

MassHealth

Section 1115 Waiver –Annual Report

Demonstration Year: 20 (7/1/2016 – 6/30/2017)

Quarters 1-4

Introduction

The Commonwealth of Massachusetts' current section 1115 Demonstration agreement (Project Number II-W-00030/I) was approved on October 30, 2014. It was amended on November 4, 2016 and is in effect until June 30, 2017. The goals of the Commonwealth under this demonstration period are:

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

In accordance with the Special Terms and Conditions (STCs) of the Demonstration and specifically STC 60, the Massachusetts Executive Office of Health and Human Services (EOHHS) hereby submits its annual operational report for Demonstration Year 20, ending June 30, 2017.

STC 62a – Financial/Budget Neutrality Development/Issues

The attached budget neutrality (BN) statement includes actual expenditures and member months through the fourth quarter of state fiscal year (SFY) 2017. These data are combined with the MassHealth and Health Safety Net (HSN) budget forecasts as of July 2017 for SFY 2018 – 2019 and ConnectorCare information provided by the Health Connector, which manages that program.

This BN demonstration includes actual expenditure figures, updated according to the most recent complete data available as reported on the CMS 64 for SFY 2015, SFY 2016, and SFY 2017

through the quarter ending June 30, 2017. The enrollment data for the years SFY 2015 through SFY 2017 were updated based on actual enrollment through August 18, 2017.

Safety Net Care Pool (SNCP)

Actual expenditures for SFY 2015 – 2017 were updated based on claimed expenditures in the CMS 64 report for Quarter End June 30, 2017. These include expenditures for the HSN and ConnectorCare.

Budget neutrality - summary

In sum, the total projected budget neutrality cushion is \$17.1 billion for the period SFY 2015 through SFY 2017 and \$35.4 billion for the period SFY 2009 through SFY 2022. We will continue to update CMS through quarterly reports as updated information is available.

STC 62b - Enrollment in Premium Assistance and Small Business Employee Premium Assistance

For reporting quarter April 1, 2017-June 30, 2017 MassHealth provided premium assistance to 16,824 health insurance policies (policyholders), resulting in premium assistance to 28,785 MassHealth eligible members. Over the past year (July 1, 2016-June 30, 2017) MassHealth provided premium assistance to an average of 16,000 insurance policies (policyholders) per month.

The Small Business Premium Assistance Program is still operating however the numbers continue to drop since the last reporting period. As of June 2017 we had 26 active enrollments in the SBEP program. That is a decrease of 15 enrollments from the last reporting period. The drop in enrollments continues to be mainly due to either loss of MassHealth eligibility or private insurance, or the member was determined eligible for a richer benefit and has been transferred to a Premium Assistance benefit under another category of aid.

A new premium assistance project was implemented by MassHealth in the fall of 2016 called Student Health Insurance Plan Premium Assistance (SHIP PA). This project requires current MassHealth members who are full-time college students and have access to SHIP through their college or university to enroll in their schools' SHIP and receive MassHealth premium assistance. MassHealth received approval through the 1115 demonstration in November 2016 to require students eligible for MassHealth to enroll in a SHIP plan if available. MassHealth eligible college students were previously able to decline to enroll in SHIP; it is now mandatory that they enroll and instead receive premium assistance through MassHealth. As of June 2017, 5,054 students were enrolled in the program. Participation in the program is expected to exceed 20,000 enrollments in the fall of 2017.

Premium Assistance Program	Disabled Members	Non-Disabled Members	Total MassHealth Enrolled Members
<i>Standard</i>	1,953	10,941	12,894
<i>CommonHealth</i>	2,857	0	2,857
<i>Family Assistance</i>	15	7,444	7,459
<i>CarePlus</i>	0	495	495
<i>Small Business Employee Premium Assistance (SBEPA)</i>	0	26	26
<i>Student Health Insurance Premium Assistance (SHIP PA)</i>		5,054	5,054
Total for Q4	4,825	23,960	28,785

STC 62b - Outreach/Innovative Activities

Certified Application Counselor Training and Communication

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

CAC training and certification starts with successful completion of ten online, comprehensive certification training courses (over 850 pages) to prepare CACs to assist consumers in obtaining

MassHealth/health insurance per ACA regulations, covering all aspects of MassHealth, subsidized and unsubsidized health coverage, as well as instruction on utilizing the paper and online applications in the most effective and efficient way. Learning for CACs continues throughout the year in the form of Assister emails, conference calls, webinars, meetings, and other outreach activities. All CACs must take and pass a comprehensive assessment each fall to meet annual recertification requirements.

Frequent email communications are distributed to all enrollment Assistors on a wide variety of MassHealth eligibility and related topics, as well as refreshers, in order to help Assistors assist MassHealth applicants/members/consumers effectively. Thorough communications and trainings are provided for all application changes and Health Insurance Exchange (HIX) system releases. Regular one-hour conference call trainings are also provided for the Assistors, providing a more in-depth explanation and include detailed question and answer sessions with subject matter experts. Certain trainings are considered mandatory and CACs are required to complete the training within a specific time period in order to maintain CAC certification. Mandatory events cover key topics such as policy or process updates, certification course updates, and open enrollment activities.

Q1 July 1 – September 30, 2016

CAC outreach and educational activities this quarter were focused on ensuring our 1,600+ CACs continued to be well informed about ongoing activities across both MassHealth and the Health Connector. This was accomplished through over 19 emails, 5 all-Assister conference calls, and 4 in-person educational Massachusetts Health Care Training Forum sessions across the Commonwealth. These activities covered a range of topics including training and updating Assistors about MassHealth application annual renewals in the online system, important changes to Health Safety Net (HSN) policies and how they impact current and new members, the new, optional Temporary HSN through a Presumptive Determination application process, and continued improvements to the online system at MAhealthconnector.org.

Intensive communications and training efforts were conducted throughout August to ensure all CACs and Health Connector Navigators were fully knowledgeable about several important updates. This included changes to MassHealth Managed Care Organization plan selection and enrollment process (including a new, fixed enrollment requirement), updates to the Health Connector and Mixed Households Redeterminations and Renewals process, and renewals for households with the Health Safety Net (HSN) who need to reapply for coverage in the online system. A combination of mandatory training requirements, follow-up email communications, and supporting conference calls were held to support the various changes. Four enrollment events were conducted across the Commonwealth to support the HSN renewals.

The CAC Training and Communications team collaborated with advocates, hospitals and health centers, the Health Connector, and MassHealth Operations and customer service to develop and present an August conference call refresher on Immigration. The content, now also part of

the CAC certification training, provides additional guidance and scenario based examples for when CACs are helping applicants or members complete applications and renewals.

Assister-specific email updates and conference calls also provided CACs with important details around key updates to the online system, the Health Connector's Seal of Approval process and finding local tax filing assistance outside of tax season, and other MassHealth and Health Connector changes and improvements that support Assisters as they help consumers access and retain their health insurance coverage.

A significant amount of time this quarter was dedicated by the team to the design, planning, and preparations for a key new tool for CACs and Navigators—the Assister Portal. The Assister Portal is an online tool that will let Massachusetts CACs and Navigators access the online application (HIX) with their own login to help Individuals apply online for health coverage while they are assisting them. Once logged in, CACs and Navigators will be able to use the Assister Portal to help Individuals submit new applications, report changes, enroll in Health Connector plans, and more easily respond to renewals and notices (such as Requests for Information). Other features will be available to help them manage Individuals they work with when using the Assister Portal. More details will be provided in the next quarterly update around the preparations, training, communications, and phased rollout to the Assisters.

Q2 October 1 – December 31, 2016

CAC outreach and educational activities intensified this quarter around the launch of the Assister Portal, annual CAC recertification, and Health Connector Open Enrollment activities. Over 90 emails and training reminders were sent, 23 conference calls held, and 5 in-person training sessions conducted to support these initiatives.

The rollout of the most significant initiative, the Assister Portal, started in November with five in-person training sessions across the Commonwealth for Phase I of the multi-phase rollout. The Assister Portal is an online tool that lets Massachusetts CACs and Navigators access the online application (HIX) with their own login. While logged in, CACs and Navigators can use the Assister Portal submit new applications, report changes, enroll in Health Connector plans, and more easily respond to member renewals and notices on behalf of the individual they are assisting. Other key Assister Portal features help Assisters as they plan for appointments, conduct outreach, and manage individuals they work with. A gradual, phased rollout approach has been successful in providing the right level of support for Assisters, customer service, training teams, and technical staff. It allowed time to assess training materials, call volume and types of questions being asked, and then make any necessary adjustments to ensure a proper use of the Portal and a successful rollout.

Access to the Assister Portal also requires an enhanced level of security safeguards due to the type of protected information Assisters are able to access as they help Individuals with their health insurance needs. For each phase of the rollout, we work closely with leads and IT contacts for each CAC organization to verify the identity of each CAC accessing the portal and to

ensure that computers accessing the portal are authorized to do so. We support each phase with several pre-go live conference calls with CAC leads and CACs and a series of post-go live daily check-in calls to share tips and respond to questions as CACs set up accounts and start using this new, innovative tool.

MassHealth developed and launched a new, streamlined process for the federally-mandated, annual CAC recertification. The new process incorporates ongoing, mandated educational activities occurring through the year with passing a comprehensive certification exam in December. Not only did this reduce the time CACs needed to recertify during what is typically a very busy time of year, but there were higher levels of participation and learning occurring for ongoing events.

Other activities conducted this quarter helped ensure Assisters were fully knowledgeable about Health Connector Open Enrollment activities including a training call, a series of check-in calls throughout Open Enrollment, new online shopping courses, and several Assister emails. Assister-specific email updates and conference calls also provided CACs with important details around MassHealth Mixed-Aged Household (Age 65 and Over/Under age 65) Renewals, Asset Verification, an update regarding MassHealth Student Health Insurance, and other MassHealth and Health Connector changes and improvements that support Assisters as they help consumers access and retain their health insurance coverage.

Q3 January 1 – March 31, 2017

CAC outreach and educational events continued at a high level this quarter around the continued launch of the Assister Portal and Health Connector Open Enrollment activities. Over 52 emails were sent and 28 conference calls held in support of these activities and initiative.

The phased rollout of our most significant initiative, the Assister Portal, continued in earnest this quarter bringing the rollout count to over 75% of the CACs. The Assister Portal, an online tool that lets Massachusetts CACs and Navigators access the online application (HIX) with their own login, lets Assisters submit new applications, report changes, enroll applicants in Health Connector plans, and more easily respond to member renewals and notices on behalf of the individual they are assisting.

Supporting activities for the phased rollout (which started in late November 2015) included outreach to and conference calls with technical contacts and Lead CACs at each CAC organization to facilitate and coordinate technical and federally mandated requirements. Multiple pre- and post- go live conference calls, including a series of daily check in calls, were held for each of the phases. These events, run by the CAC training team and supported by the Health Connector, contributed significantly to the success of each phase. Advocacy groups—The Massachusetts Hospital Association and the Massachusetts League of Community Health Centers—supported the Assister Portal rollout which helped raise awareness across the majority of the CAC organizations of its usefulness.

Feedback from CACs who now have access to the Assister Portal continues to be extremely positive. They report that using the Portal is straight forward and that it helps them submit applications more quickly. Assisters now have access to information in the Assister Portal, such as an applicant's eligibility determination, request for supporting documentation, and Health Connector program enrollment, which helps them better plan for appointments and understand the current status of health care coverage for their patients and clients.

Other activities conducted this quarter helped ensure Assisters were fully knowledgeable about Health Connector Open Enrollment (OE) activities including a training call and the series of OE check-in calls, a call around Year-End Tax Filing Process, individuals with Health Safety Net Eligibility, Medicare Renewals, and a ConnectorCare Special Enrollment Period.

Q4 April 1– June 30, 2017

CAC outreach and educational activities this quarter were focused on ensuring our 1,600+ CACs continued to be well informed about new and ongoing activities across both MassHealth and the Health Connector. This was accomplished through over 21 emails, 9 Assister conference calls, and 4 in-person educational Massachusetts Health Care Training Forum sessions across the Commonwealth. These activities covered a range of topics including how to help members find tax filing assistance and request certain health coverage tax filing forms, important reminders around the Health Connector and MassHealth process for requesting proof of verifications, the May/June series of enrollment events, online system updates, and helping students and young adults access health insurance coverage in Massachusetts.

In April, we implemented improvements to our Assister emails that allow us to quickly disseminate information in a professional, easy to read format and have access to tracking statistics. The new format utilizes links to attachments (rather than physically attaching documents) which greatly reduces the size of the message and makes it easy for Assisters to open and download important documents such as job aids and sample notices.

This quarter, the CAC Training team began incorporating new e-tools such as Articulate, (e-learning authoring software) that are already improving the online learning experience for CACs taking certification or new mandatory trainings in the Learning Management System. In addition to a new, updated look to the trainings, the tools provide an optional audio and narrative component, easy access to relevant resources and job aids, and improved tracking ability for course completion and certification requirements.

Robust preparations are underway for training and communications in support of the new MassHealth health plan options being introduced later this year. These activities focus on Assister education and will include online mandatory training, conference calls, bi-weekly check in calls, in-person educational events, and Assister email updates.

STC 62b - Consumer Issues

MassHealth In-Person Enrollment Events

In June 2015, MassHealth, working with each of the four MassHealth Enrollment Centers (MECs), as well as MassHealth's Central Processing Unit (CPU), began to coordinate and hold renewal/enrollment events with community partners throughout the Commonwealth. Members are assisted through the enrollment process from beginning to end, and provided the same services that MassHealth Enrollment Centers would provide, including assistance with applications for those age 65 and over.

Q1 July 1 – September 30, 2016

During August, 2016, MassHealth partnered with various community health centers (CHCs) throughout the Commonwealth to help celebrate National Health Center Week (<http://www.healthcenterweek.org/>), a celebration held every August, during the week of August 7th through the 13th, celebrating both CHC staff and their members. All four MECs and CPU participated and our presence was greatly appreciated by both CHC staff and their members.

In September, 2016, MassHealth held a special series of four enrollment events to aid MassHealth members in navigating the new Health Safety Net (HSN) policy changes that went into effect. Along with these renewals, MassHealth assisted those receiving the usual annual 2016 MassHealth renewal notices submit their renewals, and those who wished to apply for health coverage.

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

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

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

A social media communications plan, drew a very good increase of tweeting activity statewide in response to these events, up 40+% since its inauguration. This included pre-event tweets, reminder tweets and tweet blogs during event series interims, as well live tweeting during the events. Though not yet implemented, it is still planned to prepare event press releases for distribution to local community newspapers, to be distributed in both hardcopy and digital media.

The community partner publicizes the events as well, mentioning the events to their walk-ins/patients, and through e-mails, local television and radio, as well as distributing flyers to homeless shelters, hospitals and any other applicable facility.

MassHealth enrollment events will continue through calendar years 2016/17 and beyond, roughly every quarter, in conjunction with the mailing of renewal notices, and as the need arises outside the quarterly series. In addition, we are also participating in various interim event activities throughout the state, in partnership with regional community health centers.

Q2 October 1 – December 31, 2016

In late October and throughout November of 2016, MassHealth held a special series of five enrollment events to aid MassHealth members in navigating new policy changes that went into effect. Along with renewals related to these changes, MassHealth assisted those receiving their usual annual 2016 MassHealth renewal notices, and those who wished to apply for health coverage.

Q3 January 1 – March 31, 2017

In March, MassHealth attended three special healthcare events in Springfield and Lowell, providing information to MassHealth members and other attendees at these venues. In addition to providing information about MassHealth, our staff was prepared to assist members receiving the usual annual 2017 MassHealth renewal notices submit their renewals, and those who wished to apply for health coverage. Q4 April 1 – June 30, 2017

MassHealth held a single series of five enrollment events in May/June. In this series, MassHealth assisted those receiving the usual annual 2017 MassHealth renewal notices submit their renewals, and those who wished to apply for health coverage.

We are currently preparing special MCO events beginning in January 2018. Then, at the end of the 2018 eligibility/MCO Plan Selection Period, we hope to hold at least one eligibility event series sometime in June 2018, but this is not a certainty as of yet.

As of this writing, it is planned that there will be one five-event series for MCO plan selection per year, once the initial plan selection cycle for Payment Reform has completed (sometime in

2019). Once this cycle has completed, we plan to restart the quarterly Eligibility event cycle, alongside the yearly eligibility/MCO plan selection period.

In addition to our usual Eligibility and MCO events, we will also be participating in various interim event activities throughout the state, in partnership with regional community health centers and outreach groups through FY 2019.

STC 62b - Member Education

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

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

Updates include, but are not limited to, new policy and operational updates system navigation tools, troubleshooting assistance, and information about agency outreach efforts.

Member Education presentations are individually created to provide information per agency request. They are often targeted for specific populations that the agencies serve and provide program information that is appropriate to those populations.

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

Q1 July 1 – September 30, 2016

During this quarter the Member Education Representative presented an Immigration Refresher to over 100 enrollment assisters in August. This refresher was a result of many months of planning and collaborating with the Health Connector, Advocate agencies, and the Massachusetts League of Community Health Centers. The refresher was very well received by enrollment assisters. It provided enrollment assisters with tips and tools needed for successful application completion.

The Member Education Representative presented at four Massachusetts Health Care Training Forums and attended 16 community meetings providing program information and updates to participants, attended two health fairs, and presented nine tailored Power Point presentations to a numerous variety of stakeholders across the Commonwealth, for a total of 31 educational events.

Q2 October 1 – December 31, 2016

The Member Education Representative presented at four Massachusetts Health Care Training Forums and attended 23 community meetings providing program information and updates to participants, presented four tailored Power Point presentations to a numerous variety of stakeholders across the Commonwealth, for a total of 31 educational events.

Q3 January 1 – March 31, 2017

The Member Education Representative presented at four Massachusetts Health Care Training Forums and attended 21 community meetings providing program information and updates to participants, presented six tailored Power Point presentations to a numerous variety of stakeholders across the Commonwealth, for a total of 27 educational events.

Q4 April 1 – June 30, 2017

The Member Education Representative presented at four Massachusetts Health Care Training Forums and attended 23 community meetings providing program information and updates to participants, presented ten tailored Power Point presentations to a numerous variety of stakeholders across the Commonwealth, for a total of 37 educational events.

STC 62b - Operational Issues

July 1 – September 30, 2016

During this quarter, MassHealth continued to work with the Massachusetts Health Connector and our systems integration vendor to enhance functionality in the HIX system, including enhancements to logic for Address Standardization to confirm attested address by matching with USPS, functionality to generate large-print, Braille or Spanish notices, and application reactivation logic to allow only one provisional period every twelve months. In addition, MassHealth implemented logic in the HIX system to conduct annual renewals for MassHealth members who are in a household with other household members who are receiving benefits through the Health Connector, to allow a coordinated renewal process with both agencies.

Also during the quarter, MassHealth continued to finalize requirements for the Asset Verification System to conduct checks of financial institutions for members subject to an asset test for eligibility and plan for implementation in December 2016. Otherwise, MassHealth operations for the Traditional Medicaid population (Aged, Blind, Disabled) continued as normal during this quarter.

Q2 October 1 – December 31, 2016

During this quarter, MassHealth continued to work with the Massachusetts Health Connector and our systems integration vendor to enhance functionality in the HIX system. These enhancements included logic to implement Express Lane Renewals for MassHealth members who are also receiving SNAP benefits, and Administrative Renewals for MassHealth members

with SSDI as their only source of income. These two streamlined renewal processes will automatically renew a member's eligibility based on information available from electronic data matches. In addition, MassHealth and the Health Connector implemented a new portal in the HIX for Certified Assistance Counselors (CAC) and Navigators (NAV). These certified assisters can use this portal to help members create profiles, applications, complete eligibility review forms, find health plan details, and complete health plan enrollment on behalf of the member.

Also during the quarter, MassHealth implemented the Asset Verification System to conduct checks of financial institutions for members subject to an asset test for eligibility. Otherwise, MassHealth operations for the Traditional Medicaid population (Aged, Blind, Disabled) continued as normal during this quarter.

Q3 January 1 – March 31, 2017

During this quarter, MassHealth continued to work with the Massachusetts Health Connector and our systems integration vendor to enhance functionality in the HIX system. These enhancements included logic to implement periodic data matching in the HIX system. MassHealth has implemented periodic data matching with the Massachusetts Department of Revenue for quarterly wage information. If a match is returned and indicates a member has wage information that is not reasonably compatible with income currently on file and the quarterly wage information would result in a downgrade or termination of benefits, a Job Update form is generated to allow the member to indicate if the new income information is correct and provide verification. MassHealth also implemented periodic data matching for SSA data for federal disability information, Medicare coverage, death status and Title II income.

Q4 April – June

During this quarter, MassHealth continued to work with the Massachusetts Health Connector and our systems integration vendor to enhance functionality in the HIX system. These enhancements included logic to support eligibility determinations for Transitional Medical Assistance (TMA). In addition, logic was added to allow an eligibility worker to identify a member is medically frail and upgrade coverage from MassHealth CarePlus to MassHealth Standard. The addition of the logic for these two areas eliminated operational workarounds using our legacy eligibility system (MA21). MassHealth and the Health Connector also added new logic in the HIX to capture Responsible Party information for child-only applications.

During this quarter, MassHealth continued utilizing periodic data matching and renewal activities for the Medicaid/CHIP population.

STC 62b - Payment Reform Initiatives Related to Safety Net Care Pool, including DSTI, ICB grants and Payment Reform Efforts

DSTI

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

Q1 July 1 – September 30, 2017

During this quarter, DSTI hospitals submitted their final reports for SFY16, which were due on July 31, 2016. The independent assessor reviewed the reports and found that the hospitals completed 100% of the metrics reported. The hospitals requested payments as follows:

Notable accomplishments for SFY16 include:

- Over half of the patients enrolled in Boston Medical Center’s Comprehensive Diabetes Management program have stabilized their A1c levels;
- Lawrence General Hospital decreased the percentage of patients in a target population with high-risk medication utilization; and
- Mercy Medical Center saw a significant reduction in the number of Emergency Department visits for patients seeking non-emergent care.

The hospitals requested payments as follows:

DSTI Hospital	Payment Requested
Boston Medical Center	\$82,566,524.45
Cambridge Health Alliance	\$36,195,250
Holyoke Medical Center	\$5,346,045.37
Lawrence General Hospital	\$7,124,110.06
Mercy Medical Center	\$10,549,070.23
Signature Healthcare Brockton	\$10,988,141.21
Steward Carney Hospital	\$4,289,807.40

Payments were made on September 30, 2016 in these amounts to all hospitals. Payments requested in the previous quarter were also made to all of the hospitals on August 12, 2016.

Q2 October 1 – December 31, 2017

During this quarter, MassHealth worked with the DSTI hospitals on their Community High-Utilizer (HU) Collaboratives. The goal of the collaborative is to review the overall care coordination and management process for the HU population and opportunities for further development, which may be highlighted through case reviews. The collaborative(s) should also

identify and address treatment and delivery system gaps within the community, with a focus on the HU population.

The collaboratives include medical, social, and/or behavioral health service providers, as applicable to the defined HU population or subpopulation. The collaborative(s) must include partners both within and outside of the hospital system. Community HU Collaboratives must be formally established, meet regularly, and include key local providers and relevant community partners that provide a significant portion of care for the hospital's HU population/subpopulation. Descriptions of a few of the hospitals' plans are listed below:

Cambridge Health Alliance

CHA's Community High Utilizer/High Risk Patient (HU) Collaborative addresses the overall care coordination and management processes for a subpopulation of CHA's identified HU patients that are over the age of 55, representing about half of CHA's HU patients. Many of these patients have dual insurance coverage and typically have multiple complex chronic conditions which create a high risk for inpatient hospitalizations. The Community HU Collaborative organized by CHA focuses on the care coordination and care management of this subpopulation with an explicit goal of optimizing services across the healthcare and social service continuum to reduce and eliminate the unnecessary use of more acute and intensive healthcare services.

The Community HU Collaborative will include representatives from CHA Primary Care and Ambulatory Care, CHA's Department of Care Integration and Care Management, CHA Behavioral Health, Somerville Cambridge Elder Services, Mystic Valley Elder Services, the Visiting Nurse Association of Eastern Massachusetts (VNA of EM), and All Care VNA. These agencies were selected to form the core group of the HU collaborative as they have historically worked together to strengthen and support patients returning home after a hospital stay and have demonstrated a commitment to CHA's HU subpopulation.

Clinical goals for CHA's Collaborative:

- Successful transitions of care from acute care setting to home, skilled nursing facility, or other appropriate location;
- Enhanced engagement with ambulatory care for timely follow-up appointments with PCPs and specialists;
- Home visits to assess for home safety, medication adherence, food security, and caregiver supports in the patient's home environment; and
- Increase the effectiveness of communication, referrals and integration amongst Collaborative members so that patient care planning leverages the appropriate social, community, and medical supports.

Outcome measures for CHA's Collaborative and entire HU population include:

- Number and percentage of HU patients with formal participation in CHA care management;
- Number and percentage of HU patients with active care plans;
- Rate of follow-up contact after inpatient discharge within an established amount of time for HU patients participating in care management; and
- Rate of follow-up after emergency department visit within an established amount of time for HU patients participating in care management.

Signature Healthcare Brockton Hospital

Signature Healthcare employs a claims processing software that uses predictive analytics to identify patients that are high risk and high cost. Claims data received from health plans is entered into the claims-based predictive software which then generates a cost-predictive report. In addition to showing disease and utilization factors, the claims-based predictive software assigns a relative risk score to patients based on a proprietary algorithm using pharmacy and medical claims data, background, and demographics.

The list generated by the claims-processing software using predictive analytics provides patient-specific utilization data such as ER visits, admissions, risk factor and total cost, as well as identify those who are predicted to cost the most in the future. This same list is risk-stratified and sorted based on predicted cost and relative risk score, then divided into sub-lists for each provider's panel. Every physician will receive a list of their high-utilizer patients where the highest 5%, representing their highest utilizers, is highlighted. The software has identified approximately 6,000 high-utilizers.

Signature Healthcare follows a subset of these patients closely through the Personalized Care Clinic, which was established to help manage this vulnerable high-risk population, incorporating coordinated patient-centered care. With this population's complex needs in mind, a community collaborative was established around the Personalized Care Clinic and is based on the priorities of its patients and their caregivers. The collaborative includes representatives from our own Signature Medical Group, a Visiting Nurse Association, an Aging Services Access Point, the Health Plan, a Palliative Care service, Hospice, and Signature Healthcare's Pharmacy team.

Patients in the Personalized Care Clinic are newly discharged patients who are identified to need close monitoring. In order to better serve these patients, enrollees are allotted longer appointments with the provider, in lieu of the regular 15-min time spent with primary care providers. During the assessment, it is often determined that patients also need assistance with non-medical needs such as meals, finances, and transportation.

Patients' cases are presented at weekly Personalized Care Team meetings which are attended by representatives from our different community partners. There, the appropriate services or assistance for the patient are determined and set up. Progress made by previous clinic patients is also discussed and additional services are arranged if needed. Community providers offer updates each week on the status of each case.

Each DSTI hospital submitted a description of its structure to MassHealth for review over the summer. MassHealth reviewed and provided feedback on the structure and composition of the collaboratives to ensure that they addressed the needs of high utilizers. After incorporating this feedback, MassHealth approved all of the hospitals' Community HU Collaboratives.

Q3 January 1 – March 31, 2017

During this quarter, the DSTI hospitals submitted their semi-annual reports for payment on January 31, 2017. The reports and supporting data were sent to the independent assessor for their review of the reports and to ensure the hospitals met their metrics and earned their corresponding payment.

Notable accomplishments include:

- Holyoke Medical Center saw significant improvement over baseline performance in screening for depression and substance abuse, as well as receiving brief interventions and treatment referrals;
- Steward Carney Hospital demonstrated a decrease in Emergency Department utilization for high utilizers; and
- Cambridge Health Alliance increased enrollment of their target population in their Complex Care Management program.

The DSTI hospitals' reports claimed the following amounts for payment:

Hospital	Payment Requested	Approved by Independent Assessor?
Boston Medical Center	\$8,082,091.11	Yes
Cambridge Health Alliance	\$13,291,232.65	Yes
Holyoke Medical Center	\$4,756,412.00	Yes
Lawrence General Hospital	\$10,875,516.67	Yes
Mercy Medical Center	\$3,877,661.33	Yes
Signature Healthcare Brockton Hospital	\$11,398,493.34	Yes
Steward Carney Hospital	\$2,470,253.12	Yes

All payments claimed by the DSTI hospitals were approved by the independent assessor. Payments will be made in the first quarter of SFY18 (July – September 2018).

Q4 April 1 – June 30, 2017

DSTI hospitals continued to make progress on projects and their Category 4A and 4B measures, and worked on completing their final semi-annual reports, due July 31, 2017.

Q1 July 1 – September 30, 2017

MassHealth is including the work accomplished in this quarter since the DSTI program ended on June 30, 2017.

DSTI hospitals submitted their final semi-annual reports to MassHealth by July 31, 2017. Hospitals were required to report their progress on their projects, Category 4A and 4B measures. In the Category 4B measure slate, all hospitals were required to demonstrate performance on 30-day all-cause readmission rates, which equaled 5% of each hospital’s total allotment. The results for the measure are listed below:

Hospital	Target OE Ratio	Final OE Ratio	Target Achieved?
Boston Medical Center	1.0205	0.9870	Yes
Cambridge Health Alliance	1.1872	1.0285	Yes
Holyoke Medical Center	0.8862	0.6983	Yes
Lawrence General Hospital	0.9139	0.8269	Yes
Mercy Medical Center	0.8442	0.7993	Yes
Signature Healthcare Brockton Hospital	1.0567	0.9734	Yes
Steward Carney Hospital	1.0318	1.1100	No

Notable accomplishments include:

- DSTI hospitals achieved their performance targets on nearly all of the Category 4A and 4B measures, demonstrating progress on outcomes and improvement.
- DSTI hospitals implemented a number of projects and achieved outcome and improvement measures in order to set themselves up for success in the Commonwealth’s new payment and delivery system reform strategy.

DSTI hospitals requested the following amounts for payment:

Hospital	Payment Requested	Approved by Independent Assessor?
Boston Medical Center	\$ 93,897,291.99	Yes
Cambridge Health Alliance	\$ 36,047,433.71	Yes
Holyoke Medical Center	\$ 3,272,995.42	Yes
Lawrence General Hospital	\$ 3,338,438.42	Yes
Mercy Medical Center	\$ 11,104,438.21	Yes
Signature Healthcare Brockton Hospital	\$ 5,060,807.08	Yes
Steward Carney Hospital	\$ 3,845,601.29	Yes

All payments claimed by the DSTI hospitals were approved by the independent assessor. Payments associated with the January 31 and July 31 reports were made in August and September 2017, respectively.

Infrastructure and Capacity Building Grants (ICB)

Pursuant to the MassHealth 1115 Demonstration 11-W-00030/1, the Commonwealth distributed \$8.0M in Infrastructure and Capacity Building (ICB) grants for State Fiscal Year (SFY) 2017 in accordance with Special Term and Condition (STC) 54(c), STC 55(c), Charts A and B of Attachment E, and Expenditure Authority Section 19. The purpose of this program is to help providers establish integrated delivery systems that provide more effective and cost-efficient care to patients in need.

On November 16, 2016, EOHHS issued a request for applications for SFY 2017 ICB grants. In March 2017, EOHHS made payments pursuant to the procurement to support two categories of ICB projects:

- Project A: Support for Pilot ACOs' Implementation of Their Total Cost of Care and Quality Management Models
- Project B: Support for Primary Care Payment Reform (PCPR) Providers' Continued Integration of Care

Six Pilot ACOs received funding to support Project A and three PCPR Providers received funding to support Project B. Specific ICB-funded projects focus on enhancing care coordination and management, developing data warehouses, creating more robust data, analytics, and reporting capabilities, integrating behavioral health, and improving quality measures. Awardees had until August 22, 2017 to finalize projects and submit reports. Three awardees submitted projects by August 22 and six requested extensions as permitted. All nine final reports will be submitted by December 31, 2017 if not earlier.

In addition to administering the grants described above, EOHHS released an additional \$4.6 million out of a potential \$5 million ("ICB Round 2") for SFY 2017. ICB Round 2 provides eligible acute care hospitals with funding to complete independent financial and operational audits and to implement recommendations from the audits. The audits and resulting projects focus on enhancing sustainability and efficiency and improving or continuing health care services that benefit the uninsured, underinsured, and MassHealth populations. Draft regulations governing the payments were posted for public comment in March 2017. EOHHS promulgated final regulations and released corresponding guidance in June and July of 2017. In July 2017, \$4.6M was awarded to 47 of the 53 eligible hospitals (6 providers chose not to participate in the program).

EOHHS has continued to review and finalize remaining ICB reports for SFY 2015. Seventy-eight ICB-funded projects began in December 2015 with initial terms ending on June 30, 2016.

EOHHS approved 45 extensions to ICB grantees who sought to extend the duration of their projects. As of August 30, 2017, EOHHS had received a total of 75 final reports. EOHHS is working with grantees to finalize the three outstanding reports. EOHHS began reviewing the final reports in Q2 SFY 2017 to ensure that grantees had completed their projects and spent their funding appropriately.

Payment Reform Activities

Q1 July 1 – September 30, 2017

During this quarter, MassHealth drafted and posted a Request for Responses (RFR) for the Accountable Care Organization (ACO) Initiative (DOCUMENT #: 17EHSMHACOINITIATIVE), along with supporting materials such as model contracts and related appendices. The RFR identifies three models pursuant to which EOHHS seeks to enter into contract with Accountable Care Organizations:

- **Accountable Care Partnership Plan** – An Accountable Care Partnership Plan is either (1) an MCO with a separate, designated ACO Partner (2) a single integrated entity. Each Accountable Care Partnership Plan has an exclusive group of primary care providers (PCPs), and all members enrolled in an Accountable Care Partnership Plan receive primary care from these PCPs. Like a MassHealth MCO, the Accountable Care Partnership Plan is paid a capitated rate for Members, and is at risk for losses and savings beyond the capitation rate. The Accountable Care Partnership Plan must meet requirements currently associated with MCOs, including capital reserves and other financial considerations. Accountable Care Partnership Plans must also meet the requirements for ACOs, including provider-led governance and Commonwealth of Massachusetts Health Policy Commission (HPC) certification. Because the Accountable Care Partnership Plan is an MCO, it will perform many of the administrative functions that MassHealth MCOs perform (e.g., paying claims, maintaining the provider network, prior authorization, etc.). The Accountable Care Partnership Plan will communicate directly with Members what it offers and how to access services. Accountable Care Partnership Plans do not have to cover an entire specified geographic region. Accountable Care Partnership Plans will define their service areas, with MassHealth approval, and will need to have network adequacy in those service areas.
- **Primary Care ACO**– A Primary Care ACO is an ACO that has an exclusive group of participating Primary Care Clinicians (PCCs), and all Members enrolled in a Primary Care ACO receive primary care from these PCCs. Unlike Accountable Care Partnership Plans, Primary Care ACOs are not paid a capitation to provide services. Instead, their Members receive non-behavioral health care from MassHealth’s fee-for-service network, which is paid for directly through the MassHealth claims system. Members enrolled in Primary Care ACOs are also automatically enrolled in MassHealth’s behavioral health carve-out vendor. The Primary Care ACO is accountable through shared savings and losses

payments based on Total Cost of Care (TCOC) and quality performance for the Primary Care ACO's population of Enrollees.

- **MCO-Administered ACO** – An MCO-Administered ACO is an ACO that is part of the PCP network(s) for one or more MassHealth-contracted MCO(s). An MCO-Administered ACO may contract with multiple MCOs; an MCO may also contract with multiple MCO-Administered ACOs as part of its network. Each MCO-Administered ACO has an exclusive group of participating PCPs. Members who enroll in an MCO may be attributed to an MCO-Administered ACO. MCO-Administered ACOs are accountable to their MCOs through shared savings and losses payments. MassHealth must approve these financial arrangements and the associated requirements in the contracts between an MCO-Administered ACO and its MCOs.

In order to answer questions from prospective bidders and to continue to engage with stakeholders, MassHealth prepared for the first Bidders' Conference (held in October, 2016)

In addition, MassHealth focused on identifying and developing requirements for the information technology systems needed to support its payment reform initiatives, including a Data Mart to provide business intelligence reporting to internal and external audiences and a Clinical Data Repository to collect, store, and analyze clinical quality data from ACOs.

MassHealth drafted an RFR for Infrastructure and Capacity Building (ICB) grants for hospitals.

Finally, MassHealth began preparing for the launch of the ACO Pilot, finalizing policy details, negotiating contracts, and working with the selected vendors in this collaborative initiative.

Q2 October 1 – December 31, 2017

During this quarter, MassHealth finalized contracts and began operations for the ACO Pilot program with six Pilot ACOs on December 1st, 2016. Approximately 150,000 members are now experiencing accountable care through the 320 practices participating in the ACO pilot program. MassHealth produced test claims and member roster reports in November, and created the first production versions of these reports in December. A monthly series of ACO implementation meetings was begun with the ACOs in November, where implementation concerns could be discussed with the Pilot ACOs. Based on ACO feedback from these meetings, changes were made to the format of claims reports and member rosters to make them easier for ACOs to use in their existing data systems. Changes to our MMIS claims processing system allowed a new claims edit to be applied that reflected when a claim that would have been otherwise denied due to a referral requirement was paid because the rendering provider was listed on an ACO specific list of referral circle providers, which in the first month of operation was used to pay more than 5,000 claims.

MassHealth also produced four amendments to our Full ACO program procurement totaling over 150 pages, and four additional bidder's conferences for potential bidders on the Full ACO

program. The ACO program team answered over 200 questions on the Full ACO program and the associated procurement in a Q and A document, and produced a 30+ page document on our pricing methodology used in determining ACO capitation rates and TCOC targets.

Q3 January 1 – March 31, 2017

MassHealth produced a fifth amendment to our Full ACO program procurement, held an additional bidder's conference for potential Full ACO bidders, and responded to over 50 additional questions from those potential bidders in a Q and A document. MassHealth also held two stakeholder meetings regarding pricing methodology for the ACOs. During this quarter, MassHealth received twenty-one responses to the ACO Procurement Request for Responses and began the process of reviewing and evaluating those responses.

Q4 April 1 – June 30, 2017

MassHealth completed the evaluation of the twenty-one Responses to the ACO Procurement Request for Responses (RFR). This included issuing a Request for Clarification (RFC) to the bidders in order to gain additional insight into key areas of the RFR, and evaluating each of the RFC responses as part of the overall review process. The evaluation committee developed and finalized a 67 page recommendation memo, summarizing the findings of the committee, and selected eighteen of the bidders to enter into contract negotiations.

The ACO program team hosted a contract negotiation kick off meeting with the selected ACOs and hosted one-on-one meetings with each of them to discuss priority issues prior to contract execution. The team developed a communications strategy to receive and respond to inquiries and input from each of the selected ACOs throughout the contract negotiation process. The team also finalized and sent out contracts for review by the ACOs, which included integration of a number of programmatic changes. The ACO team requested feedback on the contract language from the selected ACOs for consideration prior to contract execution.

Rates and Total Cost of Care (TCOC) Benchmarks were released for each of the ACOs in June. Each ACO received a unique capitation rate (Accountable Care Partnership Plans) or TCOC Benchmark (Primary Care ACOs and MCO-Administered ACOs) as well as a detailed explanation of how rates were developed. The ACO team hosted multiple meetings with bidders, in partnership with EOHHS' actuarial vendor, to describe the rate setting process and respond to questions.

STC 62b - Quality Assurance/Monitoring Activity

Quality activities in FY17 covered the following topics:

- Managed care quality monitoring activities
 - One Care Program quality monitoring activities
 - Managed Care Program quality monitoring activities

- Senior Care Options (SCO) Program quality monitoring activities
 - External Quality Review Organization (EQRO) Activities
- Payment Reform Quality Activities
 - Primary Care Payment Reform quality monitoring activities
 - MassHealth Quality Committee
 - MassHealth ACO Quality Strategy Workgroup and Sub-Groups
 - External Accountable Care Organization (ACO) Quality Workgroup
- CMS Quality Grant activities
 - CMS Adult Medicaid Quality grant
 - Contraceptive Use grant

Managed Care Quality Activities

Managed Care Program (under 65, non-disabled)

Over the course of the year, the Managed Care Organizations (MCOs) participated in a number of quality measurement activities, most notably HEDIS. During Quarters 1 and 2, data from the 2016 MCO IDSS submissions were extracted, analyzed, and evaluated with regard to past performance and national Medicaid benchmarks. Performance information was used to identify trends as well as any areas for potential quality improvement efforts. A formalized report detailing MCO and overall MassHealth performance was drafted and was posted to the MassHealth website in Quarter 3. Finally in quarter 4, each MCO submitted their 2017 IDSS submission. Evaluation of MCO 2017 HEDIS performance is slated to begin in Quarter 1 (July/August 2017) of the next project year.

In addition to participating in quality measurement activities, the MCOs also participated in quality improvement activities. In September 2016 (Quarter 1), the MCO plans submitted information about their continued/new quality improvement activities required under the QI goal section of their current contract. The MCO submissions present information about work that was conducted in calendar year 2015 and were evaluated by MassHealth quality staff in Quarter 2. Reports for each MCO regarding their performance were drafted, reviewed by MassHealth Leadership, and provided to the managed care plans in Quarter 3. Performance across plans was generally good with reviewers' comments being positive. In addition to finalizing the quality improvement activities for 2016, the MassHealth managed care program began the process of redesigning the quality improvement project requirements of the MCO contract. Major modifications to the requirements include: reducing the overall number of QIPs from 8 to 4; requiring MCOs to submit quality improvement plans for approval prior to project implementation; and increasing the frequency of reporting and technical assistance offered to plans.

Finally, plans continued to participate in the external quality review process as required by the managed care rule. The EQR activities consisted of performance measure validation, performance improvement projects, and a compliance audit. Plans submitted the requested data and wrapped up the onsite/telephonic review process for the 2016 External Quality Review (Q1). Preliminary scores for the performance improvement project and performance measure validation were calculated and plans were asked to submit more information when necessary. External Quality Review activities for 2016 wrapped up during Quarter 2. Scores for the performance improvement project and performance measure validation were finalized and drafts of the technical reports were developed. All external quality review (EQR) technical reports for MCO plans were drafted and finalized during Quarter 3. Plans received kick-off information about the 2017 EQR cycle, including key dates for compliance, performance improvement, and performance measurement validation activities. All PIP telephone calls were scheduled, and plans participated in a training event to review the new PIP reporting templates. Plans began collecting EQR related data in Q4.

One Care Program (under 65, disabled)

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

Similar to the managed care program, the One Care Plans participate in the collection and submission of HEDIS data. During Quarters 1 and 2 data from One Care 2016 IDSS submission was analyzed to identify trends in performance. Additionally, information from the IDSS was used to support preliminary discussions (in Quarters 3 and 4) about creating a One Care HEDIS summary report. Decisions about a potential report are still under consideration and will likely be made in the next fiscal year.

In accordance to CMS requirements, One Care plans also participate in annual quality improvement projects. These QIPs are conducted on a calendar year cycle (2016) and were well underway during Q1, and completed in during Q2. During Q2 plans also submitted their proposals for future QIP work (CY17) to CMS for review and approval. Final reports on CY16 QIPs were submitted to CMS in Q3, with work on CY17 QIPs beginning in Q3 and continuing into Q4. The QIPs work conducted as part of the CMS also serve as the basis for the performance improvement projects required as part of External Quality Review.

During quarter 1, the One Care plans began the process of gathering data for the 2016 EQR cycle and received a request for information in June 2016. Data was submitted to the EQR vendor in September 2016, with site visits and telephone calls scheduled to discuss performance measure validation and performance improvement project validation respectively. The site visits and phone call will be occurring in October 2016. During quarter 2, One Care plans wrapped up the onsite/telephonic review process for the 2016 External Quality Review (EQR). Preliminary scores for the performance improvement project and performance measure validation were calculated and plans were asked to submit more information when necessary. During quarter 3, all EQR technical reports for OneCare plans were drafted and finalized. In quarter 4 plans received kick-off information about the 2017 EQR cycle, including key dates for compliance, performance improvement, and performance measurement validation activities. All PIP telephone calls were scheduled, and plans participated in a training event to review the new PIP reporting templates.

SCO Program (65 and over)

The SCO plans continued to participate in both quality measurement and EQR activities. With regard to the quality measurement activities, SCO HEDIS data was submitted and reviewed (Q2). Analysis and evaluation of the SCO data continued into Quarters 3 and 4. A draft SCO HEDIS report comparing individual SCO plan performance against other MassHealth SCO Plans

and national benchmarks was prepared. It is anticipated that the HEDIS report will be finalized in Q1 of the next reporting period.

With regard to EQR activities, SCO plans submitted the requested data and wrapped up the onsite/telephonic review process the 2016 EQR during quarter 1. Preliminary scores for the performance improvement project and performance measure validation were calculated and plans were asked to submit more information when necessary. External Quality Review activities for 2016 wrapped up during quarter 2. Scores for the performance improvement project and performance measure validation were finalized and drafts of the technical reports were developed. All SCO technical reports were finalized during quarter 3. Additionally plans received kick-off information about the 2017 EQR cycle, including key dates for compliance, performance improvement, and performance measurement validation activities. PIP telephone calls were scheduled, and plans participated in a training event to review the new PIP reporting templates. MassHealth worked with the EQRO vendor to plan for inclusion of a new SCO plan in EQR activities for the 2017 cycle. During the final quarter, SCO Plans began the process of gathering information for the 2017 HEDIS review.

External Quality Review Activities

During the first quarter, the EQR 2016 review activities were well underway for the MCO and SCO programs, and an initial kick-off meeting with a request for information was held for One Care plans. In the second quarter, the EQRO completed performance measure validation activities for managed care entities and finalized performance improvement validation scores, which represented the remaining activities for this reporting cycle. The EQRO produced 2016 technical reports for the MCO and SCO programs, with OneCare technical report drafts which were completed in the third quarter and submitted to CMS in advance of the April 30th deadline.

In March, the EQRO revised performance improvement templates for 2017 reporting in coordination with EOHHS and facilitated an in-person training on March 29 for quality managers. The training focused on how to effectively report on performance improvement projects using the new templates. Minor edits were made to performance improvement project templates in response to the March training for quality managers and final versions were distributed to plans. During the fourth quarter, the EQRO completed all guidelines and metrics for compliance reviews and began collecting documentation from plans.

The EQRO conducted a Stakeholder Satisfaction Survey to assess satisfaction with annual technical reports. They achieved improvements in all areas compared to the prior year, most notably in the areas of design and quality of writing. A comparative report template was drafted for 2017, and planning began for a modified PIP process in 2018.

Primary Care Payment Reform (PCPR)

Primary Care Payment Reform (PCPR) performance improvement activities for the reporting quarter comprise data aggregation and calculations to determine P4R/Q for YR 2 (2015) of the Program. The YR 2 Quality incentive plan is a combination of P4R (10 clinical measures) and P4Q (two measures). Performance in the 12 measures are calculated for each practice and then combined to determine organizational performance and, finally, at the risk pool level. Performance at the risk pool levels modifies the amount of incentive payment each organization receives for YR 2. The calculations and reports for YR 2 2015 performance scores were completed in Q4 2015. The reports were distributed to the practices in mid-January 2017. PCPR performance improvement activities for the reporting quarter are pending due to the claims lag for the Year 3 CY2016 performance results. YR 3 CY 2016 will be calculated in Q4 2017 with a plan to distribute the results to the participating providers in 2018.

MassHealth Quality Committee

The goal of the MassHealth Quality Committee is to support and inform development and alignment of quality goals, strategies and activities across current and new programs. After a brief hiatus, the Quality Committee recommenced meeting in October 2016. The Committee, which meets monthly, includes representatives from each of the core MassHealth programs which include MCO, PCC, 438.6 (c), ACO, Hospital P4P, with additional representatives addressing special populations (e.g., seniors, behavioral health, long term services and supports).

Work of the Quality Committee in SFY 2017 focused primarily on assessing the expanded CMS requirements and updating the MassHealth managed care quality strategy for 2018. These efforts recognize current and new programs for inclusion and aligning quality goals, measurement and other quality management activities across the various programs where possible.

The Quality Committee continues to focus its work specifically addressing measurement, patient experience, benchmarking strategies, plans for addressing disparities, quality improvement priorities, and approach to evaluation and reporting. FY18 will focus on these topics to inform and review a draft of the managed care strategy in preparation for stakeholder review and submission to CMS.

MassHealth ACO Quality Strategy Workgroup and Sub-Groups

During Quarter 1, the internal ACO Quality Strategy Workgroup took the recommendations made earlier in 2016 by the ACO Quality Workgroup (described below), to make additions and changes to the ACO quality measure slate. Sub-groups also convened to support these efforts around specific measurement areas and issues (e.g., prevention/wellness and chronic disease, behavioral health, integration, long term services and supports). Activities include developing measure definition and specifications, approaches to benchmarking and payment, and a

strategy for member experience surveying. Workgroup activities continued into Quarter 2. The preliminary quality measure slate was finalized and the process for developing and refining the specifications began. Additionally, the workgroup initiated the process of soliciting input on potential patient experience tools (CAHPS) as well as any needed supplemental question sets required to accomplish program objectives. In Quarter 3, the Workgroup continued to draft specifications for each ACO quality measure. The team held frequent conversations with internal and external quality experts on various components of measure construction including (but not limited to) risk adjustment, value set identification, feasibility, and the copyrighting requirements of national metrics. Additionally, the workgroup made substantial progress on finalizing timelines, specific populations, and associated sample sizes needed to meet all ACO patient experience measurement requirements

Finally in Quarter 4, the Workgroup prepared working drafts of approximately half of all measures included in the ACO Quality program. These specifications were presented to the DSRIP Quality Subcommittee for review, feedback, and soliciting recommended changes. Subsequently, these measures were sent to CMS for review on June 30th. Simultaneously, work continued on the remaining EOHHS developed “novel” measures whereby specifications are due to CMS by July 31st.

ACO External Quality Workgroup

The ACO quality workgroup, which consists of 40 external stakeholders met in early 2016, making significant recommendations with regard to the optimal measurement for accountability and payment for ACOs and developed a draft ACO quality measure slate. The workgroup reconvened in late September 2016 (Quarter 1) with the purpose of revisiting additions and changes to the quality measure slate as a result of the recommendations made earlier in the year, as well as discuss the benchmarking and payment methodology and member experience survey approach. During this Quarter 2, the ACO External Quality Workgroup continued the process of reviewing modifications to the ACO quality measure slate as well as continued to discuss benchmarking and payment methodologies.

Additionally the external Workgroup began the process of exploring different options for reporting clinical quality data back to MassHealth, e.g. use of web based data portal or secure file transfer site. During Quarter 3, the ACO External Quality Workgroup held decision-making sessions focused on appropriate “lookback period” methodologies. For example, for quality measures requiring the collection of data prior to the official start date of the ACO program, the group had to define how members would be attributed to ACOs during this lookback timeframe. Furthermore, the group considered various options for defining Severe Mental Illness (SMI) needed to identify the eligible population for several behavioral health related quality measures.

Finally, in Quarter 4, the Workgroup made final decisions regarding which measures in the quality slate would be risk-adjusted as well as the general methodology for achieving the adjustments. Furthermore, the team further defined standards by which measures would be considered “EOHHS developed” versus “nationally adapted.” This distinction is important as it relates to how specifications will be referenced, updated, communicated and validated as the program moves forward.

CMS Grant Activities

CMS Adult Core Quality Grant

All activities related to Aims 1 and 2 were completed in December 2015. Work on Aim 3 continued into this quarter and focused on building capacity and infrastructure at MassHealth to gather and use data. MassHealth continues to report on the results for the adult and child core measure sets voluntarily. All activities related to the CMS Adult Core Quality Grant were completed during the quarter 2, including those related to AIM 3 for which there was a no cost extension. A final grant report has been drafted and will be submitted to CMS in March 2017.

Contraceptive Use Grant

During this Fiscal Year, MassHealth reported on the Contraceptive Care for Women measure for the second time. Additionally, it also calculated and reported on the Contraceptive Care for Postpartum Women measure for the first time.

The grant team obtained access to data submitted to John Snow, Inc. by Title X funded providers in MA, and used that data to create reports on use rates for most/moderately effective contraceptive methods, including Long Acting Reversible Contraceptives (LARCs) by women who received services from Title X funded providers. A template of the report was initially shared with a small group of providers, and interviews with these providers were undertaken to obtain feedback on the content and format of the report. Feedback received from these interviews was used to modify the report template, and in June of 2017, the final report was shared with 15 of the largest-volume providers of family planning services within the group of Title X funded providers. Prior to the end of this FY, the grant team began a series of discussions with the providers that received the report. These discussions will be completed over the next month or so, and will focus on the providers’ review and assessment of the data, comparing contraceptive use rates by women seen at their practice to use rates by women seen at other practices in the providers’ region, and statewide, and will address opportunities for improvement, and/or identification of best practices. The information gathered through the discussions with practices will help to inform future technical assistance efforts through the grant.

The grant team has begun planning for its next round of practice reports, and its next round of calculating and reporting on the contraceptive measures.

STC 62c - Policy Development/Issues

During quarter 1, considerable policy development efforts took place. Most importantly, Massachusetts posted our proposed 1115 Waiver Extension Request for public comment. After the posting of the Waiver, we held two public listening sessions in for stakeholders and the public. Based on this feedback, MassHealth submitted its final 1115 Waiver Extension Request to CMS on July 22, 2016.

During quarter 2, CMS approved Massachusetts' new 1115 Waiver. The approval was for both an Amendment to the current Waiver, which is effective until June 30, 2017, as well as a five-year Extension. The Extension began on July 1, 2017 and is authorized through June 30, 2022.

The new Waiver provides the opportunity for Massachusetts to move from its current fee-based model to a system of Accountable Care Organization models (ACO) who will work in close partnership with community-based organizations to better integrate care for behavioral health, long-term services and supports and health-related social needs.

The Extension also authorizes the new Delivery System Reform Incentive Program (DSRIP) funding to support the move to ACOs, invests in Community Partners for behavioral health and long term services and supports, and allows for innovative ways of addressing the social determinants of health. It also authorizes safety net care payments over five years to hospitals and the health safety net for the uninsured and underinsured, and for subsidies to assist consumers in obtaining coverage on the Massachusetts Health Connector. In addition, the Waiver allows for an expansion of the services provided for substance use disorder treatment.

The Extension to the Waiver has five broad goals:

1. Enact payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care;
2. Improve integration of physical health, behavioral health, LTSS, and health-related social services;
3. Maintain near-universal coverage;
4. Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals;
5. Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder (SUD) services.

For further relevant policy development, please refer to the Payment Reform Activities section for greater detail on the payment and delivery system reform activities approved under the 1115 waiver amendment and extension.

STC 62d - Enrollment Information

Eligibility Group	Enrollees as of June 30, 2017
<i>MassHealth Demonstration</i>	
Base Families	809,769
Base Disabled	226,323
1902 (r) (2) Children	23,013
1902 (r) (2) Disabled	17,001
Base Childless Adults (19-20)	27,218
Base Childless Adults (ABP1)	28,599
Base Childless Adults (CarePlus)	299,099
BCCTP	1,165
CommonHealth	25,756
e - Family Assistance	8,048
e - HIV/FA	644
SBE/IRP	40
Safety Net Care Pool	
Base Fam XXI RO*	
1902 (r) (2) XXI RO*	
CommonHealth XXI*	
Fam Assist XXI*	
Asthma	
Autism	
TANF/EAEDC	
End of the Month Coverage	
<i>Total Demonstration</i>	1,466,675

Delivery System for MassHealth-Administered Demonstration Populations

	SFY2017 Q3	SFY2017 Q4	
MassHealth Enrollment (Members)	Average	Average	Difference
MCO	851,770	878,201	26,431
PCC	377,459	396,302	18,842
FFS / PA	614,111	582,576	-31,535
Total	1,843,340	1,857,078	13,738
MBHP (Includes PCC and TPL)	441,012	457,950	16,938
PA Only (included in FFS above)	18,628	18,866	238

STC 62f - Safety Net Care Pool

MassHealth continued to work on a number of Safety Net Care Pool (SNCP) Initiatives. In particular, Massachusetts worked with CMS to gain approval of its 1115 Waiver Extension, effective July 1, 2017. The 1115 Waiver Extension renewed the federal and state commitment to the safety net by authorizing nearly \$8 billion of SNCP payments over the next five years. While the extension authorized the Delivery System Reform Incentive Program (DSRIP), MassHealth worked with CMS to finalize the DSRIP protocol, which governs the program. Under the waiver extension the number of safety net providers expands from seven to fifteen in the SNCP.

STC 62h - Evaluation Activities and Issues

MassHealth continues to work on the evaluation design for the Extension. MassHealth submitted a draft of the evaluation design to CMS in March and included updates to the design draft with the waiver amendments that were submitted in June and September 2017. The overall evaluation will also encompass the DSRIP evaluation. This will require evaluation of the success of delivery system reform based on many factors, including patient satisfaction, cost and quality of care, shared savings and losses, and the overall success of the Community Partners program. MassHealth will also work with the evaluator on designing metrics for determining maintenance of universal coverage and support to safety net providers, as well as the expansion of substance use disorder treatment. MassHealth has selected Commonwealth Medicine, the public service consulting and operations division of UMass Medical School, to be the overall waiver evaluator as well as the DSRIP evaluator.

Additionally, MassHealth will be working to procure the DSRIP independent assessor. The independent assessor will review ACO and CP proposals, progress reports, and other related documents to ensure compliance with approved STCs and Protocols. The independent assessor will also assist with the progress reports and mid-point assessment and any other ongoing reviews of the DSRIP project plan; and assist with continuous quality improvement activities.

State Contact

For any questions or comments regarding this quarterly report, please contact:

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Date Submitted to CMS

09/29/2017

Federal Budget Neutrality Summary SUBJECT TO PUBLIC COMMENT PROCESS

Room Under the Budget Neutrality Cap \$ **35,378,788,200**

State Fiscal Year	Total				
	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	SNCP Expenditures	Variance
Third Waiver Extension Period					
SFY09 Actual	\$ 6,777,034,966	\$ 4,811,977,227		\$	\$ 1,965,057,740
SFY10 Actual	\$ 7,753,610,499	\$ 5,322,714,724		\$	\$ 2,430,895,775
SFY11 Actual	\$ 8,780,601,248	\$ 6,024,863,090		\$	\$ 2,755,738,159
SFY09-11 SNCP				\$ 4,750,359,454	\$ (4,750,359,454)
	\$ 23,311,246,713	\$ 16,159,555,040		\$ 4,750,359,454	\$ 2,401,332,219
Fourth Waiver Extension Period					
SFY12 Actual	\$ 9,367,766,216	\$ 6,119,516,134		\$ 1,387,797,555	\$ 1,860,452,527
SFY13 Actual	\$ 10,066,274,983	\$ 6,124,873,255		\$ 1,467,440,578	\$ 2,473,961,150
SFY14 Actual	\$ 11,292,578,515	\$ 6,787,347,604		\$ 1,476,875,200	\$ 3,028,355,712
SFY12-14 SNCP				\$	\$ -
	\$ 30,726,619,715	\$ 19,031,736,993		\$ 4,332,113,333	\$ 7,362,769,389
Fifth Waiver Extension Period					
SFY15 Actual	\$ 13,368,030,744	\$ 7,089,056,002		\$ 1,958,533,333	\$ 4,320,441,409
SFY16 Actual	\$ 14,755,222,967	\$ 7,733,004,559		\$ 1,271,800,000	\$ 5,750,418,408
SFY17 Actual	\$ 15,560,027,850	\$ 7,225,099,577		\$ 1,266,000,000	\$ 7,068,928,273
SFY15-17 SNCP				\$	\$ -
	\$ 43,683,281,561	\$ 22,047,160,137		\$ 4,496,333,333	\$ 17,139,788,090
Sixth Waiver Extension Period					
SFY18 Projected	\$ 16,490,172,789	\$ 7,477,309,403	\$ 6,234,215,867	\$ 1,909,079,437	\$ 869,568,083
SFY19 Projected	\$ 17,474,418,969	\$ 7,820,926,271	\$ 6,764,610,202	\$ 1,758,009,538	\$ 1,130,872,958
SFY20 Projected	\$ 19,677,628,064	\$ 8,095,310,374	\$ 8,152,859,218	\$ 1,620,119,977	\$ 1,809,338,495
SFY21 Projected	\$ 21,054,794,455	\$ 8,419,883,034	\$ 8,920,682,547	\$ 1,578,786,338	\$ 2,135,442,537
SFY22 Projected	\$ 22,567,200,796	\$ 8,757,972,619	\$ 9,763,123,185	\$ 1,516,428,562	\$ 2,529,676,429
SFY18-22 SNCP				\$	\$ -
	\$ 97,264,215,074	\$ 40,571,401,701	\$ 39,835,491,019	\$ 8,382,423,852	\$ 8,474,898,502
Total	\$ 171,674,116,349	\$ 81,650,298,832	\$ 39,835,491,019	\$ 17,210,870,518	\$ 35,378,788,200

* Calculation will vary based on annual Federal DSH Allotment