, at a minimum;
 - i. How many individuals with incomes between 133 and 300 percent of the FPL have taken up QHP coverage with the assistance of the Health Connector subsidy program?
- b. Evaluation Design Process: Addressing the research questions listed above will require a qualitative and, where applicable, quantitative research methodologies. When developing the master DSTI plan, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XII of the STCs. From these domains of focus, the state must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

research plan in response to each research question considered:

- i. Quantitative or qualitative outcome measures;
 - ii. Proposed baseline and/or control comparisons;
 - iii. Proposed process and improvement outcome measures and specifications;
 - iv. Data sources and collection frequency;
 - v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
 - vi. Cost estimates;
 - vii. Timelines for deliverables.
- c. Sources of Measures. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).
- d. The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state.
- e. Levels of Analysis: The evaluation designs proposed for each research question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

91. Interim Evaluation Reports. In the event the Commonwealth requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the Commonwealth must submit an interim evaluation report as part of its request for each subsequent renewal.

92. Final Evaluation Design and Implementation. CMS must provide comments on the draft evaluation design described in STC 90 within 60 business days of receipt, and the Commonwealth shall submit a final design within 60 business days after receipt of CMS comments. The Commonwealth must implement the evaluation design and submit progress of the programs described therein in the quarterly and annual progress reports. The Commonwealth must submit to CMS a draft of the evaluation report within 120 calendar days after expiration of the demonstration. CMS must provide comments within 60 business days after receipt of the report. The Commonwealth must submit the final evaluation report within 60 days after receipt of CMS comments.

93. Final Evaluation Report. The state must submit to CMS a draft of the evaluation final report within 60 business days after receipt of CMS comments in accordance with STC 92. The final report must include the following:

- a. An executive summary;
- b. A description of the demonstration, including programmatic goals, interventions implemented and resulting impact of these interventions;
- c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
- d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
- e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
- f. Successes, challenges, and lessons learned.

94. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration, the Commonwealth must fully cooperate with federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

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

Date - Specific	Deliverable	STC Reference
Within 120 days from the award of the demonstration	Draft Evaluation Design	Section XII, STC 90
Within 60 days of receipt of CMS comments	Final Evaluation Design and Implementation	Section XII, STC 92
October 1, 2015	Draft SNCP Financing Report	Section VIII
February 1, 2016	Final SNCP Financing Report	Section VIII
March 1, 2016	Draft Sustainability Report	Section VIII
June 30, 2016	Final Sustainability Report	Section VIII
Within 180 days after the expiration of the demonstration	Final Report	Section IX, STC 64
Annually		
October 1 st	Draft Annual Report, including HCBS report beginning in 2012	Section IX, STC 62 Section V, STC 40
30 days of the receipt of CMS comments	Final Annual Report, including DSTI reporting, ICB and HCBS report	Section IX, STC 62 Section VIII, STC 53(c) , STC 53(d) Section V, STC 40
No later than 45 days after enactment of the state budget for each SFY	Updates to Charts A-B of Attachment E that reflect projected annual SNCP expenditures and identify the non-Federal share for each line item	Section VIII, STC 53(a)
No later than 45 days after enactment of the state budget for each SFY	Projected annual DSHP expenditures	Section VIII, STC 53(b)
180 days after the close of the SFY (December 31 st)	Updates to Charts A-B of Attachment E that reflect actual SNCP payments and expenditures	Section VIII, STC 53(a)
At Least Semi-Annually		
	DSTI Hospital Reporting, ICB Reporting	Section VIII, STC 53(c), STC 53(d)
	Diversions Behavioral Health Services/ IMD reporting	Section IX, STC 61
Quarterly		
60 days following the end of the quarter	Quarterly Operational Reports, including DSTI reporting, ICB reporting and eligible member months	Section IX, STC 60 Section VIII, STC 53(c), STC 53 (d) Section X, STC 72

	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Unborn Targeted Low Income Child	0 through 200%	Uninsured	No (through December 31, 2013) Yes (effective January 1, 2014)	Separate XXI		Healthy Start (through December 31, 2013) Standard (effective January 1, 2014)	
Newborn Children Under age 1	AFDC-Poverty Level Infants 0 through 185%	Any	Yes	XIX via Medicaid state plan	<u>Base Families</u> <i>Without Waiver</i>	Standard	
	185.1 through 200%	Insured	Yes	XIX via Medicaid state plan	<u>1902(r)(2) Children</u> <i>Without Waiver</i>	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI Medicaid Expansion (via Medicaid state plan and XXI state plan) Funded through title XIX if XXI is exhausted	<u>1902(r)(2) XXI RO</u> <i>Without Waiver</i> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
	200.1 through 300%	Insured	Yes	XIX via demonstration authority only	E-Family Assistance	Family Assistance Premium Assistance	No additional wraparound benefit is provided
		Uninsured at the time of application	Yes	Separate XXI		Family Assistance	

This chart is provided for informational purposes only.

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Newborn Children Under Age 1 and Disabled	200.1-300%	Insured	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance with wraparound to direct coverage CommonHealth	
		Uninsured at the time of application	Yes (if XXI is exhausted)	Separate XXI Funded through XIX if XXI is exhausted via demonstration authority	<u>CommonHealth XXI</u> <i>Hypothetical</i> (member months and expenditures for these children are only reported if XXI	CommonHealth	The CommonHealth program was in existence prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The

					funds are exhausted)		CommonHealth program is contained in the separate title XXI state plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate title XXI program but expenditures are claimed under title XXI until the title XXI allotment is exhausted.
Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Newborn Children Under Age 1 and Disabled (continued)	Above 300%	Any	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth or CommonHealth Premium Assistance With wraparound to direct coverage CommonHealth	
Children Ages 1 through 18 Non-disabled	AFDC-Poverty Level Children Age 1-5: 0 through 133% FPL	Any	Yes	XIX	<u>Base Families</u> <i>Without waiver</i>	Standard	

	Age 6 through 17: 0 through 114% Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets						
	AFDC-Poverty Level Children	Insured	Yes	XIX	<u>Base Families</u> <i>Without waiver</i>	Standard	
	Age 6 through 17: 114.1% through 133% Age 18: 0 through 133%	Uninsured	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	<u>Base Fam XXI</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	
Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon applicatio n	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Ages 1 through 18 Non-disabled (continued)	Medicaid Expansion Children Ages 1 through 18: 133.1 through 150%	Insured	Yes	XIX	1902(r)(2) Children <i>Without waiver</i>	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	<u>1902(r)(2) Children RO</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

	All children Age 1 through 18: 150.1 through 200%	Insured	Yes	XIX via demonstration authority only	<u>E-Family Assistance</u>	Family Assistance Premium Assistance Direct Coverage	No additional wraparound is provided to ESI
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Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Ages 1 through 18 Non-disabled (continued)	All children Age 1 through 18: 150.1 through 200% (continued)	Uninsured at the time of application	Yes	Separate XXI Funded through XIX if XXI is exhausted	<u>Fam Assist XXI RO</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Family Assistance Premium Assistance Direct Coverage	No additional wrap is provided to ESI Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children's Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the title XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under the 1115 demonstration and as authorized under the separate title XXI

							program, but expenditures are claimed under title XXI until the title XXI allotment is exhausted.
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Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Ages 1 through 18 Non-disabled (continued)	All children Age 1 through 18: 200.1 through 300%	Insured	Yes	XIX via demonstration authority only	<u>E-Family Assistance</u>	Family Assistance Premium Assistance	No additional wraparound provided
		Uninsured at the time of application	Yes	Separate XXI			
Children Aged 1 through 18 and Disabled	0 through 150%	Any	Yes	XIX via Medicaid state plan	<u>Base Disabled Without Waiver</u>	Standard	
	150.1 through 300%	Insured	Yes	XIX via demonstration authority only	<u>CommonHealth Hypothetical</u>	CommonHealth/ Premium Assistance With wrap to direct coverage CommonHealth	

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Aged 1 through 18 and Disabled (continued)	150.1 through 300% (continued)	Uninsured at the time of application	Yes	Separate XXI Funded through XIX if XXI is exhausted	<u>CommonHealth XXI</u> <i>Hypothetical</i> (member months and expenditures for these children are only reported if XXI funds are exhausted)	CommonHealth	The CommonHealth program was in existence prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI state plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate XXI program, but expenditures are claimed under title XXI until the title XXI allotment is exhausted.
Children Aged 1 through 18 and Disabled	Above 300%	Any	Yes	XXI via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance With wraparound to direct coverage	

						CommonHealth	
Children Aged 19 and 20	0 through 133%	Any	Yes	XIX via Medicaid state plan	Base Childless Adults	Benchmark 1	
Non-disabled	Medicaid Expansion Children Ages 19 and 20: 133.1 through 150%	Any	Yes	XIX via Medicaid state plan	1902(r)(2) Children <i>Without waiver</i>	Standard	
Children Aged 19 and 20 and Disabled	0 through 150%	Any	Yes	XIX via Medicaid state plan	<u>Base Disabled</u> <i>Without Waiver</i>	Standard	

Cost-sharing imposed upon individuals enrolled in the demonstration varies across coverage types and by FPL. However, in general, no co-payments are charged for any benefits rendered to individuals under age 21 or pregnant women. Additionally, no premiums are charged to any individual enrolled in the demonstration whose gross income is less than 150 percent of the FPL. In the event a family group contains at least two members who are eligible for different coverage types and who would otherwise be assessed two different premiums, the family shall be assessed only the highest applicable premium. Family group will be determined using MassHealth rules for the purposes of assessing premiums as described in STC 20.

Demonstration Program	Premiums (only for persons with family income above 150 percent of the FPL)	Co-payments
MassHealth Standard/Standard ABP	\$0	All co-payments and co-payment caps are specified in the Medicaid state plan.
MassHealth CarePlus	\$0	MassHealth Standard co-payments apply.
MassHealth Breast and Cervical Cancer Treatment Program	\$15-\$72 depending on income	MassHealth Standard co-payments apply.
MassHealth CommonHealth	\$15 and above depending on income and family group size	MassHealth Standard co-payments apply.
CommonHealth Children through 300% FPL Children with income above 300% FPL adhere to the regular CommonHealth schedule	\$12-\$84 depending on income and family group size	MassHealth Standard co-payments apply.
MassHealth Family Assistance: HIV/AIDS	\$15-\$35 depending on income	MassHealth Standard co-payments apply.
MassHealth Family Assistance: Premium Assistance	\$12 per child, \$36 max per family group	Member is responsible for all co-payments required under private insurance with a cost sharing limit of 5 percent of family income

MassHealth Family Assistance: Direct Coverage	\$12 per child, \$36 max per family group	Children only-no copayments.
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Breast and Cervical Cancer Treatment Program Premium Schedule	
Percent of FPL	Premium Cost
Above 150 to 160	\$15
Above 160 to 170	\$20
Above 170 to 180	\$25
Above 180 to 190	\$30
Above 190 to 200	\$35
Above 200 to 210	\$40
Above 210 to 220	\$48
Above 220 to 230	\$56
Above 230 to 240	\$64
Above 240 to 250	\$72

CommonHealth Full Premium Schedule		
Base Premium	Additional Premium Cost	Range of Premium Cost
Above 150% FPL—start at \$15	Add \$5 for each additional 10% FPL until 200% FPL	\$15 — \$35
Above 200% FPL—start at \$40	Add \$8 for each additional 10% FPL until 400% FPL	\$40 — \$192
Above 400% FPL—start at \$202	Add \$10 for each additional 10% FPL until 600% FPL	\$202 — \$392
Above 600% FPL—start at \$404	Add \$12 for each additional 10% FPL until 800% FPL	\$404 — \$632
Above 800% FPL—start at \$646	Add \$14 for each additional 10% FPL until 1000% FPL	\$646 — \$912
Above 1000% FPL—start at \$928	Add \$16 for each additional 10% FPL	\$928 + greater

*A lower premium is required of CommonHealth members who have access to other health insurance per the schedule below.

CommonHealth Supplemental Premium Schedule	
% of FPL	Premium requirement
Above 150% to 200%	60% of full premium per listed premium costs above
Above 200% to 400%	65% per above
Above 400% to 600%	70% per above
Above 600% to 800%	75% per above

Above 800% to 1000%	80% per above
Above 1000%	85% per above

Small Business Employee Premium Assistance* (effective January 1, 2014)	% of FPL	Premium Requirement for Individual	Premium Requirement for Couples
Small Business Employee Premium Assistance* provides premium assistance to certain employees who work for a small employer	Above 150% to 200%	\$40.00	\$80.00
	Above 200% to 250%	\$78.00	\$156.00
	Above 250% to 300%	\$118.00	\$236.00

* Premium requirements for individuals participating in the Small Business Employee Premium Assistance program are tied to the state affordability schedule, as reflected in the minimum premium requirement for individuals enrolled in QHP Wrap coverage through the Health Connector. The premium amounts listed in this table reflect the 2013 state affordability schedule and are subject to change without any amendment to the demonstration.

Under section IX, STC 60, the Commonwealth is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration.

The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the Commonwealth. A complete quarterly progress report must include an updated budget neutrality monitoring workbook as well as updated Attachment E, Charts A-C.

NARRATIVE REPORT FORMAT:

Title Line One – MassHealth

Title Line Two – Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 18 (7/1/2014 – 6/30/2015)

Quarter 1: (7/14 – 09/14)

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The Commonwealth should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the Commonwealth should indicate that by “0”.

Note: Enrollment counts should be person counts, not member months.

<u>Eligibility Group</u>	<u>Current Enrollees (to date)</u>
Base Families	
Base Disabled	
1902(r)(2) Children	
1902(r)(2) Disabled	
Base Childless Adults (19-20)	
Base Childless Adults (ABP1)	
Base Childless Adults (CarePlus)	
BCCTP	

<u>Eligibility Group</u>	<u>Current Enrollees (to date)</u>
CommonHealth	
e-Family Assistance	
e-HIV/FA	
SBE	
Basic	
DSHP- Health Connector Subsidies	
DSHP- Temporary Coverage*	
DSHP- CommCare Transitional Coverage	
Base Fam XXI RO	
1902(r)(2) XXI RO	
CommonHealth XXI	
Fam Assist XXI	
Asthma	
Autism	
TANF/EAEDC	
End of Month Coverage	
Total Demonstration	

* For temporary coverage, the Commonwealth must report how many individuals were found to have income above 400 percent of the FPL.

Enrollment in Managed Care Organizations and Primary Care Clinician Plan

Comparative managed care enrollments for the previous quarter and reporting quarter are as follows:

Delivery System for MassHealth-Administered Demonstration Populations

Plan Type	June 30, 2008	September 30, 2008	Difference
MCO			
PCC			
MBHP			
FFS			
PA			

Enrollment in Premium Assistance and Small Business Employee Premium Assistance

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Safety Net Care Pool

Provide updates on any activities or planning related to payment reform initiatives or delivery system reforms affecting demonstration population and/or undertaken in relation to the SNCP. As per STC 60, include projected or actual changes in SNCP payments and expenditures within the quarterly report. Please note that the annual report must also include SNCP reporting as required by STCs 51, 53 and 54.

Operational/Issues

Identify all significant program developments that have occurred in the current quarter or near future, including but not limited to, approval and contracting with new plans, the operation of MassHealth and operation of the Commonwealth Health Insurance Connector Authority. Any changes to the benefits, enrollment, grievances, quality of care, access, proposed changes to payment rates, health plan financial performance that is relevant to the demonstration, cost-sharing or delivery system for demonstration populations receiving premium assistance to purchase health insurance via the Commonwealth Health Insurance Connector Authority must be reported here.

Policy Developments/Issues

Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the Commonwealth’s actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
<u>Base Families</u>				
<u>Base Disabled</u>				
<u>1902(r)(2) Children</u>				
<u>1902(r)(2) Disabled</u>				
<u>New Adult Group</u>				
<u>BCCTP</u>				
<u>CommonHealth</u>				

MassHealth

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Demonstration Approval Period: October 30, 2014 through June 30, 2019

TANF/EAEDC				
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B. For Informational Purposes Only

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
<u>e-HIV/FA</u>				
<u>Small Business Employee Premium Assistance</u>				
<u>DSHP- Health Connector Subsidies</u>				
<u>DSHP- Temporary Coverage</u>				
<u>DSHP- CommCare Transitional Coverage</u>				
<u>Base Fam XXI RO</u>				
<u>1902(r)(2) RO</u>				
<u>CommonHealth XXI</u>				
<u>Fam Assist XXI</u>				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also, discuss feedback received from other consumer groups.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

The table below lists the calculated per-member per-month (PMPM) figures by eligibility group (EG) used to develop the demonstration budget neutrality expenditure limits for the first 14 years of the MassHealth demonstration. All demonstration years are consistent with the Commonwealth's fiscal year (July 1 – June 30).

After DY 5, the following changes were made to the per member/per month limits:

1. MCB EG was subsumed into the Disabled EG;
2. A new EG, BCCTP, was added; and
3. the 1902(r)(2) EG was split between children and the disabled

DY	Time Period	Families		Disabled		MCB		1902(r)(2) Children		1902(r)(2) Disabled	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
1	SFY 1998	\$199.06	7.71%	\$491.04	5.83%	\$438.39	5.83%	\$177.02	5.33%	\$471.87	4.40%
2	SFY 1999	\$214.41	7.71%	\$519.67	5.83%	\$463.95	5.83%	\$186.49	5.35%	\$497.12	4.80%
3	SFY 2000	\$230.94	7.71%	\$549.97	5.83%	\$491.00	5.83%	\$196.93	5.60%	\$524.96	5.50%
4	SFY 2001	\$248.74	7.71%	\$582.03	5.83%	\$519.62	5.83%	\$208.16	5.70%	\$554.88	5.30%
5	SFY 2002	\$267.92	7.71%	\$615.96	5.83%	\$549.91	5.83%	\$220.02	5.70%	\$586.51	5.70%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
6	SFY 2003	\$288.58	7.71%	\$677.56	10.0%	\$236.98	7.71%	\$645.16	10.0%	\$1,891.62	10.0%
7	SFY 2004	\$310.83	7.71%	\$745.32	10.0%	\$255.26	7.71%	\$709.67	10.0%	\$2,080.78	10.0%
8	SFY 2005	\$334.79	7.71%	\$819.85	10.0%	\$274.94	7.71%	\$780.64	10.0%	\$2,288.86	10.0%
9	SFY 2006	\$359.23	7.30%	\$824.79	7.00%	\$295.01	7.30%	\$718.13	7.00%	\$2,449.08	7.00%
10	SFY 2007	\$385.46	7.30%	\$834.71	7.00%	\$316.54	7.30%	\$660.60	7.00%	\$2,620.52	7.00%
11	SFY 2008	\$413.60	7.30%	\$901.39	7.00%	\$339.65	7.30%	\$724.31	7.00%	\$2,803.95	7.00%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
12	SFY 2009	\$466.84	6.95%	\$1,011.95	6.86%	\$382.45	6.95%	\$791.46	6.86%	\$3,052.78	6.86%
13	SFY 2010	\$499.05	6.95%	\$1,081.37	6.86%	\$407.87	6.95%	\$846.68	6.86%	\$3,265.69	6.86%
14	SFY 2011	\$533.73	6.95%	\$1,115.55	6.86%	\$436.22	6.95%	\$904.76	6.86%	\$3,489.72	6.86%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
15	SFY 2012	\$562.02	5.3%	\$1,224.88	6.0%	\$457.59	4.9%	\$959.04	6.0%	5.3%	\$3,674.67
16	SFY 2013	\$591.81	5.3%	\$1,298.38	6.0%	\$480.02	4.9%	\$1,016.59	6.0%	5.3%	\$3,869.43
17	SFY 2014	\$623.17	5.3%	\$1,376.28	6.0%	\$503.54	4.9%	\$1,077.58	6.0%	5.3%	\$4,074.51

#	Type	Applicable caps	State law or regulation	Eligible providers	Total SNCP Payments per SFY					Total for SFY15-17*	Applicable footnotes
					SFY 2015	SFY 2016	SFY 2017	SFY 2018**	SFY 2019**		
1	Public Service Hospital Safety Net Care Payment	Provider		Cambridge Health Alliance	\$ 88.0	\$88.0	\$88.0	TBD	TBD	\$264.0	(1)
				Boston Medical Center	\$52.0	\$52.0	\$52.0	TBD	TBD	\$156.00	(1)
2	Health Safety Net Trust Fund Safety Net Care Payment	Provider	101CMR 613.00, 614.00	All acute hospitals	\$156.3	\$156.3	\$156.3	TBD	TBD	\$468.90	(2)
3	Institutions for Mental Disease (IMD)	Provider	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	\$24.0	\$24.0	\$24.0	TBD	TBD	\$72.00	(3)
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	Provider		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	\$45.0	\$45.0	\$45.0	TBD	TBD	\$135.00	(4)

5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	Provider		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	\$77	\$77	\$77	TBD	TBD	\$231.00	
6	Delivery System Transformation Initiatives	n/a		Eligible hospitals outlined in Attachment I	\$230.3	\$230.3	\$230.3	TBD	TBD	\$690.8	(5)
7	Public Hospital Transformation and Incentive Initiative	n/a		Cambridge Health Alliance	\$220.0	\$220.0	\$220.0	TBD	TBD	\$660.0	(6)
8	Designated State Health Programs (DSHP) – Other	DSHP		n/a	\$385.0	\$257.0	\$129.0	TBD	TBD	\$771.0	(7)

	State-Funded Programs										
9	DSHP - Health Connector subsidies*	n/a		n/a	\$41.8	\$75.2	\$78.3	\$81.2	\$84.2	\$360.7	(8)
10	DSHP – CommCare Orderly Closeout	n/a		n/a	\$175.4	n/a	n/a	n/a	n/a	\$175.4	(9)
11	Designated State Health Programs – Temporary Coverage	n/a		n/a	\$560.2	n/a	n/a	n/a	n/a	\$560.2	(10)
12	Infrastructure and Capacity-Building	Infrastructure		Hospitals and CHCs, primary care practices, and physicians	\$30.0	\$30.0	\$30.0	TBD	TBD	\$90.0	(11)
	Total				\$2,085	\$1,255	\$1,130	\$81.2*	\$84.2*	\$4,635	

*The amount included in the Total includes DSHP Health Connector Subsidies for SFY 18-19.

**Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) for DY 18-20, and has provided in the STCs that Massachusetts will not make such DSH payments in DY 18-20, but instead will make provider support payments under the SNCP. In DYs 21 and 22 Massachusetts is not currently authorized to make SNCP provider payments. Massachusetts and CMS will collaborate to reach agreement on a redesigned SNCP structure for DYs 21 and 22. If an amendment to the demonstration for restructured SNCP provider payments for DYs 21 and 22 is not approved, Massachusetts will resume making DSH payments in accordance with an approved State plan pursuant to section 1902(a)(13)(A)(iv)

of the Social Security Act.

The following notes are incorporated by reference into chart A

- (1) The provider-specific Public Service Hospital Safety Net Care payments are approved by CMS. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. The Commonwealth may decrease these payment amounts based on available funding without a demonstration amendment; any increase will require a demonstration amendment.
- (2) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding.
- (3) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD category; inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification centers.
- (4) Expenditures for items #4-5 in chart A are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth.
- (5) Delivery System Transformation Initiative funds will be distributed to participating hospitals pursuant to STCs 50 and 52.
- (6) Public Hospital Transformation and Incentive Initiative Funding will be distributed to Cambridge Health Alliance pursuant to STC 50 (e).

(7) DSHP programs are described in Chart C with dates of service beginning as of date of approval letter through June 30, 2017.

(8) Expenditures for DSHP Health Connector Subsidies are approved beginning January 1, 2014 and based on actual enrollment and premium assistance costs. Consequently, the amount of total expenditures may vary. The Health Connector Subsidies are authorized for five additional years, SFYs 2015-2019. The Health Connector Subsidies are not subject to the overall SNCP cap or the DSHP cap. Here are the projected totals (in millions) during the renewal period for the Health Connector Subsidies by SFY.

SFY 2015: \$41.8

SFY 2016: \$75.2

SFY 2017: \$78.3

SFY 2018: \$81.2

SFY 2019 \$84.2

(9) Expenditures for DSHP – CommCare Transitional Coverage are provided effective January 1, 2014 through February 28, 2015, and are based on actual enrollment. Consequently, the amount may vary. These expenditures are not subject to the DSHP cap.

(10) Expenditures for DSHP –Temporary Coverage are approved effective January 1, 2014 through February 28, 2015, and are based on actual enrollment. Consequently, the amount may vary. These expenditures are not subject to the DSHP cap.

(11) Infrastructure and Capacity-Building (ICB) funds support Commonwealth-defined health systems improvement projects, and are approved by CMS pursuant to STCs 50(c) and 51(b). Participating providers (including hospitals, community health centers, primary care practices and physicians) and provider-specific amounts are determined based on a formal request for responses (RFR) process. Spending for ICB is subject to the limit described in STC 51(b).

#	Type	State law or regulation	Eligible providers	Total SNCP payments per SFY									
				SFY 2015	Source of Non-federal share	SFY 2016	Source of Non-federal share	SFY 2017	Source of Non-federal share	SFY 2018**	Source of Non-federal share	SFY 2019**	Source of Non-federal share
1	Public Service Hospital Safety Net Care Payment		Boston Medical Center Cambridge Health Alliance	\$140.0		\$140.0		\$140.0		TBD		TBD	
2	Health Safety Net Trust Fund Safety Net Care Payment	101 CMR 613.00, 614.00	All acute hospitals	\$156.3		\$156.3		\$156.3		TBD		TBD	
3	Institutions for Mental Disease (IMD)	130 CMR 425.408, 101 CMR 346.00	Psychiatric inpatient hospitals Community-based detoxification centers	\$24.0		\$24.0		\$24.0		TBD		TBD	
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	\$45.0		\$45.0		\$45.0		TBD		TBD	
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	\$77.0		\$77.0		\$77.0		TBD		TBD	
6	Delivery System Transformation Initiatives		Eligible hospitals outlined in Attachment I	\$230.3		\$230.3		\$230.3		TBD		TBD	
7	Public Hospital Transformation and Incentive Initiative		Cambridge Health Alliance	\$220.0		\$220.0		\$220.0		TBD		TBD	
8	Designated State Health Programs (DSHP) - Other State-Funded Programs		n/a	\$385		\$257.0		\$129.0		TBD		TBD	
9	DSHP – Health Connector Premium		n/a	\$41.8		\$75.2		\$78.3		\$81.2		\$84.2	

	Assistance Subsidies												
10	DSHP – Commonwealth Care Orderly Closeout		n/a	175.4		n/a		n/a		n/a		n/a	
11	DSHP-Temporary Coverage (AA Population)		n/a	\$560.2		n/a		n/a		n/a		n/a	
12	Infrastructure and Capacity-Building for Hospitals and Community Health Centers		Hospitals and, community health centers, primary care practices and physicians	\$30.0		\$30.0		\$30.0		TBD		TBD	
	Total			\$2,085		\$1,255		\$1,130		TBD		TBD	

**Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) for DY 18-20, and has provided in the STCs that Massachusetts will not make such DSH payments in DY 18-20, but instead will make provider support payments under the SNCP. In DYs 21 and 22 Massachusetts is not currently authorized to make SNCP provider payments. Massachusetts and CMS will collaborate to reach agreement on a redesigned SNCP structure for DYs 21 and 22. If an amendment to the demonstration for restructured SNCP provider payments for DYs 21 and 22 is not approved, Massachusetts will resume making DSH payments in accordance with an approved State plan pursuant to section 1902(a)(13)(A)(iv) of the Social Security Act.

Designated State Health Programs (DSHP). The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and the applicable Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. No demonstration amendment is required for CMS approval of updates to Chart C of Attachment E to include additional DSHP programs. This chart shall be updated pursuant to the process described in STC 53(b).

Chart C: Approved Designated State Health Programs (DSHP)

Dates of Service from the date of the approval letter through June 30, 2017

This DSHP is subject to the overall DSHP cap and the overall SNCP cap.

<u>Agency</u>	<u>Program Name</u>
<u>Previously Authorized Programs</u>	
DMH	Homeless support services
DMH	Individual and family flexible support
DMH	Comprehensive psychiatric services
DMH	Day services
DMH	Child/adolescent respite care services
DMH	Community rehabilitative support
DMH	Adult respite care services
DMH	Department of Corrections – DPH/Shattuck Hospital Services
DPH	SANE Program
DPH	Growth and nutrition program
DPH	Multiple Sclerosis
DPH	Universal Immunization Program
DPH	Pediatric Palliative Care
EHS	Children’s Medical Security Plan
ELD	Prescription Advantage
ELD	Enhanced Community Options
ELD	Home Care Services
ELD	Home Care Case Management and Admin
ELD	Grants to Councils on Aging
HCF	Community Health Center Uncompensated Care Payments
HCF	Fisherman’s Partnership
MCB	Turning 22 Program – respite
MCB	Turning 22 Program – training
MCB	Turning 22 Program – co-op funding
MCB	Turning 22 Program – mobility
MCB	Turning 22 Program – homemaker
MCB	Turning 22 Program – client supplies
MCB	Turning 22 Program – vision aids

MRC	Turning 22 Services
MRC	Head Injured Programs
VET	Veteran's Benefits
<u>New Authorized Programs</u>	
DMH	Prescription Monitoring Program
DMH	Substance Abuse Trust Fund
DMH	Naloxone Project
DMH	MA Child Psychiatric Access Project
DMH	Clubhouse Services
DMH	Program of Assertive Community Treatment
DMH	Peer Services Recovery and Learning Community
DMH	Mental Health Jail Diversion Programs and Comprehensive Community Intervention Team
DMH	Community and School Therapeutic Support
HPC	CHART Grants
DPH	Domestic Violence Prevention
DPH	Suicide Prevention and Intervention Program
DPH	Prevention and Wellness Grant Program
DPH	Postpartum CHW Pilot Program
DCF	Domestic Violence Prevention – Residential
DCF	Family Resource Centers
DESE	Substance Abuse Counselors
DDS	Oral Healthcare for Developmentally Disabled

Dates of service January 1, 2014 through February 28, 2014

These DSHPs are subject to the overall SNCP cap and are not subject to the DSHP cap.

Agency	Program Name
HealthConnector	Commonwealth Care Orderly Closeout
EOHHS	Temporary Coverage for a state-funded program to ensure temporary Fee for Service (FFS) state operated coverage for individuals who are not able to receive a full eligibility determination for MassHealth or Marketplace coverage.

Dates of service July 1, 2014 through June 30, 2019

This DSHP is not subject to the aggregate SNCP cap or the DSHP cap.

Agency	Program Name
HealthConnector	Health Connector Premium Assistance Subsidies

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

INTRODUCTION

The Pediatric Asthma Pilot Program will utilize an integrated delivery system for preventive and treatment services through methodologies that may include a payment such as a per member/per month (PMPM) payment to participating providers for asthma-related services, equipment and supports for management of pediatric asthma for high-risk patients, to improve health outcomes, reduce asthma-related emergency department utilization and asthma-related hospitalizations, and to reduce associated Medicaid costs. These methodologies are subject to CMS approval of this pilot program protocol.

This protocol describes Phase 1 of the Pediatric Asthma Pilot Program. In accordance with STC 39(e), the Commonwealth will not expand the pilot program or implement a Phase 2 until after Phase 1 has been implemented, evaluated, and CMS has issued its approval of an expansion or Phase 2. The Commonwealth must operate Phase 1 of the demonstration for at least one (1) full year before beginning to evaluate the pilot program (see STC Protocol Requirements 8 below for additional information regarding the timing of the evaluation of Phase 1). Phase 1 may last for up to three years to ensure a seamless transition to Phase 2, if approved by CMS.

In accordance with STC 39(g) “Required Protocols Prior to Claiming Federal Financial Participation (FFP)”, this protocol describes how the Commonwealth plans to meet the milestones required before enrolling beneficiaries and claiming FFP under this pilot program.

To develop these protocols, the Commonwealth established an internal program design team, which includes three physicians, a nurse, a pharmacist, several policy experts, data analysts, and a legal counsel. MassHealth also convened an external Advisory Committee with 20 members, each of whom has expertise in treating high-risk pediatric asthma patients, designing and implementing clinical programs to prevent and manage high-risk pediatric asthma, and/or designing and implementing global or bundled payment structures. Advisory Committee members include physicians, nurses, pharmacists, researchers, representatives of professional organizations, and health care administrators.

This section sets forth the Commonwealth’s proposal for establishing eligibility criteria for member participation in the pilot and the process for enrolling members in the pilot. Because the proposed intervention is intensive, it can only be implemented in a cost neutral way if it is targeted to the patients who are most likely to require hospital treatment for asthma in the absence of intervention. In order to target these children, the advisory committee recommended restricting eligibility to members with poorly controlled asthma, as described in section A.6. below.

The advisory committee also recommended enabling Participating Practices to enroll eligible members into the pilot through the process described in section B below, in order to enroll eligible members at the time that they most need the intervention. Participating practices may have documentation supporting a member’s eligibility that is not available or not yet available through MassHealth claims data. For example, a member may have been hospitalized for asthma prior to his or her enrollment in MassHealth.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

A. **Eligibility.** Patients who meet the criteria in section A1 through 6 below may be enrolled in the Children's High-Risk Asthma Bundled Payment Pilot (CHABP) as CHABP Enrollees:

1. Are between the ages of 2 and 18 years at the time of CHABP enrollment;
2. Are a MassHealth member;
3. Are enrolled in the MassHealth Primary Care Clinician (PCC) plan, as described in STC 42a, and on the PCC panel of the participating practice, as identified by its provider identification and service location number (PID/SL);
4. Have a clinical diagnosis of asthma;
5. Meet the clinical criteria for high-risk asthma, as demonstrated by meeting at least one of the following criteria within the 12 months prior to the date of CHABP enrollment:
 - a. Inpatient hospital admission for asthma;
 - b. Hospital observation stay for asthma;
 - c. Hospital emergency department visit for asthma; or
 - d. Oral systemic corticosteroid prescription for asthma; and,
6. Have poorly controlled asthma, as evidenced by a score of 19 or lower on Quality Metric's asthma control test (ACT) (see attachment A) at least twice within any 2 month period in the 12 months prior to the date of enrollment, based on responses by the patient if the patient is at least 12 years old or else by the patient's caregiver. The ACT may be completed in person or by telephone.

B. **Enrollment Process.** Patients who meet the eligibility criteria described in section A will be enrolled in the CHABP through one of the following two pathways.

1. Members identified by MassHealth:
 - a. The Executive Office of Health and Human Services (EOHHS) will, within 10 working days of the contract start-date and every 90 calendar days thereafter, give the participating practice a list of the members on the participating practice's PCC panel who, based on MassHealth claims data, meet the clinical criteria for high-risk asthma set forth in section A.1 through A.5 above.
 - b. The participating practice must make and document its best efforts to schedule each eligible member in its practice for an office visit within 90 days of the date of the list described in paragraph 1.

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- c. At the office visit described in paragraph 2, the participating practice must assess each member on the list described in paragraph 1 above for poorly controlled asthma in accordance with section A.6 above and list members who meet all eligibility criteria specified in section A on the patient enrollment report (see attachment B). The practice must report to the state on the patient enrollment report the reason for not enrolling any member on the list.
2. Members identified by the participating practice.
The participating practice may also enroll on its panel PCC plan members who meet all eligibility criteria (listed in section A), but were not included on the list described in paragraph 1 above, by documenting their eligibility for the CHABP using the patient enrollment report. EOHHS will verify Member eligibility using MassHealth eligibility and claims data, to the extent it is available.
3. The participating practice must submit an initial patient enrollment report within 75 days of the contract start-date. The participating practice may submit changes to this enrollment report by the second Friday of each month for enrollment in the CHABP for the following month. Enrollment is effective as of the first of the month following submission of the enrollment report.
4. The participating practice must send a letter, approved by EOHHS, notifying each PCC plan member enrolled in the CHABP of the CHABP and the services available through the CHABP.

C. Disenrollment

1. A parent or guardian who does not wish their child to receive services through the CHABP may notify the Participating Practice in writing and request to be disenrolled from the CHABP. If the Participating Practice receives such a request, it will report the Member as “disenrolled” on the next Patient Enrollment Report it files.
2. Members who, according to the monthly enrollment roster available through the MassHealth provider online service center (POSC), (1) lose MassHealth coverage, (2) are disenrolled from the PCC plan, or (3) are enrolled with a different PCC site location, will be simultaneously disenrolled from the CHABP. If a member is disenrolled for one of these reasons and the member subsequently is (1) re-enrolled in MassHealth, and (2) re-enrolled in the PCC plan, and (3) reenrolled with the previous participating practice PCC site location, then the participating practice must re-enroll the member in the CHABP; in this case prior eligibility for the CHABP will serve as sufficient documentation of eligibility on the patient enrollment report.

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3. Members will be not be disenrolled during Phase 1 of the CHABP, as further described below, for turning age 18 after being enrolled in the CHABP, nor for failing to continue to meet the clinical criteria for high-risk asthma described in section A.1 through A.5, nor for having an ACT test that fails to meet the criterion in section A.6 above, nor for any reason other than those listed in C.1 and C.2 above.

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STC PROTOCOL REQUIREMENTS

1. A description and listing of the program specific asthma-related benefit package that will be provided to the pilot participants.

A. Traditional MassHealth Covered Services

The Participating Practice will continue to provide or arrange for all medically necessary services for the effective treatment and management of pediatric asthma for Children's High-risk Asthma Bundled Payment Demonstration Program (CHABP) enrollees, in addition to providing required CHABP services (listed in section B) and contingent CHABP services (listed in section C). The participating practice must monitor and manage high-risk asthma services for CHABP enrollees according to their needs and based on national asthma guidelines contained in expert panel report 3 (EPR 3): "Guidelines for the diagnosis and management of asthma" (see <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>)¹, as those guidelines may be periodically updated). The participating practice may bill MassHealth for any such medically necessary traditional MassHealth covered services it provides on a fee-for-service basis. Payment for traditional MassHealth covered services is *not* included in the Phase 1 bundled payment.

In particular, the participating practice must:

1. Assess the member's PCC plan enrollment status at each visit.
2. Assess and monitor asthma control, impairment, and risk, and classify asthma as described in EPR 3, as part of a physician office visit;
3. Administer the asthma control test (ACT) at every well-child and asthma-related visit;
4. Provide or arrange for all medically necessary MassHealth-covered services for the effective treatment and management of pediatric asthma;
5. Ensure that the CHABP Enrollee has a written asthma action plan, in a patient-friendly format, listing the enrollee's primary care provider's and parents' contact information, triggers that exacerbate the CHABP enrollee's symptoms, symptoms to watch for, the names and doses of medications the CHABP Enrollee needs and when to use them, and instructions on when to call the primary care provider and when to see a doctor immediately. The primary care provider must review the asthma action plan at least annually and update it as necessary;
6. Provide asthma self-management education to the CHABP Enrollee and family in the office, including education on the asthma action plan;

¹ Accessed as of February 1, 2012

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7. Provide or arrange for the CHABP enrollee to receive an inactivated flu vaccine when seasonally appropriate;
8. Provide care coordination by a case manager or clinician, to help CHABP enrollees access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma; and,
9. Provide clinical care management of multiple co-morbidities by a licensed clinician, including communication with all clinicians treating the patient, as well as medication review, reconciliation and adjustment.

B. Required CHABP Services

For each CHABP enrollee, the participating practice must:

1. At least once per month, review available data for each CHABP Enrollee to identify the need for follow-up. This review shall include:
 - a. Identifying Enrollees who are due for an office visit, phone call, or other service; and
 - b. Identifying cases for review and discussion by the Interdisciplinary Care Team. The ICT shall at minimum review cases for Enrollees:
 - i. who had an unscheduled office visit, emergency department visit, observation stay and/or inpatient admission for asthma;
 - ii. whose most recent ACT score was 19 or lower; or
 - c. who were recommended for review by a clinician or a member of the ICT.
2. Contact families of CHABP enrollees within three months of enrollment and at least once every six months thereafter:
 - a. To schedule office visits. The participating practice must make every effort to ensure each CHABP enrollee has an office visit within three months of enrollment into the CHABP and at least once every six months thereafter. The participating practice must help families, as needed, to arrange transportation and to avoid missing appointments and document this assistance in the CHABP enrollee's record; and,
 - b. To administer the Asthma Control Test (ACT), as well as the following two additional questions:

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- 1) During the past 4 weeks, how many days of school/daycare/summer program did the CHABP Enrollee miss because of his/her asthma?
- 2) During the past 4 weeks, how many days was a CHABP Enrollee's caregiver unable to work or carry out usual activities because of the Enrollee's asthma?
3. Offer and encourage families of CHABP enrollees to accept a home visit by a community health worker (CHW) or nurse to provide supplemental family education and conduct an initial environmental assessment to identify potential asthma triggers in the home; if a family declines a home visit, then the participating practice must offer supplemental family education and care coordination in the office or by telephone and document this in the CHABP enrollee's record;
4. Request permission from the CHABP enrollee's parent or guardian to contact the CHABP enrollee's school and any childcare provider. With written permission, the Participating Practice must share the CHABP Enrollee's Asthma Action Plan with the school and childcare provider and offer to explain the plan; and,
5. Contact families of CHABP Enrollees each August, either by phone or during an pre-scheduled office visit as needed, in order to:
 - a. Review medications that the CHABP Enrollee currently takes or may need to re-start after the summer; and,
 - b. Request updated school and childcare contact information and, with permission, share the CHABP Enrollee's Asthma Action Plan with new school and childcare personnel.

C. CHABP Services to be provided on an as needed basis

The participating practice must effectively manage their use of CHABP funds to meet individual CHABP enrollees' and families' needs in addition to the minimum requirements listed in section B above. The participating practice must provide additional services and supplies, based on the enrollee's assessed needs, which include, but are not limited to the following:

1. Additional home visits by a CHW or nurse to provide supplemental family education and a full home environmental assessment to identify and document the presence of environmental asthma triggers in the home;
2. Supplies to mitigate environmental triggers, such as hypoallergenic mattress and pillow covers, vacuums, HEPA filters, air conditioner units, and pest management supplies and services, as well as training by a CHW to use these supplies correctly;

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3. Support by CHWs for families' advocacy with landlords and property managers to promote healthy environmental conditions in the home;
4. Care coordination, provided by a CHW, as a supplement to traditional care coordination provided by a case manager or clinician, to help CHABP enrollees and their caregivers access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma; and,
6. Contacting families of CHABP Enrollees each May, either by phone or during an office visit, in order to:
 - a. Review medications that the CHABP enrollee currently takes and adjust as necessary for the summer; and,
 - b. Request contact information for any summer programs that the CHABP enrollee may be enrolled in and, with permission, share the CHABP enrollee's asthma action plan with new school and childcare personnel. Clinical data indicates that many patients experience improvement in asthma symptoms during the summer; Participating Practices should focus their efforts to coordinate with summer programs on CHABP enrollees who have not demonstrated such improvement.
7. Delivering an Enrollee's prescribed medications to a school or childcare, along with the Enrollee's Asthma Action Plan, with written consent from a parent or guardian.

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2. **Rationale for the inclusion of each benefit in the asthma-related benefit package that will be provided to the pilot participants**

The CHABP is intended to allow primary care practitioners to use a variety of evidence-based innovations in care delivery and decision-making to control asthma in children and adolescents at high risk of serious complications or death in a culturally competent and clinically relevant manner.

The recommendations of this benefit package are based on the structure provided in the latest report of the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (2007)ⁱ, but with evidence-based content designed to accommodate new and emerging best practices in the field.

The NAEPP Guidelines structures asthma management into four components:

- (1) Measures of Asthma Assessment and Monitoring;
- (2) Education for a Partnership in Asthma Care;
- (3) Control of Environmental Factors and Co-morbid Conditions That Affect Asthma; and,
- (4) Medications.

Traditional care for asthma generally focuses on medication and education in the office setting. Phase 1 of the pilot covers currently unreimbursed services, allowing flexible use of funds to support community-based interventions. According to the NAEPP guideline, individual interventions alone are often ineffective unless they are part of a comprehensive and holistic approach to medical care. Transportation, money, and time limit traditional asthma education programs set in clinic or school settings and often cause difficulty attracting and retaining participantsⁱⁱ. The benefit package review will thus largely focus on home and community-based interventions for improved asthma outcomes.

Healthy People 2020 outlines select goals and objectives related to home interventions with an environmental focus to reduce asthma morbidity.ⁱⁱⁱ

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Table 1: Select HealthyPeople 2020 Objectives relating to environmental strategies to reduce asthma morbidity	
Objective Description	
EH-13	Reduce indoor allergen levels
RD-1	Reduce asthma deaths
RD-2	Reduce hospitalizations for asthma
RD-3	Reduce hospital emergency department visits for asthma
RD-4	Reduce activity limitations among persons with current asthma
RD-5	Reduce the proportion of persons with asthma who miss school or work days
RD-6	Increase the proportion of persons with current asthma who receive formal patient education
RD-7	Increase the proportion of persons with current asthma who receive appropriate asthma care according to National Asthma Education and Prevention Program (NAEPP) guidelines

Potential CHABP Evidence-based Interventions

Recommendations from numerous advisory groups concur that a comprehensive, multi-faceted approach to asthma management is necessary.

Table 2: Advisory group recommendations regarding a comprehensive approach to asthma management	
Publication & Advisory Group	Findings
<i>Guidelines for the Diagnosis and Management of Asthma</i> The National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 2007	This report states that patients who have asthma at any level of severity should reduce, if possible, exposure to allergens to which the patient is sensitized and exposed, and that effective allergen avoidance requires a multifaceted, comprehensive approach; individual steps alone are generally ineffective.
<i>Characteristics of successful asthma programs: Asthma Health Outcomes Project^{iv} (AHOP)</i> U.S. Environmental Protection Agency	Presents quantitative and qualitative data on 223 asthma programs throughout the world that include at least one environmental component. The report findings indicated that programs were more likely to report a positive impact on health outcomes if they (1) were community based, (2) engaged the participation of community-based organizations, (3) provided program components in a clinical

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<p>2009</p>	<p>setting, (4) provided asthma training to health-care providers, (5) collaborated with other organizations and institutions and with government agencies, (6) designed a program for a specific racial/ethnic group, (7) tailored content or delivery based on individual health or educational needs, and (8) conducted environmental assessments and tailored interventions based on these assessments.</p>
<p><i>Global Strategy for Asthma Management and Prevention^v</i></p> <p>Global Initiative for Asthma (GINA)</p> <p><i>Updated 2011</i></p>	<p>GINA works with health care professionals and public health officials around the world to reduce asthma prevalence, morbidity, and mortality. The organization published asthma guidelines that state “. . . among inner-city children with atopic asthma, an individualized home-based, comprehensive environmental intervention decreased exposure to indoor allergens and resulted in reduced asthma-associated morbidity.”</p>
<p><i>Housing Interventions and Health: a Review of the Evidence</i></p> <p>National Center for Healthy Housing & CDC</p> <p>2007</p>	<p>Published the conclusions of an expert panel convened by the National Center for Healthy Housing and the CDC in December 2007 to weigh the strength of a variety of housing interventions. Home-based environmental interventions to reduce asthma triggers were among the interventions discussed. After reviewing the evidence, the panel found that interventions such as multifaceted, tailored, home-based environmental interventions and integrated pest management for asthma were effective and appropriate for implementation.</p>
<p><i>Effectiveness of Home-Based, Multi-Trigger, Multi-component Interventions with an Environmental Focus for Reducing Asthma Morbidity: A Community Guide Systematic Review</i></p> <p>Taskforce on Community Preventive Services: A collaboration between USDHHS and CDC with public and private partners</p> <p>2011</p>	<p>The Task Force recommends the use of home-based, multi-trigger, multi-component interventions with an environmental focus for children and adolescents with asthma, on the basis of strong evidence of effectiveness in reducing symptom-days, improving quality of life scores or symptom scores, and reducing the number of school days missed. The evidence was considered strong on the basis of findings from 23 studies in the effectiveness review.</p>

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Home Environment Strategy: Decrease Triggers & Housing Resources

Exposure to allergens and irritants within the home can trigger or exacerbate episodes of asthma. The most common asthma triggers within the home include allergens from house dust mites, pets, cockroaches, rodents, and mold as well as irritants such as environmental tobacco smoke (ETS) and indoor air pollutants. Targeting these triggers can decrease the number and severity of asthma exacerbations. Poor housing quality has been shown to be strongly associated with poor asthma control even after controlling for potentially confounding factors such as income, smoking, overcrowding, and unemployment^{vi}. Moisture from leaky plumbing, high humidity, and cracks in floors and walls can contribute to mold growth; provide water for cockroaches, mice, and dust mites; and provide avenues through which cockroaches and mice can enter the home.

INTERVENTION: CHABP will address the environmental asthma triggers through an environmental assessment of the home by a specially trained community health worker (CHW). Based on the results of the home assessment, a determination of an appropriate mitigation plan would be developed. Supplies that could contribute to asthma control include HEPA vacuums, air conditioning units, allergenic covers would be available to qualifying households based on specific triggers, patient sensitization, and need. CHWs will also be trained to support families' advocacy with landlords and property managers to promote healthy environmental conditions in the home; CHWs can educate families as to landlords' legal responsibilities for maintaining their property and help families to articulate requests for corrective action.

Home-based Education Strategy:

The NAEPP recommends asthma self-management education at multiple points of care. There is evidence that using multiple approaches to address environmental triggers, specifically approaches that use both education and remediation, could be more effective than interventions that use either alone^{vii}.

INTERVENTION: The CHABP pilot would provide funding for CHWs who have specialized training in asthma and environmental mitigation to the high risk asthma patients and their families. The cost effectiveness of CHWs for asthma education has been established in numerous settings.^{viii,ix,x,xi} The CHW training will result from a collaboration with DPH and community partners and includes a core competency training as well as additional asthma environmental mitigation training.

The education that could be supplemented by the CHW assessment and follow-up include the following:

- asthma education for caregivers
- self-management skills to promote control
- allergen control interventions
- tobacco cessation and/or avoidance for household members
- asthma action plan review
- advocacy training around housing rights

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Importantly, the education is to be tailored to patient and caregiver level of literacy, will test understanding, and will be provided in a culturally and linguistically competent manner.

Office-based Strategy

In addition to the normal standard of care provided in the office setting, the CHABP is designed to allow practices the flexibility to enhance a care coordination strategy for the high risk patients identified by training CHWs to provide care coordination services for both CHABP enrollees and their caregivers. CHABP establishes a mechanism for linking office and home-based strategies for valuable information regarding the home environment, reinforcement of asthma management education concepts, and feedback to the practices regarding the patient's control. The office would also be able to offer other significant benefits to appropriate families including supplies to mitigate environmental triggers (as mentioned above) to households that qualify. The goal is to decrease asthma exacerbations and improve function by providing enhanced services that yield more timely and actionable information to prevent costly asthma exacerbations and best serve the needs of the child.

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3. **Eligibility, qualifications and selection criteria for participating providers, including the RFP for preapproval:**

The following eligibility, qualification, and selection criteria will be used to assess provider applications for the CHABP program, and will be reflected in procurement documents. EOHHS may also consider any relevant information about the practice known to EOHHS.

A. Minimum Qualifications

To be considered for selection as a participating provider, applicants, in addition to all other requirements specified herein, must:

1. Participate as a PCC in the MassHealth PCC plan;
2. Have a MassHealth PCC plan provider identification and service location number (PID/SL) for the applicant site;
3. Have high-risk asthma patients ages 2-18 enrolled in the PCC panel, as evidenced by MassHealth claims data;
4. Possess secure broadband Internet access; and,
5. Not participate in the MDPH Reducing Ethnic/Racial Asthma Disparities in Youth (READY) study or another initiative that pays for similar services for pediatric patients with high-risk asthma at this practice site location identified by its PID/SL.

B. Participating Practice Evaluation Criteria

1. In order to be considered for participation in the CHABP, an applicant must:
 - i. Demonstrate that it meets the minimum practice qualifications identified in section A;
 - ii. Not receive payment or funding from any other source for services, activities, or expenses that will be funded through the CHABP; and,
 - iii. Submit a complete and timely application.
2. The quality of the responses to the questions in the application will be evaluated in accordance with the following criteria: comprehensiveness, feasibility, appropriateness, clarity, effectiveness, innovation, and responsiveness to the needs of EOHHS and the goals of the CHABP;
3. EOHHS will also evaluate responses from each applicant based on the following criteria:

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- i. The extent to which the practice demonstrates commitment to participate in the CHABP for at least three years;
- ii. The number of high-risk asthma patients ages 2 through 18 enrolled in the applicant's PCC plan panel based on MassHealth claims data;
- iii. The extent to which the applicant demonstrates its ability to manage high-risk asthma in a coordinated fashion as demonstrated by the applicant's responses to the questions in the application;
- iv. The extent to which EOHHS determines that the applicant satisfies EOHHS' goals of selecting a group of pediatric primary care practices which, taken together, are diverse in terms of:
 - Practice structure (e.g., solo, group, community health center);
 - Practice affiliation (e.g., independent, hospital-owned);
 - Geographic location;
 - Bilingual and multilingual capability; and,
 - Patient mix, as defined by racial and ethnic composition.

EOHHS may consider any relevant information about the practice known to EOHHS.

C. Contract Requirements for Participating Practice Staffing

The Participating Practice must:

1. Designate a financial/operational project leader. The financial/operational project leader must manage the financial resources required to manage and treat CHABP Enrollees. During Phase 1, the financial/operational project leader will participate in monthly meetings, in person or by phone, with EOHHS-designated staff to discuss development of the Phase 2 Bundled Payment;
2. Designate a clinical project leader for the CHABP demonstration program. The clinical project leader must ensure that each Interdisciplinary Care Team (ICT), as described below, manages CHABP Enrollees' asthma according to their needs, with a goal of preventing asthma-related hospital admissions and emergency department utilization and improving health outcomes. The clinical project leader must be a licensed clinician on staff at the Participating Practice and will act as the clinical director for the CHABP within the Participating Practice;
3. Designate a group of health care professionals within the Participating Practice that must comprise an ICT for each CHABP Enrollee which must collectively provide, coordinate and supervise the provision of asthma care, services and supplies in a continuous, accessible, comprehensive and coordinated manner. The ICT must

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include, at a minimum, the member's primary care provider, a Community Health Worker (CHW), and the clinical supervisor for the CHW. The ICT must include CHABP Enrollees' specialty providers who offer treatment for asthma, if any, and establish a standard procedure for communicating with specialists;

4. Employ or contract for the services of at least one full-time or part-time Community Health Worker (CHW) or train an existing staff member to become a CHW (if training an existing staff member, training must be completed prior to the provision of CHABP services). CHWs must be culturally competent in the cultures, and preferably languages, of a Participating Practice's CHABP Enrollees and must:
 - a) Demonstrate their knowledge, skill and ability in the following core competencies:
 - i. Knowledge and identification of environmental asthma triggers;
 - ii. Environmental intervention and treatment;
 - iii. Ability to counsel caregivers and pediatric asthma patients on the reduction of environmental asthma triggers and self-management; and
 - iv. Effective communication and patient follow-up skills;
 - b) Complete a seven (7) day CHW core competency training, sponsored by the Massachusetts Department of Public Health (DPH), an Area Health Education Center (AHEC), or a Massachusetts Community College. The core competency curriculum includes leadership skills, assessment techniques, public health, outreach, cross cultural communication, community organizing, special focus on specific diseases groups and health issues, techniques for connecting families with community services, and techniques for talking about smoking cessation. If the Participating Practice is unable to access the DPH training free of charge, the cost of training will be the responsibility of the Participating Practice;
 - c) Complete a four (4) day asthma mitigation training, sponsored by DPH or provided by the Participating Practice using a curriculum approved by DPH. The asthma mitigation curriculum includes recognizing uncontrolled asthma, how to read an action plan, how to reinforce messages, environmental assessment and mitigation, and a discussion of housing law and tenants rights. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for training the CHW;
 - d) Complete a two day refresher asthma mitigation and core competency training, sponsored by DPH, each year the practice is participating in the CHABP. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for the cost of the training for the CHW;
 - e) Participate in quarterly CHW trainings or collaborative learning sessions organized by DPH. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for the cost of the training for the CHW; and

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- f) Obtain CHW certification through DPH within one year of the date that such certification becomes available.
5. Assign a clinical supervisor for the CHW. The clinical supervisor may be any clinical member of the Participating Practice who participates in the ICT(s). The clinical supervisor must participate in a half-day training, sponsored by DPH, on how best to utilize the CHW and how to integrate the CHW into the care team.
6. Designate or contract for the services of at least one individual to provide care coordination to help CHABP Enrollees and caregivers access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma. Care coordination may be provided by a CHW, case manager, or clinician.
7. Designate or contract for the services of at least one licensed clinician to provide clinical care management of multiple co-morbidities, including communication with all clinicians treating the patient, as well as medication review, reconciliation and adjustment.

D. Preapproval of RFP

The Commonwealth must submit the Request for Proposals (RFP) to the CMS Regional and Central Offices for review and preapproval prior to public release. The RFP must be submitted to CMS for review and preapproval at least 45 business days prior to the expected release date.

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4. **A plan outlining how this pilot may interact with other federal grants, such as for related research (e.g. NIH, HUD, etc.) and programmatic work (e.g. CHIPRA grant related to pediatric health care practices in multi-payer medical homes, etc.). This plan should ensure no duplication of federal funds and outline the state's coordination activities across the various federal support for related programmatic activities to address potential overlap in practice site selection, patient population, etc.**

If a practice participates in the Patient Centered Medical Home Initiative (PCMHI) as a Technical Assistance Plus Practice and participates in the CHABP, the Commonwealth will reduce the CHABP payment by the amount of the PCMHI payment. The PCMHI Medical Home Activity Fee and the PCMHI Clinical Care Management Fee will be deducted from the PMPM CHABP Phase 1 bundled payment amount.

If a Practice participates, either on its own or as part of a PCC, in the Primary Care Payment Reform (PCPR) initiative, the PCPR participants' PMPM payment for medical home services will be deducted from the \$50.00 PMPM CHABP Phase 1 Bundled Payment Amount. The PCPR PMPM payment for medical home services will be calculated by multiplying the PCPR medical home load by the risk score by the expected external service provision adjustment.

Applicants to participate in the CHABP must certify that they do not receive payment or funding from any other source for services, activities, or expenses that will be funded through the CHABP at this practice site. The application form requires applicants to respond to a number of questions regarding other related programmatic activities which may be federally funded.

In evaluating the CHABP, the Commonwealth will attempt to match Participating Practices with other practices that are participating in the same set of related programmatic activities in order to discern interactions among these activities.

Application to Participate in the Massachusetts Children's High-risk Asthma Bundled Payment (CHABP) Demonstration Program Sample Questions

- a. Indicate whether the practice is participating in any of these initiatives. (Participation in these initiatives is not a prerequisite to participation in the CHABP. The Practice may participate in both the CHABP and one or more of these initiatives as long as they do not provide payment or funding for services, activities, or expenses that will be funded through the CHABP at this practice site.) Check all that apply.
- (1) Massachusetts CHIPRA Medical Home Demonstration Project
 - (2) Safety Net Medical Home Initiative
 - (3) Medicare Care Management for High-cost Beneficiaries Demonstration
 - (4) Medicare Federally Qualified Health Center Advanced Primary Care Practice (FQHC ACP) Demonstration
 - (5) State Demonstration to Integrate Care for Dual Eligible Individuals
 - (6) Patient Centered Medical Home Initiative (PCMHI)
 - (7) Other medical home initiative (describe)
 - (8) None of the above

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b. If the practice is participating in one or more of the initiatives listed above, are the staff committed to providing time and effort to the other initiative(s)? Explain the practice's plan to complete all initiatives successfully.

c. Is the PCC plan provider participating in the MDPH Reducing Ethnic/Racial Asthma Disparities in Youth (READY) study or another initiative that pays for similar services for pediatric patients with high-risk asthma at a different practice site?

Yes No

If yes, please provide the name of the initiative and the participating practice site.

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5. **A plan for the purchase and dissemination of supplies within the pilot specific benefit package, including procurement methods, by the state and/or providers including volume discounts:**

During Phase 1, CHABP providers will be responsible for the purchase and dissemination of the environmental mitigation supplies provided as necessary to CHABP beneficiaries. Providers are required to submit a plan to procure, store and disseminate environmental mitigation supplies under this pilot during the application process; this plan must also address the delivery, installation, and ease of consumer use for each supply. This plan should also address how the provider will utilize volume discounts (either its own or the Commonwealth's) in its procurement of mitigation supplies, and how the practice will instruct the CHABP parent/guardian in the use of the supplies.

The Commonwealth is responsible for the oversight of providers' environmental mitigation supply purchasing and dissemination procedures to ensure that supplies are comparable in the areas of patient outcome, safety and relative costs. The Commonwealth must also assure standardized equipment pricing, the availability of items to all CHABP enrollees, and must provide any beneficiary supports necessary to access provider-distributed environmental mitigation supplies.

Participating providers will be required to report the type, make, model, cost and quantity for each supply procured and disseminated to CHABP members on the CHABP Expenditure Report. The Commonwealth will evaluate this information on a quarterly basis to ensure consistency and quality of purchased supplies for each practice. The state will ensure there is a process to disseminate supplies as needed to best meet individual CHABP enrollees' needs. If the Commonwealth finds that a provider(s) is unable to purchase or disseminate mitigation environmental supplies where medically necessary to support the goals of the pilot, the Commonwealth must immediately notify CMS and provide a mitigation strategy that begins with the Commonwealth intervening in order to ensure needs are met.

As part of the evaluation of Phase 1 and as a condition of approval for Phase 2, the Commonwealth will conduct a value analysis to assess the environmental mitigation supplies purchased and disseminated in terms of patient outcome, safety, and relative costs to develop product selection and standardization guidelines to be used during Phase 2 of the Pilot. The purpose of this analysis will be to determine how the bundled payment model and products provided under this contingent service correlate with costs, outcomes, and safety.

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6. Payment rate setting methodology outlining the per member per month (PMPM) payment for the pilot services and supplies, consideration of risk adjustment and the estimated/expected cost of the pilot.

Providers who contract with the MassHealth PCC Plan will be reimbursed on fee for service (FFS) basis. Under Phase 1 of CHABP, participating PCCs will receive a prospective, monthly PMPM payment to cover the CHABP asthma mitigation services not currently reimbursed by MassHealth for members with high risk asthma (services include home visits by CHW, supplies and services to mitigate environmental asthma triggers). The data used to develop the Phase 1 PMPM is included in the tables below.

The PMPM payment is built up from an estimated cost of the covered benefits and an estimate of how many members will receive each supply or service. Supply costs were estimated based on actual costs incurred by Massachusetts health care providers who are currently distributing these supplies through their practices.

The budget table below includes an estimate of the percent of CHABP Enrollees that will receive a specific supply or service during a given year. Not all Enrollees will require each supply on an annual basis (for example, a family may already own a vacuum cleaner with a HEPA filter). Participating providers may distribute supplies to CHABP members in subsequent years of Phase 1 for a number of reasons, including for example:

- The member was newly eligible for CHABP because the member recently turned 2 years of age, enrolled in MassHealth, enrolled in the PCC Plan, was assigned to the Participating Practice's PCC Panel, met the clinical criteria for high-risk asthma, and/or met the criteria for poorly controlled asthma.
- The family had previously declined a home visit, but accepted a home visit in the second year. The environmental assessment identified the need for supplies that had not been identified previously through conversations with the family in the office and by telephone.
- The supply is no longer operational and required replacement.
- The family moved to a new housing situation and was unable to bring the supply with them.

The estimated percentage of members that will receive a supply during a year takes these contingencies into account. The estimates were based on the experience of existing programs, where for example, 30% of members declined a home visit where supplies were provided, as well as a consensus of the pilot advisors.

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Estimated cost of Community Health Worker Visits and Phone Calls

	Visit	Phone Calls
CHW salary/hour	\$ 15.00	\$ 15.00
Hours per visit, including prep	4	0.25
Salary cost/visit	\$ 60.00	\$ 3.75
Supervision cost (10%)	\$ 6.00	\$ 0.38
Fringe, travel, indirect (45%)	\$ 29.70	\$ 1.86
Cost/visit	\$ 95.70	\$ 5.98

Budget for an average panel of high-risk asthma Members

Supply	Average Cost Each	Number	Price per Member	% of Members Receiving Supply	Cost per Member
Vacuum	\$140.00	1	\$140.00	70%	\$98.00
Filters	\$40.00	1	\$40.00	70%	\$28.00
Bedding	\$90.00	1	\$90.00	70%	\$63.00
Pillows	\$14.00	2	\$28.00	70%	\$19.60
Environmental Kits	\$55.00	1	\$55.00	45%	\$24.75
Educational Materials	\$20.00	1	\$20.00	100%	\$20.00
A/C Units	\$115.00	1	\$115.00	10%	\$11.50
Pest Management	\$130.00	1	\$130.00	50%	\$65.00
Total Supplies Cost					\$329.85
CHW initial visit/education	\$95.70	1	\$95.70	70%	\$66.99
CHW 2nd & 3rd visit, environmental mitigation	\$95.70	2	\$191.40	50%	\$95.70
CHW 4th & 5th visit follow-up education	\$95.70	2	\$191.40	30%	\$57.42
Total home visit cost					\$220.11
Phone calls	\$5.98	9	\$53.83	100%	\$53.83
Total cost per member per year					\$603.79
Cost per member per month					\$50.32

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Supply Item	Required Features
Vacuum	High Efficiency Particulate Air (HEPA) filter that removes 99.97% of particles at least 0.3 microns in size; double bag
Vacuum bags	Fits vacuum
Mattress cover	Allergen-impermeable, allergen-proof, zippered, waterproof
Pillow	Allergen-impermeable, allergen-proof
Air conditioner	High Efficiency Particulate Air (HEPA) filter that removes 99.97% of particles at least 0.3 microns in size

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7. **Payment methodology outlining cost and reconciliation for the infrastructure payments to participating provider sites, and the eligibility and reporting requirements associated with the infrastructure payments.**

The Commonwealth will not make infrastructure payments as part of the CHABP initiative to participating provider sites during Phase 1 of the pilot. The Commonwealth must request CMS approval in order to implement infrastructure payments during Phase 2. During Phase I, the Commonwealth must work with stakeholders, including providers and an advisory committee, to develop the cost and reconciliation methodology for infrastructure payments, which will be submitted as a condition for approval Phase 2.

During Phase 1, the financial/operational project leader will participate in monthly meetings, in person or by phone, with EOHHS-designated staff and/or with the project Advisory Committee to discuss development of the Phase 2 Infrastructure Payment and Reconciliation Methodology.

During Phase 1, the Participating Practice will develop, or contract with another entity to provide, any additional infrastructure necessary to meet the specifications that EOHHS ultimately establishes for managing the Phase 2 Bundled Payment. This infrastructure may include, but is not limited to:

- a. Systems to coordinate ambulatory services provided by other health care providers, including specialists;
- b. Contracts and other documentation necessary to make payments to these other providers;
- c. Financial systems to accept Bundled Payments from EOHHS and to use them to pay for services provided by these other health care providers; and
- d. Information technology systems to track Bundled Payments received from EOHHS and payments made to these other providers.

During Phase 2, Participating Provider sites may be eligible for up to \$10,000 per practice site for infrastructure changes. The amount of infrastructure support is variable up to this maximum; actual awards will vary depending on the provider's readiness, EOHHS's review and finding of such readiness, and CMS' concurrence on the use of the proposed funding for the Participating Practice. A description of the award, distribution, and reconciliation process for these funds must receive CMS approval prior to implementation during Phase 2. Infrastructure payments are subject to the spending limitation of the infrastructure and capacity-building (ICB) component of the Safety Net Care Pool (SNCP), and are further contingent on continued CMS approval of the SNCP and the ICB.

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8. Evaluation Design

The Commonwealth must develop an evaluation design for the CHABP pilot program which will be incorporated into the evaluation design required per STC 90 following CMS review and approval. The Commonwealth must submit the evaluation design to CMS no later than 60 calendar days after the approval of this Pediatric Asthma Pilot Program Protocol.

The objective of the evaluation is to determine the benefits and savings of the pilot as well as design viability and inform broader implementation of the design. The evaluation design must include an evaluation of programmatic outcomes for purposes of supporting any future expansion of the pilot project, including Phase 2. As part of the evaluation, the state at a minimum must include the following requirements:

- i. Collect both baseline and post-intervention data on the service utilization and cost savings achieved through reduction in hospital services and related provider services for the population enrolled in the pilot. This data collection should include the quality measure on annual asthma-related emergency room visits outlined in the initial core set of children's health care quality measures authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA) beginning with a baseline set at the onset of the pilot, adjusted for the age range enrolled in the pilot program;
- ii. A detailed analysis of how the pilot program affects the utilization of acute health services, such as asthma-related emergency department visits and hospitalizations by high risk pediatric asthma patients, and how the pilot program reduces or shifts Medicaid costs associated with treatment and management of pediatric asthma;
- iii. A detailed analysis of the provision of mandatory and optional CHABP services provided to enrollees, which must include an analysis of purchasing strategies, supply costs, and stratification of distribution and provision of CHABP services by enrollee age, as well as an analysis of any optional services provided to enrollees that differ from those specified in this protocol;
- iv. An assessment of whether the cost projections for the provider payment were appropriate given the actual cost of rendering the benefits through the pilot program; and,
- v. A detailed analysis of how the effects of the pilot interact with other related initiatives occurring in the state.

The goal of the evaluation is to assess the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation as demonstrated by changed practices in asthma care and improved health outcomes at the same or lower cost. The Phase 1 hypotheses are that:

1. There will be a lower rate of asthma-related hospitalization and emergency department visits among enrollees compared to the comparison group.

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2. Enrollees will attain better asthma control as measured by lower numbers of days absent from school/work/summer program as compared to the comparison group.
3. Total expenditures for the pilot including bundles payments for optional services for enrollees will be equal to or less than overall expenditures for the comparison group.

Specifically, the Commonwealth will examine changes in: 1) the way providers deliver services to CHABP Enrollees; 2) CHABP Enrollees' self-management of asthma; 3) CHABP Enrollees' health service use (i.e. emergency department use); 4) CHABP Enrollees' healthcare expenditures; and 5) CHABP Enrollees' quality of asthma care. This will include a cost-effectiveness analysis to examine the relative value between the pilot and the usual care.

Additionally, the Commonwealth will conduct a value analysis to assess the impact of environmental mitigation supplies purchased and disseminated in terms of patient outcome, safety, and relative costs. The purpose is to determine how the bundled payment model and products provided under this optional service correlate with costs, outcomes and safety.

The evaluation will use a mix of qualitative and quantitative methods. Data will be collected from Participating Practices and CHABP Enrollees, and extracted from Medicaid claims data and the MassHealth program office. Individuals with characteristics comparable to participating members will be identified for comparisons. The Commonwealth must submit its evaluation of the first full year of Phase 1 to CMS within 180 days of the end of the pilot year. To the extent that Phase 1 remains in place while the Commonwealth is conducting the evaluation and awaiting approval of its Phase 2 proposal, it will conduct an evaluation of each subsequent full pilot year on an annual and cumulative basis. Year one Phase 1 evaluation data will be a component of CMS' review of the Commonwealth's Phase 2 proposal. If CMS' review of the Commonwealth's Phase 2 proposal begins after the end of a subsequent full pilot year of Phase 1, then CMS may also include data from the Commonwealth's evaluation of that subsequent year in its review of the Commonwealth's Phase 2 proposal.

Data Sources

Data will be collected from Participating Practices to evaluate changes in the practice at 1 year intervals following implementation of Phase 1 of the pilot. The Commonwealth will also collect data from CHABP Enrollees at the pilot enrollment and 1 year after the enrollment to assess changes in asthma control and the number of days absent from school/work. Medicaid claims data will be used to evaluate changes in service use and healthcare expenditures. Additionally, data collected from participating members, healthcare expenditures paid by Medicaid, and program operation costs from the pilot management office will be used for the cost-effectiveness analysis.

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Comparison Group

To mitigate the potential bias that any observed changes in outcomes are resulting from high service utilization or poor asthma control prior to the pilot participation or from concurrent changes in healthcare environment, the Commonwealth will identify a matched comparison group. To the extent available and comparable, the Commonwealth will include practices that applied for the pilot but were not chosen for the 1st phase in this comparison group. Both practice and member characteristics will be considered in the matching algorithm. Exact matching on important characteristics and propensity score matching techniques will be used to ensure the comparability of characteristics between Participating Practices/members and the comparison group. Considering these practice characteristics in the matching algorithm and subsequent statistical analysis are intended to isolate the effect of the pilot from other initiatives. This approach also addresses requirements set forth by STC 90.

Measures

Measures used in this evaluation are organized into three groups: changes in provider practice, changes in self-management of asthma, changes in service use (i.e. emergency department use), number of days missed from school/work/summer program due to asthma, healthcare expenditures, and quality of care. The initial core set of children's healthcare quality measured authorized by the Children's Health Insurance program Reauthorization Act (CHIPRA) will serve as the guide for service use and quality of care measures (see Measures: changes in service use, healthcare expenditures, and quality of care). Also, healthcare expenditures and program operation costs will be included in the analysis to assess the viability of the pilot and to develop a payment rate for the program (see Measures: measures for the cost-effectiveness analysis).

Changes in provider practice

Qualitative semi-structured key informant interviews with members of the interdisciplinary care team in each Participating Practice will be conducted at 1 year intervals after implementation of Phase 1 of the pilot. These interviews will assess changes in the way providers deliver services by identifying key components of changes in the practice and potential barriers in implementing the pilot.

Changes in self-management on asthma

Telephone and/or mail surveys will be used to evaluate changes in asthma management and the effect of the pilot. The survey instrument includes the asthma control test (ACT) measure and questions on the number of days absent from school for children/teens and from work for parents. These measures will also represent the effects in the cost-effectiveness analysis. The Commonwealth will conduct the surveys on all participating members and individuals in the comparison group at the baseline and at 12 month after baseline as budget permits.

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Changes in service use, healthcare expenditures, and quality of care

MassHealth claims data will be used to derive healthcare service utilization, healthcare expenditures, and quality of care measures before the pilot enrollment and through the first year of the pilot participation. Key healthcare service utilization measures include asthma-related emergency department (ED) visits and asthma-related hospitalizations. Other types of service use also will be analyzed to examine possible shifting in services. Quality of care will be evaluated based on Healthcare Effectiveness Data and Information Set (HEDIS) specifications for asthma care and on the use of asthma-control medications following NQF 1799 Medication Management for People with Asthma.

Measures for cost-effectiveness analysis

In addition to healthcare expenditures from claims data, cost data will include program operation costs. Healthcare expenditures are MassHealth payment amounts for providers which are reported in claims. Program operation costs include the per-capita bundled payments for participating members and program-related administrative costs; and costs of environmental mitigation supplies purchased by providers. The MassHealth PCC plan staff will provide information on program operation costs. These cost data will represent the cost to Medicaid in the cost-effectiveness analysis.

Data Analysis

Qualitative data collected from staff in Participating Practices will be analyzed to identify common themes of changes in service delivery across Participating Practices. Innovative approaches and barriers for service delivery related to the pilot implementation will be summarized by the practice.

A difference-in-differences analytical framework will be used to analyze outcomes from claims data and data collected from Participating Members. The Commonwealth will compare changes in services use, healthcare expenditures, asthma control, and number of days absent from school/work for participating members to those for individuals in the matched comparison group. Outcome measures will be available for each individual for two or more times before and during the first year of the pilot. Measures for an individual at different time points are likely to be correlated. The Commonwealth will apply generalized estimating equations to account for the within-subject correlations. Given the usual time lag of claims data and the seasonal nature of acute events associated with asthma, quantitative analysis using claims data will begin at 1 year after the pilot implementation.

The Commonwealth will develop a measure of total cost based on health care expenditures, adjusted for case mix, plus program operations costs. The Commonwealth will conduct cost-effectiveness analysis to estimate the relative value between the pilot and the usual care. The ACT score and the number of days being absent from school/work measures the effect of the pilot, which is independent from the costs included in the analysis. Results will show the incremental costs associated with each day not absent from school or work.

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Notice of Opportunity to Participate in Pediatric Asthma Advisory Committee

Published on the Commonwealth Procurement Access and Solicitation Site (Comm-PASS) April 6, 2011.

The Executive Office of Health and Human Services (EOHHS), Office of Medicaid seeks individuals to serve on the Pediatric Asthma Bundled Payment Pilot Advisory Committee.

St.2011, C.131, S.154 directs EOHHS to “develop a global or bundled payment system for high-risk pediatric asthma patients enrolled in the MassHealth program, designed to prevent unnecessary hospital admissions and emergency room utilization.” This legislation also provides for EOHHS to consult with relevant providers in designing and implementing the pediatric asthma project. The University of Massachusetts Medical School (UMMS) is working with EOHHS to help develop this initiative.

EOHHS wishes to establish and consult an Advisory Committee on designing and implementing the high-risk pediatric asthma global or bundled payment demonstration program. The Advisory Committee may make recommendations on issues such as specifying the target patient population to be included in the initial demonstration, the basket of services to be included in the bundled payment, the risk adjustment methodology, the infrastructure required to manage the bundled payment, the evaluation metrics, and potential strategies for sharing savings between the MassHealth program and participating providers. EOHHS anticipates that this Advisory Committee will meet approximately once or twice per month or as EOHHS determines necessary beginning in or around April, 2011 through approximately December, 2012.

EOHHS seeks individuals, including representatives of providers who wish to participate in the high-risk pediatric asthma global or bundled payment demonstration program, to serve on this Advisory Committee. To be eligible to participate in the Advisory Committee, such individuals must have expertise (1) treating high-risk pediatric asthma patients, and/or (2) designing and implementing clinical programs to prevent and manage high-risk pediatric asthma, and/or (3) designing and implementing global or bundled payment structures. EOHHS will not compensate individuals for serving on this Advisory Committee. Participation in this Advisory Committee is not a pre-requisite for participation in the global or bundled payment demonstration program.

Interested individuals should submit an up-to-date resume or Curriculum Vitae and a letter of interest highlighting their relevant experience and expertise by April 13, 2011.

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EOHHS and UMMS will review the responses and select individuals who bring the greatest breadth and depth of relevant knowledge and expertise to serve on the Advisory Committee. EOHHS reserves the right to request additional information from potential participants, solicit additional individuals for participation, and reject applicants for participation as it determines appropriate to assure that the Advisory Committee meets the agency's needs.

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Advisory Committee Members

Name	Title	Institution/ Employer	Qualifications
Gary Adamkiewicz, PhD, MPH	Research Scientist	Harvard School of Public Health	<ul style="list-style-type: none"> • Research on the studies of indoor environmental conditions • Member of the Healthy Public Housing initiative – a community-centered asthma intervention project • Member of the Asthma Regional Council • Provide training on healthy homes issues • Several publications and research on asthma
Stacey Chacker	Director of Environmental Health and Asthma Regional Council	Health Resources in Action, Inc.	<ul style="list-style-type: none"> • Member Steering Committee Massachusetts Asthma Action Partnership • ARC and UMass developed tools – Investing in Best Practices for Asthma and Insurance Coverage for Asthma: A Value and Quality Checklist • November 2010 – Symposium leader for Improving Asthma Management in a Changing Healthcare System
May Chin, RN, MS, MBA	Project Director Asthma Prevention and Management Initiative	Floating Hospital for Children at Tufts Medical Center	<ul style="list-style-type: none"> • Registered Nurse for over 40 years • Designed and implemented the Asthma Prevention and Management Initiative at Tufts • Cardiac Care demonstration project which resulted in full implementation as a reimbursable standard of care
Patricia Edraos, JD	Health Resources Policy Director	Massachusetts League of Community Health Center	<ul style="list-style-type: none"> • Assisted Medicaid agency in CHIP expansion • Educational programs for global payment
Jim Glauber, MD, MPH	Senior Medical Director	Neighborhood Health Plan	<ul style="list-style-type: none"> • Pediatrician in practice for 19 years • Management of children with special healthcare needs i.e. asthma, prenatal diabetes • Developed asthma disease management program • Received grant for Implementation of an Enhanced Asthma Home Environmental Program
Polly Hoppin, ScD	Research Professor and Program Director	School of Health and Environment University of Massachusetts, Lowell	<ul style="list-style-type: none"> • Senior advisor to the Regional Director of DHHS • Principal Investigator on project to better understand how health insurance plans make decisions to cover preventive measures • Designing a coordinated asthma home visit system for the city of Boston • Several publications on the subject of Asthma • Secretary’s Award for Distinguished Service in 1998 for developing five-year strategic plan to combat Asthma

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Name	Title	Institution/ Employer	Qualifications
Lara Khouri, MBA, MPH	Director, Integrated Care	Children’s Hospital	<ul style="list-style-type: none"> • Business Perspective – Accounting & Management • Managed Care Contracting on behalf of large academic medical centers • Developed innovative payment structures – pay for performance
Ted Kremer, MD	Director, Pediatric Sleep Medicine	UMass Memorial Medical Center	<ul style="list-style-type: none"> • Pediatrician in practice for over 12 years • Board certified in Pediatric Pulmonology • Member of the Division of the Pediatric Pulmonary, Asthma, Sleep and Cystic Fibrosis Center at UMass Memorial
Kimberly Lenz, Pharm.D.	Clinical Consultant Pharmacist	UMass Medical School – Commonwealth Medicine	<ul style="list-style-type: none"> • Registered pharmacist 8 years • Participated in an asthma outreach program while a student at St. Louis Children’s Hospital • Member of the Pediatric Pharmacy Advocate Group
William Minkle, MS	Executive Director	ESAC (Ecumenical Social Action Committee, Inc.)	<ul style="list-style-type: none"> • Supervise ESAC’s Boston Asthma Initiative (BAI) for 4 years • 30 years non-profit experience with community programs • Member Boston Community Asthma Initiative Steering Committee
Neil Minkoff, MD	Chief Medical Officer	1776 Healthcare	<ul style="list-style-type: none"> • Has been practicing medicine for 15 years • Currently clinical lead for creating bundled payment • Extensive medical management experience
Shari Nethersole, MD	Medical Director for Community Health	Children’s Hospital, Boston	<ul style="list-style-type: none"> • Pediatrician in practice for over 25 years • Drafted the MA Provider Consensus Statement in conjunction with the Asthma Regional Council • Oversaw the design and establishment of the Community Asthma Initiative at Children’s.
Dorothy Page, MSN, FNP	Pediatric Nurse Practitioner	UMass Memorial Medical Center	<ul style="list-style-type: none"> • Registered Nurse for 40 years • Member of the Pediatric Pulmonary, Asthma, Sleep and Cystic Fibrosis Center – Umass Memorial • Developed the clinical asthma program working with school nurses for the high risk and poorly controlled asthmatics
Margaret Reid, RN, BA	Director, Division of Healthy Homes and Community Supports	Boston Public Health Commission	<ul style="list-style-type: none"> • Registered Nurse for 17 years – currently working on Master’s • Convened the Boston Asthma Home Visit Stakeholders Group • 2009 –EPA National Environment Leadership Award in Asthma Management • Member Massachusetts Asthma Action Partnership

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Name	Title	Institution/ Employer	Qualifications
Elaine Erenrich Rosenburg, MS	Executive Director	Asthma & Allergy Foundation of America/New England Chapter, Inc.	<ul style="list-style-type: none"> • Member of the Steering Committees for the Boston Urban Asthma Coalition and the Massachusetts Asthma Action Program and the Health Access Resource Network • Work closely with parents of asthma patients • Help to manage children's asthma to reduce asthma incidents especially those requiring ER visits
Matthew Sadof, MD, FAAP	Director, Medical Home and Primary Care Asthma Intervention Programs	Baystate Medical Center	<ul style="list-style-type: none"> • Pediatrician in practice for 25 years • Received numerous grants for Asthma research • Directs a program that utilizes CHW's to extend care to children with asthma • Cares for a high-risk pediatric population with asthma at a local clinic
Megan Sandel MD, MPH, FAAP	Director & Co- Founder	Doc4kids project	<ul style="list-style-type: none"> • Pediatrician in practice for 15 years focused solely on care for low income children • Member Asthma Regional Coordinating Council • Ongoing research on How Much is Too Much to Wheeze: Asthma • Co-authored with Jean Zotter a publication on How substandard Housing affects children's health
Winthrop Whitcomb, MD, MHM	Medical Director, Healthcare Quality	Baystate Medical Center	<ul style="list-style-type: none"> • Physician for over 20 years • Chair of the total hip replacement bundled payment program pilot at Baystate
Elizabeth Woods, MD, MPH	Director of the Children's Hospital Boston's Community Asthma Initiative	Children's Hospital, Boston	<ul style="list-style-type: none"> • Pediatrician in practice for over 25 years • April 12, 2007 Elizabeth Woods Day in Boston for community asthma efforts • Principal investigator on a grant providing coordination of asthma care at home • Principal investigator on a grant addressing health disparities for children living in Jamaica Plain, Roxbury and Dorchester dealing with asthma

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References

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Attachment H
Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
Approved December 17, 2013

Introduction

This cost limit protocol will meet the required protocol specifications pursuant to Massachusetts 1115 Demonstration Special Terms and Conditions (STC) 51(f). According to this protocol:

- 1) The cost limit must be calculated on a provider-specific basis.
- 2) Only the providers receiving SNCP payments for uncompensated care pursuant to STC 50(b) will be subject to the protocol.
 - a. All Medicaid Fee-for-Service payments for services and managed care payments, including any supplemental or enhanced Medicaid payments made under the State plan ¹, SNCP payments subject to the Provider Cap pursuant to STC 51(c), and any other revenue received by the providers by or on behalf of Medicaid-eligible individuals or uninsured patients are offset against the eligible cost. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance- and incentive-based payments and grants and awards both currently in existence and those that may be implemented during future demonstration renewal periods, such as those listed below.
 - b. Performance- and incentive-based payments, including but not limited to:
 - i. Pay-for-performance payments made under the Medicaid state plan;
 - ii. Quality incentive payments associated with an alternative payment arrangement authorized under the Medicaid state plan or the section 1115 demonstration;
 - iii. Delivery System Transformation Initiative payments made under the 1115 demonstration;
 - iv. The Cambridge Health Alliance Public Hospital Transformation and Incentive Payments made under the 1115 demonstration;
 - v. Patient Centered Medical Home Initiative payments, including care management and coordination payments, made under the 1115 demonstration;

¹ State Plan supplemental payments include, but may not be limited to, Essential MassHealth Hospital Payments, Freestanding Pediatric Acute Hospital Payments, Acute Hospitals with High Medicaid Discharges Payments, and Infant and Pediatric Outlier Payment Adjustments. Safety Net Care Pool supplemental payments under the 1115 demonstration include Public Service Hospital Payments.

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Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
Approved December 17, 2013

- vi. Shared savings and other risk-based payments under an alternative payment arrangement (e.g., Primary Care Payment Reform, subject to CMS approval), authorized under the Medicaid state plan or the section 1115 demonstration;
 - vii. Medicaid EHR incentive payments, including eligible provider and hospital Electronic Health Record (EHR) incentive payments, made in accordance with the CMS-approved state Medicaid Plan and CMS regulations.
- c. Grants and awards:
- i. Infrastructure and Capacity Building grants and any other grants or awards awarded by the Commonwealth of Massachusetts or any of its agencies;
 - ii. Any grants or awards through the CMS Innovation Center or other federal programs;
 - iii. Any grants or awards by a private foundation or other entity.

Acute Inpatient and Outpatient Hospital Protocol for Medicaid and Uncompensated Care Cost

Determination of Allowable Medicaid and Uninsured Costs

- a. Disproportionate Share Hospital (DSH) Allowable Costs
 - i. Per STC 51(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or

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dentists' services, at the option of the State, to individuals [who are eligible]..." per Section 1905 of the Act.

- b. Medicaid State Plan Allowable Costs
 - i. Massachusetts will use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by acute inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
 - 1. Inpatient acute hospital services: Medical services provided to a member admitted to an acute inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - 2. Outpatient acute hospital services: Outpatient Hospital Services include medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services. Outpatient Services include medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, hospital-based physicians' offices, hospital-based nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
 - i. 1115 Demonstration Expenditures: Costs incurred by acute hospitals for providing Medicaid state plan services to members eligible for Medicaid through the 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the Medicaid state plan and are provided by acute hospitals under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.

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1. The Commonwealth may claim costs for the Pediatric Asthma Pilot Program according to STC 39(g).
2. Intensive Early Intervention Services for Children with Autism Spectrum Disorder. The Commonwealth must not claim costs for the Intensive Early Intervention Services for Children with Autism Spectrum disorder until CMS approves the Intensive Early Intervention Services for Children with Autism Spectrum Disorder payment protocol as specified in STC 40(h).
3. Diversionary Behavioral Health Services.
- d. Medicaid Managed Care Costs: Costs incurred by acute hospitals for providing services to members enrolled in Medicaid managed care organizations including Senior Care Organizations (SCOs) and Integrated Care Organization (ICOs), prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
- e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
- f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

I. Summary of 2552-10 Cost Report (CMS 2552 cost report)

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses
Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

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Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53

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(determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts hospitals because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and

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uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth will use the CMS 2552² and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the CMS 2552 cost report, hospitals subject to the cost limit protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Acute hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid- and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid- eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are

² Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.” Additionally, costs associated with the Medicaid- eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Administrative costs of the hospital’s billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and	X	X						

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Retiree Benefits								

UCCR Instructions

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

Column 1 – Reported Costs

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

Column 2 – Reclassification of Observation Costs and inclusion of Post-Stepdown Costs

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS 2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

Column 3 – Total Costs

Sum of costs from column 1 and column 2. [This column will auto-populate.]

Column 4 – Charges

Enter charges from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

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Column 5 – Hospital Cost-to-Charge Ratios

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Inpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

- MassHealth FFS Inpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

Column 7 – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

Column 8 – MassHealth Fee-for-Service Outpatient Charges

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Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204; and
 - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

- MassHealth FFS Outpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan); or
 - Charges associated with the professional component of hospital-based physician services.

Column 9 – MassHealth Fee-for-Service Outpatient Costs

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers

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must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

Column 1 – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

Column 2 – Total Inpatient Days

Enter total patient days for each routine cost center from CMS 2552 Worksheet S-3, Part 1, Column 8.

Column 3 – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

Column 4 – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

Column 5 – Total MassHealth FFS Inpatient Costs

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

Column 6 – Medicaid Managed Care Inpatient Days

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 7 – Total Medicaid Managed Care Inpatient Costs

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Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

Column 8 – HSN and Uninsured Care Inpatient Days

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 9 – Total HSN and Uninsured Care Inpatient Costs

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent,

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diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:

- Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

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Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

Column 6 – Total Massachusetts Medicaid Managed Care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

Column 7 – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

Column 8 – HSN and Uninsured Care Inpatient Costs

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

Column 9 – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

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Column 10 – HSN and Uninsured Care Outpatient Costs

Uncompensated care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

Column 11 – Total HSN and Uninsured Care Costs

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
 - Charges associated with the professional component of hospital-based physicians services.

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;

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- MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
- Charges associated with professional component of hospital-based physician services.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).

- HSN and Uninsured Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of a particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

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If the overhead costs related to physicians' services were adjusted out of the physicians' costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians' Costs

Total Physicians' costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians' costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

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Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Total Massachusetts Medicaid Fee-for-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee-for-service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the

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Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

Column 1 – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures
Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

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For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

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Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

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Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

III. Reconciliation

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552³ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 50(b), each provider's

³ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund payments, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 50(b), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the

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final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

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Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient
Hospital Protocol for Medicaid and Uncompensated Care Cost

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
 - i. Per STC 51(f), the cost limit protocol will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
 - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid state plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
 - 1. Inpatient chronic disease and rehabilitation hospital services: Inpatient services are routine and ancillary services that are provided to recipients admitted as patients to a chronic disease or rehabilitation hospital. Such services

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are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.

2. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 3. Outpatient chronic disease and rehabilitation hospital services: Rehabilitative and medical services provided to a member in a chronic disease or rehabilitation outpatient setting including but not limited to chronic disease or rehabilitation hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services include, but are not limited to, radiology, laboratory, diagnostic testing, therapy services (i.e., physical, speech, occupational and respiratory) and Day surgery services. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 4. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members eligible for Medicaid through the section 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
 1. Diversionary Behavioral Health Services.
 - d. Medicaid Managed Care Costs: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.

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- e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
- f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

I. Certified Public Expenditures – Determination of Allowable Safety Net Care Pool Costs

In accordance with the approved MassHealth Section 1115 demonstration, beginning July 1, 2014, the estimated fiscal year expenditures will be based on the actual fiscal year CMS 2552 and UCCR cost reports.

General Description of Methodology

The certified public expenditures (CPEs) for special population State-Owned Non-Acute hospitals operated by the Department of Public Health (DPH) and Department of Mental Health (DMH) are claimed annually under the Safety Net Care Pool (SNCP) based upon the unreimbursed Medicaid and uninsured. The CPE interim payments made under the SNCP will follow the same methodology as contained in the Commonwealth's Medicaid State Plan.

II. Summary of 2552-10 Cost Report

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply

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- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

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Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

III. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those

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incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth will use the CMS 2552⁴ and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient Hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth based on the 2552 and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

⁴ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the Medicare 2552 cost report.

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“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.” Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable	X	X	X	X	X	X		

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Medicare cost principles								
Administrative costs of the hospital’s billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal		X						

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
support for at risk pregnancies. CMS 255-10, Line 193								
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionsary	X	X	X	X	X	X	X	X

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Behavioral Health Services								
Public Hospital Pensions and Retiree Benefits	X	X						

UCCR Instructions

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

Column 1 – Reported Costs

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS 2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

Column 3 – Total Costs

Sum of costs from column 1 and column 2. [This column will auto-populate.]

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Column 4 – Charges

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

Column 5 – Hospital Cost-to-Charge Ratios

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

- MassHealth FFS Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

Column 7 – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will

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auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

Column 8 – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

- MassHealth FFS Outpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

Column 9 – MassHealth Fee-for-Service Outpatient Costs

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 11. [This column will auto-populate.]

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Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C.

Column 1 – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

Column 2 – Total Inpatient Days

Enter total patient days for each routine cost center from CMS 2552 Worksheet S-3, Part 1, Column 8.

Column 3 – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

Column 4 – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

Column 5 – Total MassHealth FFS Inpatient Costs

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

Column 6 – Medicaid Managed Care Inpatient Days

Enter total MassHealth managed care inpatient days for each routine cost center on lines 30-46 from provider records.

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Column 7 – Total Medicaid Managed Care Inpatient Costs

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

Column 8 – HSN and Uninsured Care Inpatient Days

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 9 – Total HSN and Uninsured Care Inpatient Costs

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);

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- Charges associated with patients eligible for another state's Medicaid program;
- Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

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Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

Column 7 – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

Column 8 – HSN and Uninsured Care Inpatient Costs

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

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Column 9 – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

Column 10 – HSN and Uninsured Care Outpatient Costs

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

Column 11 – Total HSN and Uninsured Care Inpatient and Outpatient Costs

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
 - Charges associated with the professional component of hospital-based physician services.

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;

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- Charges associated with claims that have been final denied for payment by MassHealth;
- Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

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Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges

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from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Total Massachusetts Medicaid Fee For Service Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee for service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

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Pursuant to Section 50(b) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

Column 1 – Total SNHCS Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

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Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay for Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

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Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

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Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

IV. Reconciliation

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552⁵ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost

⁵ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 50(b), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the Medicare cost report(s).

Final Reconciliation

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 50(b), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP

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uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

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**Institutions for Mental Diseases – Psychiatric Hospitals and Community Based
Detoxification Centers (CBDCs) Protocol for Medicaid and Uncompensated Care
Cost**

The Commonwealth will use the reports described below to collect data from these providers.

Psychiatric hospitals will fill out the CMS 2552 and UCCR, as required of other hospitals in the cost limit protocol. CBDCs are non-hospital human and social services contractors that do not file a CMS 2552 cost report; therefore, for the purposes of the protocol, the Commonwealth will use only the Massachusetts **Uniform Financial Statements and Independent Auditor’s Report (UFR)** to determine costs and revenues. The UFR is the set of financial statements and schedules required of human and social service contracting with state departments. For the calculation of provider-specific cost limits, psychiatric hospitals and CBDCs will fill out the necessary reports with the information that is relevant to the services they provide to the Medicaid-eligible and HSN and uninsured populations.

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
 - i. Per STC 51(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable psychiatric hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Pharmacy service costs are separately identified on the CMS 2552 10 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.

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- b. Medicaid State Plan Allowable Costs
 - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by institutions for mental disease. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
 - 1. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - 2. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - 3. Community Based Detoxification Center (CBDC): CBDCs are eligible to receive Safety Net Care Pool payments as Institutions for Mental Diseases (IMDs) under the section 1115 demonstration. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - a. Acute Inpatient Substance Abuse Treatment Services: Short-term medical treatment for substance withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling, and post detoxification referrals provided by an inpatient unit, either freestanding or hospital-based, licensed as an acute inpatient substance abuse treatment service by the Massachusetts Department of Public Health under its regulations at 105 CMR 160.000 and 161.000. These services are delivered in a three-tiered system consisting of Levels III-A through III-C that must conform with the standards and patient placement criteria issued and enforced by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services.

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- b. Substance Abuse Outpatient Counseling Service:
An outpatient counseling service that is a rehabilitative treatment service for individuals and their families experiencing the dysfunctional effects of the use of substances.
- ii. 1115 Demonstration Population Expenditures: Costs incurred by psychiatric hospitals and CBDCs for providing IMD services to members eligible for Medicaid through the State plan and section 1115 demonstration will be counted as allowable costs. Allowable costs for psychiatric hospital services and CBDC services provided under the 1115 demonstration include service-related expenditures (please note that all services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs). The list of allowable services is contained in the Cost Element table.
 - 1. Diversionary Behavioral Health Services
- c. Medicaid Managed Care Costs: Costs incurred by IMDs for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
- d. Other Allowable Costs, Approved 1915(c) Waivers. The list of allowable services is contained in the Cost Element table.
- e. Additional Allowable Costs – The list of allowable services is contained in the Cost Element table.

I. Summary of 2552-10 Cost Report (Psychiatric Hospitals Only)

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses
Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers

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- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs

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- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) (Psychiatric Hospitals Only)

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In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth must use the CMS 2552⁶ and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Psychiatric hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

⁶ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.” Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare	X	X	X	X	X	X		

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles								
Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute	X							

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Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
status								
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

UCCR Instructions

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

Column 1 – Reported Costs

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

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Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS 2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

Column 3 – Total Costs

Sum of costs from column 1 and column 2. [This column will auto-populate.]

Column 4 – Charges

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

Column 5 – Hospital Cost-to-Charge Ratios

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

- MassHealth FFS Charges may not include:

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- Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
- Charges associated with claims that have been final denied for payment by MassHealth;
- Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
- Charges associated with the professional component of hospital-based physician services.

Column 7 – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

Column 8 – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

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Column 9 – MassHealth Fee-for-Service Outpatient Costs

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

Column 1 – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

Column 2 – Total Inpatient Days

Enter total patient days for each routine cost center from CMS 2552 Worksheet S-3, Part 1, Column 8.

Column 3 – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

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Column 4 – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

Column 5 – Total MassHealth FFS Inpatient Costs

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

Column 6 – Medicaid Managed Care Inpatient Days

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 7 – Total Medicaid Managed Care Inpatient Costs

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

Column 8 – HSN and Uninsured Care Inpatient Days

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 9 – Total HSN and Uninsured Care Inpatient Costs

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

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- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).

- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

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Column 1 – Hospital Cost-to-Charge Ratios

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

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Column 7 – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

Column 8 – HSN and Uninsured Care Inpatient Costs

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

Column 9 – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured patients.

Column 10 – HSN and Uninsured Care Outpatient Costs

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

Column 11 – Total HSN and Uninsured Care Costs

Total uncompensated care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Care Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

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- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
 - Charges associated with the professional component of hospital-based physicians services.

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
 - Charges associated with professional component of hospital-based physician services.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).

- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the

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worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:

- Individuals with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

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For each cost center, a cost-to-charge ratio is calculated by dividing total physicians' costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

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HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Total Massachusetts Medicaid Fee-For-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid Fee-For-Service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document. .

Column 1 – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

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Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-

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based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

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Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

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Column 6 – Total Revenue

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

III. Uniform Financial Report (UFR)

CBDCs are entities that provide health care services for substance abuse that contract with the MassHealth agency, Medicaid Managed Care Entities and the Bureau of Substance Abuse Services, the latter providing services to the uninsured. Each CBDC is licensed by the Bureau of Substance Abuse Services under the requirements set forth in 105 CMR 164.000. Because CBDCs are not a hospital, they do not fill out the Medicare CMS 2552 cost report and instead fill out the Uniform Financial Report (UFR).

UFR reports are filed with the Massachusetts Operational Services Division (OSD) on an annual basis. This report captures administration and support costs, as defined in 808 CMR 1.00, which includes expenditures for the overall direction of the organization, e.g., general record keeping, budgeting, etc., but also the salaries and expenses of the organization's staff. The report will also capture expenditures for health care services, as defined in M.G.L. c. 118 § 2 (b), the pricing of which is set by the Center for Health Information and Analysis

The CBDCs are required to keep necessary data on file to satisfy the UFR reporting requirements, and books and records must be maintained in accordance with generally accepted accounting principles set forth by the American Institute of Certified Public Accountants (AICPA).

The UFR must be submitted on or before the 15th day of the fifth month after the end of the contractor's fiscal year.

The UFR reports the following data elements:

1. Net Assets
2. Total Current Assets

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3. Total Assets
4. Total Current Liabilities
5. Total Liabilities
6. Total Liabilities and Net Assets
7. Total Revenue, Gains, and Other Support
8. Total Expenses and Losses
9. Indirect / Direct Method
10. Cash from Operating Activities
11. Cash from Investing Activities
12. Cash from Financing Activities
13. Total Expenses – Programs
14. Total Expenses – Supporting Services
15. Surplus Percentage
16. Surplus Retention Liability

The UFR allows for revenue to be reported from Medicaid Direct Payments, Medicaid Massachusetts behavioral Health Partnership (MBHP) Subcontracts, Department of Mental Health, Department of Public Health, and other human and social service agencies.

The CBDC's program expense is broken down by provider type for Psychiatric Day Treatment and Substance Abuse Class Rate Services, including:

1. Psychiatrist
2. N.P., Psych N., N.A., R.N.-Masters
3. R.N.-Non Masters
4. L.P.N.
5. Occupational Therapist
6. Psychologist – Doctorate
7. Clinician (formerly Psych. Masters)
8. Social Worker – L.I.C.S.W.
9. Social Worker – L.C.S.W., L.S.W.
10. Licensed Counselor
11. Cert. Voc. Rehab. Counselor
12. Counselor
13. Case Worker/Manager – Masters
14. Case Worker/Manager
15. Direct Care/Program Staff Supervisor
16. Direct Care/Program Staff

Per unit cost from UFR. The provider will calculate a per unit cost from the UFR for inpatient detoxification programs, who do not submit the Medicare 2552 cost report, by dividing the total reimbursable program expense (Schedule B line 53E) by

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line 6SS (number of service units delivered). The per diem cost will be reported by the CBDC on the CBDC Protocol Form.

Allowable Costs

- a. From the MMIS paid claims database, the State will obtain the number of units of care, including administrative units, provided to all Medicaid patients.
- b. Providers will be required to file a supplemental schedule with EOHHS that reports the number of units, days of care, including administrative days, for services provided to Medicaid MCO and other uninsured patients.⁷
- c. The state will calculate costs by multiplying the per unit cost with the number of MassHealth, Medicaid MCO, and uninsured units described above.

Payments

- a. From the MMIS paid claims database, the state will obtain payments made to programs for services, including administrative days, provided to MassHealth patients.
- b. Providers will be required to file a supplemental schedule with EOHHS reporting payments received from all sources for services provided to Medicaid MCO and uninsured patients.

Determination of Provider-Specific SNCP Limit for CBDCs

The State will calculate a provider-specific SNCP limit for each CBDC as by subtracting all applicable payments from the allowable costs

IV. Reconciliation

Interim Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552⁸ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three after months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 50(b), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

⁷ This is not currently available on the UFR report.

⁸ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

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For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 50(b), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment

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occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

Interim Reconciliation for UFR Method

Each provider's uncompensated care costs must be computed based on the provider's as-filed Uniform Financial Report (UFR) and for the actual service period. The UFR is filed five months after the close of the cost reporting period. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service period. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not

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align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The interim reconciliation described above will be performed and completed within twelve months after the filing of the provider's UFR.

Final Reconciliation for the UFR Method

Each provider's uncompensated care costs must be recomputed based on the provider's audited UFR for the actual service period. The UFR is audited and settled by the Commonwealth to determine final allowable costs and reimbursement amounts as recognized by the Commonwealth based on this cost limit protocol. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service period. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government. Settlement of any over- or underpayment to a provider will be treated as a separate transaction rather an adjustment to the following year's interim payment.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The final reconciliation described above will be performed and completed within twelve months after the audited provider UFR is made available.