ATTACHMENT J
MASTER DSTI PLAN

I. PREFACE

1. **MassHealth Medicaid Section 1115 Demonstration Waiver**
   On December 20, 2011, the Centers for Medicare & Medicaid Services (CMS) approved the Commonwealth of Massachusetts' request to extend the term of the section 1115 Demonstration waiver, entitled MassHealth (11-W-00030/1) (Demonstration) in accordance with section 1115(a) of the Social Security Act. The new extension period was approved through June 30, 2014.

2. **Delivery System Transformation Initiatives (DSTI)**
   STC 49 of the Demonstration authorizes the Commonwealth to create Delivery System Transformation Initiatives (DSTI) funded through 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 triple 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 will 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.

   Eligible safety net hospitals (also referred to as "hospital(s)" herein) will be required to develop and implement these initiatives and activities in order to receive the incentive payments. Pursuant to STC 49(e)(3), participating hospitals must implement new health care initiatives within their respective health systems, or significantly enhance existing initiatives, in order to qualify for DSTI incentive payments. In addition, these initiatives may complement or enhance other federal initiatives in which a hospital may be participating, but they may not duplicate the exact same activities undertaken by a hospital for which that hospital receives specific funding by the U.S. Department of Health and Human Services. Pursuant to STC 49(e)(6), these incentive payments are intended to support and reward hospitals for improvements in their delivery systems; they are not direct reimbursement or payment for services, should not be considered patient care revenue, and will not be offset against other Medicaid reimbursements to a hospital system.

3. **Master DSTI Plan**
   In accordance with STCs 49(e), 52(a), 52(c), and 53(c), the master DSTI plan defines the specific initiatives that will align with the following four categories: (1) developing a fully-integrated delivery system, (2) improving health outcomes and quality, (3) developing capabilities to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments that promote system sustainability, and (4) population-focused improvements. Furthermore, the master DSTI plan describes the global context for DSTI in the Commonwealth, describes guidelines for individual hospital DSTI plans, and stipulates the structure and processes governing the DSTI program, pursuant to STC 52(a). The master DSTI plan also incorporates the required elements of the DSTI payment and funding protocol as described in STC 52(c)(4).

Following approval of the master DSTI plan by CMS and throughout the Demonstration renewal period, EOHHS may propose revisions to the master DSTI plan, in collaboration with the respective DSTI hospitals, to reflect modifications to any component of a hospital's final approved plan, including but not limited to projects, measures, metrics, and data sources; or to account for other unforeseen circumstances in the implementation of the DSTI program. CMS shall render a decision on proposed master DSTI plan revisions within 30 days of submission by EOHHS. Such revisions shall not require a waiver amendment, provided that they comport with all applicable STC requirements.

4. **Hospital Specific DSTI Plans**
Upon CMS approval of the Commonwealth's master DSTI plan, each eligible safety net hospital must submit an individual DSTI plan that identifies the projects, population-focused objectives, and specific metrics adopted from the master DSTI plan and meets all requirements pursuant to the STCs. The requirements for hospital-specific DSTI plans are described in STC 52(b) and further detailed in Section IV ("Key Elements of Proposed Hospital Specific Plans") herein.

5. **Organization of "Attachment J: Master DSTI Plan"**
This document serves as Attachment J to the STCs and contains all required elements that must be included in the Commonwealth's master DSTI plan and DSTI payment and funding protocol, pursuant to STC 52(a) and 52(c). Attachment J is organized into the following sections:

   I. Preface
   II. Commonwealth's Payment & Delivery System Progress and Goals
   III. Community Needs & DSTI Eligibility Criteria
   IV. Key Elements of Proposed Hospital Specific Plans
   V. State & Federal Review Process of Hospital Specific Plans
   VI. Non-Federal Share of DSTI Payments
   VII. Reporting & Payments in DY 15, DY 16, and DY 17
   VIII. Disbursement of DSTI Funds
   IX. Plan Modification, Grace Periods, and Carry-Forward & Reclamation
   X. Master DSTI Projects and Metrics
   XI. DSTI Evaluation

II. COMMONWEALTH'S PAYMENT & DELIVERY SYSTEM PROGRESS AND GOALS

6. **Global Context**
In April 2006, Massachusetts signed into law a landmark health care reform bill with the aim of providing access to affordable health insurance to all Massachusetts residents. The legislation, Chapter 58 of the Acts of 2006 (Chapter 58), titled *An Act Providing Access to Affordable, Quality, Accountable Health Care*, was the result of a bipartisan effort among state leaders from government, business, the health care industry, community-based groups and consumer advocacy organizations. Chapter 58 consisted of a series of bold

interdependent activities and programs, each necessary for the other to be successful and to achieve the overall goal of drastically reducing the rate of uninsurance in Massachusetts. Chapter 58 later served as an inspiration for federal health care reform legislation, the *Patient Protection and Affordable Care Act* of 2010 (ACA). As in Massachusetts, the ACA includes the creation of state health insurance exchanges, subsidies for low- and moderate-income individuals to purchase health insurance, an individual mandate to purchase insurance, shared responsibility requirements for employers, and expansions of public health insurance programs.

Health care reform in Massachusetts, with the support and partnership of CMS, has been an unrivaled success. More than 98% of the population is insured, and only 0.2% of children lacked coverage in 2010.[1] According to a recent report by the Blue Cross Blue Shield Foundation of Massachusetts, health reform not only has led to sustained increases in insurance coverage, but reform has also increased access to health care and improved health status among Massachusetts residents. Among the report's key findings are:[2]

- Massachusetts made sustained gains in access to and use of health care between 2006 and 2010. Nonelderly adults were significantly more likely to have a usual source of health care, more likely to have had a preventive care visit, more likely to have had multiple doctor visits, more likely to have had a specialist visit, and more likely to have had a dental care visit.
- Emergency departments (ED) visits, a key indicator of gaps in access to regular care, were down nearly four percentage points since 2006. ED use for non-emergency conditions similarly decreased almost four percentage points, and frequent ED use dropped by 2 percentage points.[3]
- The share of nonelderly adults in Massachusetts reporting their health status as very good or excellent increased between 2006 and 2010 (from 46.7 percent to 53.2 percent).
- Many of these gains were concentrated among low-income adults, a population that was particularly targeted by health reform initiatives to improve access to and affordability of care.

The Blue Cross Blue Shield Foundation report affirms that, despite the challenges posed by the nationwide recession that began in 2009, Massachusetts has sustained the progress made under state health reform. The Commonwealth has remained steadfast in its commitment to universal access in spite of the fact that the worst economic downturn in more than 70 years has resulted in more Massachusetts residents relying on safety net programs.

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[1] Massachusetts Division of Health Care Finance and Policy. *Key Indicators: Quarterly Enrollment Update June 2011 Edition (Released in February 2012)*. <http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/12/2011-june-key-indicators.pdf>

[2] Sharon K. Long, Karen Stockley, and Heather Dahlen. *Health Reform in Massachusetts as of Fall 2010: Getting Ready for the Affordable Care Act & Addressing Affordability*. Blue Cross Blue Shield Foundation of Massachusetts, January 2012.

[3] The reduction in overall ED use was statistically significant at the .05 level, two tailed test, and the reduction in non-emergent ED use was statistically significant at the .01 level, two tailed test. The reduction in frequent ED use was not statistically significant.

The Commonwealth's success in insuring nearly all Massachusetts residents has highlighted a new set of challenges. Massachusetts, like states around the country, the federal government, the private sector, and individuals, is burdened by health care cost inflation and in many cases utilizes a fee-for-service payment system that can reward the delivery of services rather than improvements in the health outcomes of the population. Massachusetts health care costs are currently projected to rise by an average of 6% annually during the next decade, while GDP is projected to grow at less than 4%.[4]

Rising health care costs threaten the sustainability of the reforms that have borne such success. The challenge of ensuring that improvements in access to care for low-income populations endure is particularly critical as a shrinking state budget places additional fiscal pressure on the Commonwealth's Medicaid program. More than four-fifths of insurance coverage expansion since 2006 came through the Medicaid program. Moreover, the residually uninsured population is highly concentrated in low-income, urban communities. These realities, compounded by the economic downturn, have put serious financial pressure on safety net providers who face increasing Medicaid caseloads.

To address these challenges, Massachusetts must now turn its focus to reducing the actual costs of medical care and the rate of growth over time, even as we redouble our efforts to improve quality and the patient experience while ensuring the sustainability of safety net providers.

7. **Commonwealth's Goals & Outcomes**

The Commonwealth has and will be undertaking a number of efforts with a single theme: transforming the delivery system to provide integrated care across the continuum, while adopting sustainable alternative payment systems that more directly reward systems for high quality, efficient care. Restructuring health care payment and delivery systems is fundamental to better ensuring consistent quality of care, reducing errors, decreasing health care disparities, and reining in overall health care costs.

A critical component of improving health care quality and curtailing costs will be integrating care to ensure that providers work collaboratively to meet patient care needs and do so in the most appropriate setting. Increased focus on using the right care at the right time in the right place will mean a significant behavioral change both for providers and for health care consumers, but it is also a pivotal building block in the long-term systemic transformation Massachusetts envisions. In addition, the Commonwealth views delivery system transformation and payment reform as integrally related. In order to align incentives toward more integrated, accountable models of care delivery, the Commonwealth is committed to reforming the way we pay for care, moving from volume based fee-for-service payments to payments based on maintaining access and quality.

For MassHealth, supporting safety net populations and the safety net providers that provide the majority of their care is the natural place to start to advance delivery system and payment

[4] Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health Care Spending Baseline Trends and Projections," February 4, 2009. Massachusetts Health Care Quality and Cost Council, "Roadmap to Cost Containment," page 1, October 2009.

reform. The goal of Delivery System Transformation Initiatives (DSTI) is to leverage incentive payments to advance the transformation of safety net hospitals and their networks into integrated delivery systems characterized by the Triple Aim shared by CMS and EOHHS: improving care for individuals, improving the health of populations, and reducing per-capita costs to make health care affordable for all.

Through DSTI, incentive payments will be offered to eligible safety net hospitals that serve a high proportion of low-income Medicaid and uninsured patients to support projects that will help them develop more fully integrated delivery systems, improve health outcomes and quality, and advance their capacity to respond to statewide transformation to alternative payment methods. Payments will be tied to achieving specific transformation milestones. The vision is to provide critical support that will position the eligible hospitals for payment reform and toward success in alternative payment arrangements that reward cost effective and high quality care.

8. **Payment & Delivery System Reform Efforts**

Massachusetts has been a model for the nation in expanding access to health care services, and now it is taking the lead in controlling costs and improving quality through payment and delivery system reform initiatives.

In order to advance statewide reform, the Administration and the Legislature are currently pursuing legislation that would improve quality and control costs by reforming health systems and payments. Governor Patrick introduced a bill in February 2011 that would begin moving providers and payers – including state purchasers of health care such as MassHealth, the Group Insurance Commission and the Health Connector – away from fee-for-service methods of payment and toward the use of alternatives to fee-for-service such as global payments, bundled payments, and other alternatives. The successful adoption of the reform currently contemplated will promote the transformation of the Massachusetts delivery system into an innovative care delivery and health care financing model.

The Executive Office of Health and Human Services (EOHHS) already has made significant progress in advancing the goals of payment and delivery system reform under existing initiatives and planning efforts. Ongoing initiatives include:

ACO Development

In June 2011, EOHHS issued a Request for Information to gather input, information and advice on how best to implement payment reform for state health programs, including MassHealth, Commonwealth Care, state employees' health insurance, and other programs. EOHHS received 42 responses, which came from every sector of the health care community: patient advocates, physicians, hospitals, employers, specialists, medical device companies, other providers and other industry advocates. The responses will help shape a MassHealth procurement of ACOs, currently in development, to promote coordinated care and value based purchasing. The ACO initiative is projected to launch in 2013. EOHHS aims to align the ACO initiative with DSTI and other delivery system reform efforts to promote synergies across

initiatives, in order to advance the goal of integrated delivery systems built on Patient Centered Medical Home principles.

Electronic Health Record Initiative

The MassHealth Electronic Health Record (EHR) initiative, part of the CMS Medicaid EHR Incentive Program, offers Medicaid health care providers incentive payments to encourage them to adopt, implement, upgrade, or meaningfully use certified EHR technology. Wide adoption and meaningful use of interoperable EHRs will be a critical building block for payment reform, enabling providers to manage their patients' care and costs effectively. Meaningful use of EHRs can improve patient care by simplifying administrative procedures, enhancing health care quality by making patient health information available at all points of care, reducing costs through earlier diagnosis and characterization of disease, and increasing coordination of information for patients, caregivers, and clinical staff. MassHealth plans to distribute up to $500 million over the life of the program (through 2021) to eligible health care providers to support transitions to electronic health record systems.

Patient-Centered Medical Home Initiative (PCMHI)

The Patient-Centered Medical Home Initiative (PCMHI) is a statewide, multi-payer demonstration project that supports 46 primary care practices in becoming patient-centered medical homes. The practices include community health centers, hospital-affiliated primary care offices, and group and solo primary care physician practices. PCMHI establishes a foundation for transforming the primary care landscape in Massachusetts through these pilot sites. This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. Instead, the patient-centered medical home model emphasizes enhanced chronic disease management through team-based care. Patient-centered practices place increased focus on recognizing the patient as an individual, respecting the patient's values, language and culture, and promoting the exchange of information about care options between patients and providers. Pending CMS approval, selected PCMHI practices will participate in shared savings arrangements with PCMHI payers. With this demonstration as a foundation, the Commonwealth has set the goal for all primary care practices in Massachusetts to become patient-centered medical homes by the year 2015.

Pediatric Asthma Pilot Program

The Pediatric Asthma Bundled Payment Demonstration Program is an initiative to pilot bundled payments for high-risk pediatric asthma patients enrolled in selected MassHealth Primary Care Clinician Plan practices. This pilot program will aim to improve health outcomes, reduce asthma-related emergency department utilization and asthma-related hospitalizations, and reduce associated Medicaid costs for children with high-risk asthma. The pilot will be conducted in two phases. The first phase will provide a bundled per member per month payment for services not traditionally covered by MassHealth, such as home visits by community health workers and supplies for mitigating environmental asthma triggers in the home. Following initial implementation and evaluation of outcomes from the first phase of

the pilot, the Commonwealth may request CMS approval to implement a bundled payment for all ambulatory services required for the most effective treatment and management of pediatric asthma for high-risk patients. The Commonwealth's goal in establishing the program is to evaluate the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower cost.

Non-Elderly Duals Integration Demonstration Project

Massachusetts is one of 15 states that received a $1 million planning contract from the CMS Center for Medicare and Medicaid Innovation to support the development of a design proposal for a State Demonstration to Integrate Care for Dual Eligible Individuals. The Commonwealth's proposal, recently submitted to CMS, promotes person-centered models that integrate the full range of acute care, behavioral health services and care, and long term supports and services for approximately 115,000 members between the ages of 21-64 who are eligible for Medicaid and Medicare. These dual eligible adults have disproportionately experienced the shortcomings of fragmented, uncoordinated care and payment streams. The Duals Demonstration will provide a strong foundation for payment and delivery system reform in the Commonwealth by providing dually eligible MassHealth members with access to an integrated, accountable model of care and support services financed jointly with Medicare through global payments.

MassHealth Pay for Performance

The MassHealth Acute Hospital P4P Program, implemented in 2008, seeks to reward hospitals for excelling in or improving quality for MassHealth members as evidenced by positive outcomes and cost-effective care. Quality performance goals and measures are selected based on strategic importance, relevance to Medicaid population health outcomes and status, and consistency with nationally-recognized standards for quality measurement. Current measurement approaches cover maternity/newborn, chronic conditions, surgical infection prevention, pediatric asthma, community acquired pneumonia, and clinical health disparities. MassHealth is currently exploring the possibility of expanding measurement to cover a wider range of quality domains, such as care transitions, outcomes, and patient experience of care, to support alignment with Medicaid delivery system and payment reform activities. EOHHS will continue to coordinate across initiatives to ensure that P4P measures do not duplicate quality measures tied to hospital payments in existing initiatives in a way that would result in duplication of state or federal funds.

All Payer Claims Database

Massachusetts is developing an All Payers Claims Database (APCD) that will provide timely, valid, and reliable health care claims data that will allow a broad understanding of cost and utilization across institutions and populations. This dataset will be a critical tool in informing the development of health care policies in the Commonwealth, as policymakers, payers and providers evaluate different payment methodologies and work to develop performance measures to support integrated health care delivery models. The APCD is anticipated to be available for use by

interested parties as of July 1, 2012. Potential users will apply for data release through an application and governance process.

DSTI will build upon and complement these existing initiatives by incenting safety net providers to make critical investments in developing integrated care models based on PCMH principles, implementing innovative programs to improve health care quality and outcomes, and preparing to participate in alternative payment arrangements. As the Commonwealth increasingly moves beyond pilots and demonstration programs to statewide delivery system and payment reform, DSTI will help to ensure that safety net providers are sustainable and successful in the new health care context.

III. COMMUNITY NEEDS & DSTI ELIGIBILITY CRITERIA

9. **Community Needs**

Massachusetts as a state is more affluent, better-educated, and healthier than the nation as a whole. Massachusetts has an overall poverty rate of 15%, below the national rate of 21%, and a median income of $61,000, above the national median of $50,000. Of the Commonwealth's approximately 6.6 million residents, 39% hold a bachelor's or graduate degree, compared to 28% for the nation as a whole.[5] In addition, Massachusetts has expanded health care coverage while maintaining above-average performance in key health indicators. Life expectancy in Massachusetts is 80.1 years, compared to a national figure of 78.6. The infant mortality rate is 5.6 per thousand, compared to a national rate of 6.8. Obesity and diabetes rates for both children and adults are lower than national rates.[6]

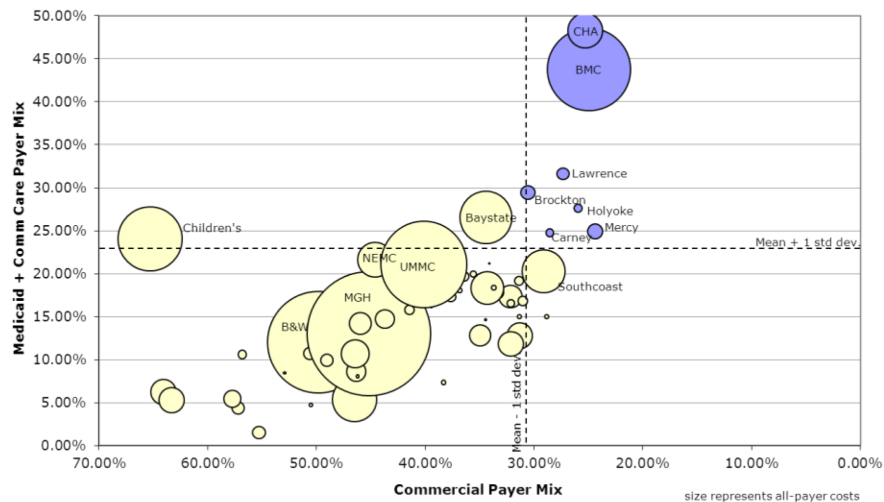
However, the communities that DSTI-eligible safety net providers serve are characterized by lower incomes, more severe socioeconomic challenges, and more adverse health status indicators than the state as a whole. For example, DSTI-eligible hospitals serve the state's largest urban population (the Boston metropolitan area) as well as a rural county with the lowest per-capita income and worst health outcomes in the state (Hampden County).[7] Populations in these communities have higher risk factors for asthma and diabetes and often face complex medical and behavioral health conditions. Linguistic, cultural, and socio-economic barriers require specialized resources and services to effectively coordinate care and promote health. Prevalence of chronic health care conditions such as diabetes, cardiovascular disease, COPD, and obesity, are higher than in other Massachusetts communities.[8] These factors create specific challenges in designing effective interventions to coordinate and manage care for safety net populations and simultaneously make the need for delivery system transformation more urgent for safety net providers.

10. **Safety Net Health Care Challenges**

Safety net hospitals have been crucial participants in Massachusetts' health reform efforts. The newly insured have continued to rely on safety net hospitals for care, as well as outreach

[5] 2010 American Communities Survey.
[6] Kaiser Family Foundation. State Health Facts: Massachusetts State Profile. < http://www.statehealthfacts.org>
[7] Massachusetts Community Health Information Profile (MassCHIP), available at <http://www.mass.gov/eohhs/researcher/community-health/masschip/welcome-to-masschip.html>
[8] Ibid.

and enrollment, in large numbers. These organizations had long been the site of care for the uninsured; naturally, the newly insured continue to seek health services where they already have a connection. As a result, these hospitals experienced a 30% increase in Medicaid patient care volume during health care reform from 2006 to 2010.[9] DSTI eligible safety net hospitals have a Medicaid and Commonwealth Care payer mix that is, on average, nearly 2.5 times the statewide acute hospital average (as illustrated in the chart below). In addition, despite the expansion in health coverage under Chapter 58 reforms, safety net hospitals continue to provide concentrated care to the residual uninsured population. Safety net hospitals currently have a weighted-average uninsured payer mix of 8% (with one provider having an uninsured rate of 13%). This disproportionately high Medicaid and low-income public payer mix, combined with historically low rates of commercial payer reimbursement and the effects of the recent economic downturn, has contributed to significant financial pressure on these safety net hospitals.



These factors have limited the capacity of the eligible safety net providers to make investments that position them well for payment reforms. The transformation to new models of care delivery require hospitals and providers to make significant up-front investments in such areas as network development and management; care coordination, quality improvement and utilization management; clinical information systems; and data analytics to enhance performance measurement.[10] Many of the eligible safety net hospitals have deferred capital investments (including IT) and operating investments (such as care coordination and management systems enabled by new clinical and financial reporting capabilities) in an effort to manage conservatively and live within their budgets. Choices like these, while necessary in the short term, threaten to undermine the ability of the Commonwealth's safety net

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[9] Aggregate increase in the annual number of Medicaid and Medicaid Managed Care patient care encounters 2006-2010 for seven safety net hospitals participating in DSTI, derived from Massachusetts Division of Health Care Finance and Policy FY2010 403 Cost Reports.

[10] Accountable Care Organization Learning Network Toolkit. Engelberg Center for Health Care Reform | The Dartmouth Institute and The Brookings Institution, January 2011.

providers to transform their delivery systems to meet the Triple Aim goals that the hospitals share with CMS and EOHHS.

DSTI presents a unique opportunity for the eligible safety net hospitals to begin to overcome these challenges and make significant progress toward delivery system transformation. The Commonwealth and eligible safety net hospitals seek to leverage DSTI funds to advance new models of care delivery that emphasize greater clinical integration and care management, as well as to advance payment models that align incentives more effectively at the provider level. Each of the DSTI hospitals, within the context of its unique starting place and community setting, aims to develop a set of core capabilities to transform health care delivery in the context of new payment reform models. With oversight by both EOHHS and CMS, participating hospitals will utilize the opportunity for DSTI incentive payments to make strategic investments in delivery system transformation initiatives with the ultimate goal of achieving the Triple Aim – better care, better health and lower costs.

11. **DSTI Eligibility Criteria**

STC 49(e)(1) describes the eligibility criteria for the DSTI program. Providers eligible for incentive payments are defined as public or private acute hospitals with a Medicaid payer mix more than one standard deviation above the statewide average and a commercial payer mix more than one standard deviation below the statewide average, based on FY 2009 cost report data. Based on the eligibility criterion specified in STC 49(e)(1), the hospitals listed below are the providers who are eligible to participate in DSTI for the term of this Demonstration approval period, and shall be eligible to earn incentive payments based on an initial proportional allotment indicated in STC 49(e)(7) and Attachment I:

- Cambridge Health Alliance
- Boston Medical Center
- Holyoke Medical Center
- Lawrence General Hospital
- Mercy Medical Center
- Signature Healthcare Brockton Hospital
- Steward Carney Hospital.

IV. KEY ELEMENTS OF PROPOSED HOSPITAL SPECIFIC PLANS

12. **Hospital Specific DSTI Plans**

Each eligible safety net hospital must submit an individual DSTI plan that identifies the projects, population-focused objectives, and specific metrics adopted from Section X ("Master DSTI Projects and Metrics") and meets all requirements pursuant to STC 49(e)(4), STC 49(e)(3), STC 52(a)(2), STC 52(b), and all requirements set forth in Section IV ("Key Elements of Proposed Hospital Specific Plans").

13. **Minimum Number of Projects**

Hospitals shall select a minimum of five projects across Categories 1, 2 and 3 from Section X ("Master DSTI Projects and Metrics"). The distribution of each hospital's projects across Categories 1, 2 and 3 shall be such that each hospital has at least one project in each of the

three categories *and* at least two projects in two of the three categories. Hospitals may submit more than five projects in total for Categories 1, 2 and 3.

In Category 4, hospitals shall report on a specified number of population-focused health improvement metrics in the core set of common measures (11 in DY 16 and 12 in DY 17) as described in Section X ("Master DSTI Projects and Metrics"), pursuant to STC 52(a)(10). Hospitals also must report a minimum of 6 hospital-specific metrics selected from among the measures described in Section X ("Master DSTI Projects and Metrics"). Hospitals may also report additional hospital-specific measures up to a total maximum of 15 as described in Section X ("Master DSTI Projects and Metrics"). Pursuant to STC 49(e)(4), Category 4 metrics may vary across participating providers, but should be consistent within projects described in the DSTI master plan to facilitate evaluation. Due to the time required for hospitals to develop new data reporting systems, eligible safety net hospitals are required to report Category 4 measures in DY 16 and DY 17 only.

14. **Organization of Hospital Specific DSTI Plans**
Hospital-specific DSTI Plans shall include the following sections:

a) Executive Summary
The Executive Summary shall provide a summary of the hospital-specific DSTI plan, a summary of the hospital's vision of delivery system transformation, and a table of the projects included in the plan, including project titles, brief descriptions of the projects, and three year goals. The Executive Summary shall also include a description of key challenges facing the hospital and how the three-year DSTI plan supports the hospital's five-year vision. The Executive Summary should address:
- How the individual projects support the five-year vision;
- How the individual projects reinforce/support each other;
- How Category 4 measures are relevant to the hospital's 5-year vision and population/outcomes health improvement.

b) Background Section
The background section shall include, at a minimum, a summary of the hospital's community context, a description of the hospital's patient population, a description of the health system, and a five-year vision of delivery system transformation. The background section also shall include a brief description of any initiatives in which the hospital is participating that are funded by the U.S. Department of Health and Human Services and are directly related to any of the hospital's DSTI projects.

c) Sections on Categories 1, 2, and 3

1) Project Narrative
Pursuant to STC 52(b)(3)(b), each hospital shall include a narrative for each project that describes the following elements of the project:

i. Goal(s)
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;

ii. Rationale
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 available baseline data, as well as a description of how the project represents a new initiative for the hospital system or significantly enhances an existing initiative (pursuant to STC 49(e)(3)), including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services;

iii. Expected Results
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;

iv. Relationship to Other Projects
A narrative describing how this project supports, reinforces, enables and is related to other projects and interventions within the hospital system plan;

v. Description of how Project can Refine Innovations, Test, and Disseminate Findings (Category 2 only)
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.

2) Milestones and Metrics Table
For each project, hospitals shall submit milestones and metrics adopted in accordance with Section X ("Master DSTI Projects and Metrics") and meet the requirements pursuant to STC 49(e)(5) entitled "DSTI Metrics and Evaluation." In a table format, hospitals shall indicate by Demonstration year, when project metrics will be achieved and indicate the data source that will be used to document and verify achievement.

d) Section on Category 4
This focus area involves population-focused improvements associated with Categories 1, 2 and 3 projects. Each eligible safety net hospital shall report on a core set of common metrics in addition to hospital-specific metrics, pursuant to Section X ("Master DSTI Projects and Metrics"). Pursuant to STC 49(e)(4), metrics include those that are related to the impact of the transformation projects undertaken by hospitals, such as health care delivery system and access reform measures on the quality of care delivered by participating providers. Metrics also include those that are related to the impact of the payment redesign and infrastructure investments to improve areas such as systems of care, coordination of care in community settings, and cost efficiency. Metrics may vary

across participating providers, and will be consistent within project options developed in Section X ("Master DSTI Projects and Metrics") to facilitate evaluation. Due to the time required for hospitals to develop new data reporting systems, eligible safety net hospitals are required to report Category 4 measures in DY 16 and DY 17 only.

e) Distribution of DSTI Funds

In this section, the hospital shall describe how its total potential DSTI funds pursuant to Attachment I will be distributed among the projects and metrics it has selected in its hospital plan. The amount and distribution of funding shall be in accordance with the stipulations of STC 49(e)(7), STC 52(c), Attachment I and Section VIII ("Disbursement of DSTI Funds").

V. STATE & FEDERAL REVIEW PROCESS OF HOSPITAL SPECIFIC PLANS

15. **Review Process**

The Executive Office of Health and Human Services (EOHHS) will review all hospital-specific DSTI plan proposals prior to submission to CMS for final approval according to the following timeline, which is based on the Commonwealth's Master DSTI Plan submission to CMS on March 15, 2012. The EOHHS and CMS review process for hospital-specific DSTI plan proposals shall include the following schedule:

a) EOHHS Review of Hospital Specific DSTI Plan

1) Submission of Hospital Specific Plans to EOHHS

By March 16, 2012, each eligible safety net hospital (identified in section III, "Community Needs & DSTI Eligibility Criteria") will submit a draft hospital-specific DSTI plan proposal to EOHHS for review.

2) EOHHS Review of Hospital Specific Plans

EOHHS shall review and assess each plan according to the following criteria:

i. The plan is in the format and contains all required elements described herein and is consistent with the special terms and conditions, including STC 49(e)(3), STC 49(e)(4), STC 49(e)(5), STC 52(b) and STC 52(c).

ii. The plan conforms to the requirements for Categories 1, 2, and 3, and 4, as described in section IV ("Key Elements of Proposed Hospital Specific Plans").

iii. Category 1, 2, and 3 projects clearly identify goals, metrics, and expected results. Category 4 clearly identifies the population-focused health improvement measures to be reported.

iv. The amount and distribution of funding is in accordance with the stipulations of STC 49(e)(7), STC 52(c), Attachment I, and Section VIII ("Disbursement of DSTI Funds").

v. The plan and all of the projects proposed within are consistent with the overall goals of the DSTI program.

By April 6, 2012, EOHHS will complete its initial review of each timely submitted hospital-specific DSTI plan proposal and will respond to the hospital in writing with any questions or concerns identified.

The hospital must respond in writing to any notification by EOHHS of questions or concerns. The hospital's response must be received by EOHHS within 3 business days of the aforementioned notification. The hospital's initial response may consist of a request for additional time to address EOHHS' comments; provided that the hospital's revised plan must address all of EOHHS' comments and must be received by EOHHS by April 24, 2012. Each hospital must further revise its plan as needed to conform to the final approved master DSTI plan. Pending CMS approval of the master DSTI plan, each hospital must submit a revised plan that conforms to the final approved master plan by May 21, 2012.

b) EOHHS Approval of Hospital Specific Plans

By May 22, 2012, pending CMS approval of the master DSTI plan, EOHHS will take action on each timely submitted revised hospital-specific DSTI plan, will approve each such plan that it deems satisfactory according to the criteria outlined in above, and submit approved plans to CMS for final review and approval.

c) CMS Review of Hospital Specific Plans

1) CMS will review each hospital's individual DSTI plan upon receipt of the plan as approved by EOHHS. CMS' review will assess whether each hospital's DSTI plan as approved by EOHHS meets the following criteria:

i. The plan is in the format and contains all required elements described herein and is consistent with the special terms and conditions, including STC 49(e)(3), STC 49(e)(4), STC 49(e)(5), STC 52(b) and STC 52(c).

ii. The plan conforms to the requirements for Categories 1, 2, and 3, and 4, as described in section IV ("Key Elements of Proposed Hospital Specific Plans").

iii. Category 1, 2, and 3 projects clearly identify goals, metrics, and expected results. Category 4 clearly identifies the population-focused health improvement measures to be reported.

iv. The amount and distribution of funding is in accordance with the stipulations of STC 49(e)(7), STC 52(c), Attachment I and Section VIII ("Disbursement of DSTI Funds").

v. The plan and all of the projects proposed within are consistent with the overall goals of the DSTI program.

2) During the 45-day review process for hospital-specific plans, CMS will complete an initial review of each eligible safety net hospital's plan and will respond to the hospital in writing, with a copy to EOHHS, with any questions or concerns identified. If CMS finds that a component of a hospital's plan is inconsistent with the specific requirements or the overall goals of the DSTI, CMS will request additional information from the eligible safety net hospital and may request a revision to the hospital's project.

The hospital must respond in writing to any notification by CMS of questions or concerns. The hospital's response must be received by CMS within 3 business days of the aforementioned notification. The hospital's initial response may consist of a request for additional time to address CMS' questions, concerns, or request for revision. If CMS has requested a revised project, the hospital must revise the project to address CMS' concerns and submit the revised project to CMS.

d) CMS Approval of Hospital Specific Plans

Pursuant to STC 49(e)(3), plans reviewed and approved by EOHHS will result in approval by CMS within 45 days of receipt from EOHHS, provided that the plan(s) meet all DSTI requirements as outlined above and in STC 49(e)(3). If CMS finds that a hospital's plan meets all DSTI requirements, CMS may approve it at any time within the 45-day period after receipt of the plan from EOHHS.

1) Within 45 days of receipt of a hospital-specific plan from EOHHS, CMS will complete its review of each eligible safety net hospital's plan and will either:

i. Approve the plan; or

ii. Notify EOHHS and the hospital if approval will not be granted for a component of the hospital's plan. Notice will be in writing and will include any questions, concerns, or problems identified in the application.

2) If CMS does not approve a hospital's plan, the hospital must submit a revised plan that addresses CMS' concerns, as described in the notification that the plan will not be approved, within 15 days of notification. CMS will respond within 15 days to the revision submitted by the hospital. If the revision meets the requirements for approval of the hospital's plan, then CMS will provide such approval and permit the first DY 15 payment of 50% of the hospital's annual proportional DSTI allotment in accordance with the expedited DY 15 process under section VII ("Reporting and Payments in DY 15, DY 16, and DY 17"). If the revision does not meet the

requirements for final approval, the hospital must continue to revise the project(s) or component(s) in question until CMS determines that the project meets all DSTI requirements and provides approval of the hospital's plan.

e) Revisions to the Master Plan
If the CMS review process for hospital-specific DSTI plans results in the modification of any component of any hospital's plan, including but not limited to projects, measures, metrics, or data sources, that was not originally included in the approved master DSTI plan, the Commonwealth may revise the master DSTI plan accordingly. CMS will review and approve these proposed revisions within 30 days of submission by EOHHS, provided that the master DSTI plan revisions are in accordance with the final approved hospital-specific plan(s) prompting the revision(s) and all applicable STC requirements. Such revisions to the master DSTI plan do not require a waiver amendment.

VI. NON-FEDERAL SHARE OF DSTI PAYMENTS

16. **Identification of Allowable Funding Sources**

a) Allowable Funding Sources

1) Allowable funding sources for the non-federal share of DSTI payments shall include all sources authorized under Title XIX and federal regulations promulgated thereunder.

2) Except as provided in paragraph 16.a.3 below, the source of non-federal share of DY 15, 16 and 17 DSTI payments will be state appropriations.

3) The source of non-federal share of DYs 15, 16, and 17 DSTI payments to Cambridge Public Health Commission d/b/a Cambridge Health Alliance (CHA) will be an intergovernmental funds transfer. EOHHS will issue a request to CHA for an intergovernmental transfer in the amount of the non-federal share of the applicable incentive payment amounts at least 15 days prior to the scheduled date of payment. CHA will make an intergovernmental transfer of its funds to EOHHS in the amount specified by a mutually agreed timeline determined by EOHHS in consultation with CHA, and in accordance with the terms of an executed payment and funding agreement, and all applicable laws. Upon receipt of the intergovernmental transfer, EOHHS will draw the federal funding and pay both the nonfederal and federal shares of the applicable DY 15, DY 16 or DY 17 payment(s) to CHA according to a mutually agreed upon timeline determined by EOHHS in the consultation with CHA, and subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals.

b) CMS Approval of Funding Source
The source of non-federal share for DSTI payments is subject to CMS approval. EOHHS shall provide CMS advance notice of a valid source of non-federal share and obtain CMS

approval prior to drawing down FFP for DSTI payments, provided that CMS shall render a decision on the source of non-federal share within 30 days of receiving sufficient documentation of the source of non-federal share.

c) Change in Funding Source
If the source of non-federal share of DSTI payments changes during the renewal period, EOHHS shall notify CMS and seek CMS' approval of such change prior to claiming FFP for any payment utilizing such funding source. No waiver amendment is required.

VII. REPORTING AND PAYMENT IN DY 15, DY 16, AND DY 17

17. **Expedited Reporting and Payment in DY 15**

a) Hospital Reporting for Payment in DY 15

1) Hospital-specific DSTI plan approval will serve as the basis for transaction of 50% of each hospital's total DY 15 DSTI incentive payment amount. EOHHS will schedule the initial payment transaction for each hospital within 30 days following approval by CMS of that hospital's plan, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals.

2) By July 31, 2012, each hospital shall submit a report to the Commonwealth demonstrating progress on the achievement of its DY 15 metrics through June 30, 2012. Pursuant to STC 53(c)(i), the report shall be submitted using the standardized reporting form approved by EOHHS and CMS. The report shall include the incentive payment amount being requested for the progress achieved in accordance with payment mechanics (see section VIII "Disbursement of DSTI Funds"). The report shall furthermore include data on the progress made for all DY15 metrics and shall provide a narrative description of the progress made. The hospital shall submit, as an attachment to the report form, a copy or list of the data source as identified per metric in the hospital's approved DSTI plan to demonstrate achievement of each DSTI metric for which the hospital is seeking an incentive payment.[11] The hospital system shall have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

This report will serve as the basis for authorizing payment of an amount up to the balance of each hospital-specific DY 15 DSTI incentive payment amount as approved by CMS in the hospital-specific DSTI plan. The actual payment amounts will be determined by EOHHS based on the achievement of the DY 15 metrics in accordance with the criteria established in Section VIII ("Disbursement of DSTI Funds"). EOHHS will schedule the payment transaction for each hospital for the approved amount of incentive funding based on each hospital's achievement of DSTI metrics within 30

[11] For non-confidential data sources, the hospital will provide a copy of the data source itself; in the case that a copy of the data itself would compromise confidential patient data, the hospital may alternatively provide a list of the data source(s) used to determine metric achievement.

days following EOHHS approval of the hospital report, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals.

b) Hospital Annual Year-end Report

Pursuant to STC 53(c)(1)(ii), each hospital shall submit an annual report by July 31, 2012. The annual report shall be prepared and submitted using the standardized reporting form approved by EOHHS and CMS. The annual report shall include data on the progress made for all metrics and shall provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The hospital system shall have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

c) Year-End Payment Reconciliation

Based on its review and verification of each hospital's annual year-end report, EOHHS will perform a reconciliation as an additional check to verify that all DSTI payments made to the hospital based on achievement of the applicable metrics were correct. If, after the reconciliation process EOHHS determines that the hospital was overpaid, the overpayment will be properly credited to the Commonwealth and the federal government or will be withheld from the next DSTI payment for the eligible safety net hospital, as determined by EOHHS. If, after the reconciliation process EOHHS determines that the hospital was underpaid, then subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals, EOHHS will schedule necessary payment transaction(s), or will add the additional amount to the next DSTI payment for the eligible safety net hospital, as determined by EOHHS.

If a governmental hospital provided the non-federal share of an overpayment determined by EOHHS, then EOHHS shall refund to the hospital the amount of the intergovernmental funds transfer attributable to the overpayment, provided that the hospital first refunds to EOHHS the full amount of the overpayment. If EOHHS determines that a governmental hospital that elects to provide the non-federal share of DSTI payments was underpaid, then EOHHS will schedule the appropriate funding and payment transactions, or will adjust the payment amounts to the next DSTI funding and payment transactions for the governmental hospital, as determined by EOHHS and consistent with all terms and conditions regarding payment under the demonstration.

d) Commonwealth Reporting to CMS in DY 15

1) Quarterly and Annual Reporting

Following approval of the master DSTI plan and hospital specific plans, pursuant to STC 53(c)(2), STC 58 and STC 59, DSTI will be a component of the Commonwealth's quarterly operational reports and annual reports related to the Demonstration. These reports will 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 84.

2) Claiming Federal Financial Participation
The Commonwealth will claim federal financial participation (FFP) for DSTI incentive payments on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set up exclusively for DSTI payments. FFP will be available only for DSTI payments made in accordance with all pertinent STCs and the stipulations of this master DSTI plan, including Section VIII ("Disbursement of DSTI Funds"). The Commonwealth and the hospital system receiving DSTI payment shall have available for review by CMS, upon request, all supporting data and back-up documentation.

18. **Reporting and Payment in DY 16 and DY 17**

a) Hospital Reporting for Payment
Twice per year, each hospital seeking payment under the DSTI shall submit reports to the Commonwealth demonstrating progress on DSTI projects, measured by category specific metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by EOHHS and CMS. The reports shall include the incentive payment amount being requested for the progress achieved on DSTI metrics in accordance with payment mechanics (see section VIII "Disbursement of DSTI Funds"). The report shall include data on the progress made for all Demonstration year metrics and shall provide a narrative description of the progress made; the mid-year report shall furthermore provide a narrative explaining how the hospital will achieve the remaining metrics for each project before the end of the year. The hospital shall submit, as an attachment to the report form, a copy or list of the data source as identified per metric in the hospital's approved DSTI plan to demonstrate achievement of each DSTI metric for which the hospital is seeking an incentive payment.[12] The hospital system shall have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

1) Reporting period of July 1 through December 31: the report and request for payment is due January 31.

2) Reporting period of January 1 through June 30: the report and request for payment is due July 31.

[12] For non-confidential data sources, the hospital will provide a copy of the data source itself; in the case that a copy of the data itself would compromise confidential patient data, the hospital may alternatively provide a list of the data source(s) used to determine metric achievement.

These reports will serve as the basis for authorizing incentive payments to each hospital for achievement of DSTI metrics. The actual payment amounts will be determined by EOHHS based on the achievement of metrics in accordance with the provisions of Section VIII ("Disbursement of DSTI Funds"). EOHHS will schedule the payment transaction for each hospital within 30 days following EOHHS approval of the hospital report, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals.

b) Mid-Year Assessment: Following submission of the semi-annual progress report due January 31, each hospital will meet with the Commonwealth for a formal presentation and assessment of progress made on all DSTI projects. This will provide an opportunity for collaboration and intervention as needed to ensure each hospital's timely progress on DSTI projects. The Commonwealth will submit a written summary of these assessments to CMS as part of the quarterly operational reports as described in paragraph 18.e below.

c) Hospital System Annual Year-End Report
Pursuant to STC 53(c)(1)(ii), each hospital shall submit an annual report by July 31 following the end of the Demonstration year. The annual report shall be prepared and submitted using the standardized reporting form approved by EOHHS and CMS. The report will include the information provided in the interim reports previously submitted for the Demonstration year, including data on the progress made for all metrics. Additionally, the eligible safety net hospital will provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The hospital system shall have available for review by the Commonwealth or CMS, upon request, all supporting data and back-up documentation.

d) Year-end Payment Reconciliation
Based on its review and verification of each hospital's annual year-end report, EOHHS will perform a reconciliation as an additional check to verify that all DSTI payments made to the hospital based on achievement of the applicable metrics were correct. If, after the reconciliation process EOHHS determines that the hospital was overpaid, the overpayment will be properly credited to the Commonwealth and the federal government or will be withheld from the next DSTI payment for the eligible safety net hospital, as determined by EOHHS. If, after the reconciliation process EOHHS determines that the hospital was underpaid, then subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals, EOHHS will schedule necessary payment transaction(s), or will add the additional amount to the next DSTI payment for the eligible safety net hospital, as determined by EOHHS.

If a governmental hospital provided the non-federal share of an overpayment determined by EOHHS, then EOHHS shall refund to the hospital the amount of the intergovernmental funds transfer attributable to the overpayment, provided that the hospital first refunds to EOHHS the full amount of the overpayment. If EOHHS determines that a governmental hospital that elects to provide the non-federal share of DSTI payments was underpaid, then EOHHS will schedule the appropriate funding and

payment transactions, or will adjust the payment amounts to the next DSTI funding and payment transactions for the governmental hospital, as determined by EOHHS and consistent with all terms and conditions regarding payment under the demonstration.

e) Commonwealth Reporting to CMS in DY 16 and DY 17

1) Quarterly and Annual Reporting
Pursuant to STC 53(c)(2), STC 58 and STC 59, DSTI will be a component of the Commonwealth's quarterly operational reports and annual reports related to the Demonstration. These reports will 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, including a summary of the mid-year assessments of hospital progress when applicable; and
iv. Evaluation activities and interim findings of the evaluation design pursuant to STC 84.

2) Claiming Federal Financial Participation
The Commonwealth will claim federal financial participation (FFP) for DSTI incentive payments on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set up exclusively for DSTI payments. FFP will be available only for DSTI payments made in accordance with all pertinent STCs and the stipulations of this master DSTI plan, including Section VIII ("Disbursement of DSTI Funds"). The Commonwealth and the hospital system receiving DSTI payment shall have available for review by CMS, upon request, all supporting data and back-up documentation.

VIII. DISBURSEMENT OF DSTI FUNDS

19. **DSTI Incentive Payments**

a) Eligibility for DSTI Incentive Payments
DSTI payments for each eligible hospital are contingent on that provider meeting project metrics as defined in the approved hospital-specific plans. As outlined in section VII ("Reporting and Payment in DY 15, DY 16, and DY 17") of the master DSTI plan, eligible safety net hospitals will be able to receive DSTI incentive payments related to achievement of their metrics upon submission and approval of the required reports for payment. DSTI incentive payments to an individual hospital may equal but not exceed the initial proportional allotment outlined in Attachment I.

b) DY15 DSTI Payments

In DY15, each hospital will receive 50% of its annual proportional DSTI allotment based on CMS approval of its hospital-specific plan, pursuant to STC 49(e)(6) and Attachments E and I. The remaining 50% of the hospital DSTI allotment will be based on successfully achieving metrics associated with approved projects within DSTI Categories 1, 2 and 3 as described in Section X ("Master DSTI Projects and Metrics") and in approved hospital-specific plans. No funding will be allotted to Category 4 in DY15.

c) DY 16 and DY17 DSTI Payments
In DY16 and DY17, DSTI funds will be available as incentive payments to each hospital based on successfully achieving metrics associated with approved projects within DSTI Categories 1, 2, 3, and 4 as described in Section X ("Master DSTI Projects and Metrics") and in approved hospital-specific plans.

20. **DSTI Funding Allocation Formula**

a) Funding Allocation Formula for Categories 1-3

1) In DY 15, 50% of total DSTI funds ($104.67 million) are available as incentive payments for successful achievement of metrics for projects in Categories 1-3. In DY16 and DY17, 75% of total DSTI funds ($157.00 million per year) are available as incentive payments for successful achievement of metrics for projects in Categories 1-3.

2) Projects within Categories 1-3 have an annual base value that is uniform across all projects, except for Project 3.9: Participate in a Learning Collaborative, for which the base value will be one-quarter that of other projects. The annual project base value is calculated by dividing the annual total available amount of DSTI funds ($104.67 million in DY 15; $157 million in DY 16 and in DY 17) by a standard number of projects (6.25). The table below specifies the annual base values for projects in Categories 1-3.

Annual Project Base Values for Categories 1-3		
DY/SFY	Base Value for Projects 1.1-3.8	Base Value for Project 3.9
DY15/SFY12	$16,746,667	$4,186,667
DY16/SFY13	$25,120,000	$6,280,000
DY17/SFY14	$25,120,000	$6,280,000

3) Metrics within Categories 1-3 will have an annual base value that is uniform across all metrics in Categories 1-3, except for metrics for Project 3.9: Participate in a Learning Collaborative, for which the annual metric base value is one-quarter that of metrics associated with other projects. The annual metric base value is calculated by dividing

the annual project base value by a standard number of metrics (5). The table below specifies these annual base values for metrics in Categories 1-3.

Annual Metric Base Values for Categories 1-3		
DY/SFY	Annual Base Value for Metrics in Projects 1.1-3.8	Annual Base Value for Metrics in Project 3.9
DY15/SFY12	$3,349,333	$837,333
DY16/SFY13	$5,024,000	$1,256,000
DY17/SFY14	$5,024,000	$1,256,000

4) On a hospital specific-basis, adjustments to the annual metric base value will be made:

i. To reflect the hospital's proportional annual DSTI allotment pursuant to STC 49(e)(7) and Attachment I. Each hospital must multiply the metric base value by its hospital-specific proportional allotment factor:

Hospital-Specific Proportional Allotment Factor	
Eligible Safety Net Hospital	Proportional Allotment Factor
Cambridge Health Alliance	0.2143
Boston Medical Center	0.4947
Holyoke Medical Center	0.0389
Lawrence General Hospital	0.0689
Mercy Medical Center	0.0727
Signature Healthcare Brocton Hospital	0.0798
Steward Carney Hospital	0.0306

ii. To adjust for the number of metrics for each project in the hospital's final approved hospital plan, if this number varies from the standard number of metrics. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratio: (5/# metrics for the project).

iii. An optional factor at the specific hospital's option to account for factors such as differences in quality infrastructure, differences in external supports for improvements, differences in patient populations, differential levels of metric goals, and differences between process metrics and improvement metrics, pursuant to STC 49(e)(7). In its individual DSTI Plan, if a hospital elects to utilize this adjustment factor, each hospital must provide a rationale for any adjustments made to metric base values. These additional adjustments must be budget neutral for the project, meaning that the total funding allotment for a project may not exceed the total funding allotment derived from the sum of annual metric base values adjusted for i and ii as described above. A metric adjustment (either up or down) may not exceed more than 20% of the metric base value.

b) <u>Funding Allocation Formula for Category 4</u>

1) No funding for Category 4 is allotted for DY 15. Funding for Category 4 in DY 16 and DY 17 is 25% of the total annual DSTI funding ($52.33 million per year). Payment for Category 4 metrics will be based on reporting of the common and hospital-specific measures in each hospital's approved individual DSTI plan.

2) Category 4 metrics have an annual base value that is uniform across all Category 4 measures. The metric base value is calculated by dividing the total annual available amount of DSTI funding in DY 16 and DY 17 for Category 4 ($52.33 million) by the total number of common measures and hospital-specific measures for Category 4. In DY 16, all hospitals will report on a minimum of 17 Category 4 measures (11 common measures and a minimum of 6 hospital-specific measures). In DY17, all hospitals will report on a minimum of 18 Category 4 measures (12 common measures and a minimum of 6 hospital-specific measures). Hospitals may elect in approved hospital plans to report on up to a total of 15 Category 4 hospital-specific measures. The table below specifies the annual base value for metrics in Category 4 based on the minimum number of measures per hospital in each Demonstration year.

Annual Metric Base Values for Category 4	
DY/SFY	Base Value for Category 4 Metrics
DY15/SFY12	N/A
DY16/SFY13	$3,078,431
DY17/SFY14	$2,907,407

3) On a hospital specific-basis, adjustments to the annual metric base value will be made:

i. To reflect the hospital's proportional annual DSTI allotment pursuant to STC 49(e)(7) and Attachment I. Each hospital must multiply the metric base value by its hospital-specific proportional allotment factor:

Hospital-Specific Proportional DSTI Allotment Factor	
Hospital	Proportional Allotment Factor
Cambridge Health Alliance	0.2143
Boston Medical Center	0.4947
Holyoke Medical Center	0.0389
Lawrence General Hospital	0.0689
Mercy Medical Center	0.0727
Signature Healthcare Brocton Hospital	0.0798
Steward Carney Hospital	0.0306

ii. To adjust for the number of hospital-specific Category 4 metrics in the hospital’s final approved hospital plan, if the hospital is reporting more than the minimum number of Category 4 measures. This adjustment is calculated by multiplying the proportionally-adjusted annual metric base value by the following metric ratios: for DY 16 (17/# metrics in Category 4 for the hospital), and for DY 17 (18/# metrics in Category 4 for the hospital).

IX. PLAN MODIFICATION, GRACE PERIODS, AND CARRY-FORWARD & RECLAMATION

21. **Plan Modification Process**

a) Pursuant to STC 52(a)(9) and consistent with the recognized need to provide the hospitals some flexibility to evolve their plans over time and take into account evidence and learning from their own experience and from the field, as well as for unforeseen circumstances or other good cause, a hospital may request modifications to its plan. A hospital must submit a request for modification to EOHHS. Requests for plan modification must be in writing and must describe the basis for the proposed modification.

b) Plan modifications include proposed changes to or replacement of selected milestones, metrics, and projects in Categories 1-3, as well as changes to or replacement of reporting measures in Category 4. Plan modifications may also address proposed changes in the

timeframe for achieving metrics in Categories 1-3. Acceptable reasons to approve a plan modification request are:

1) Learning and knowledge acquired from project experience and/or external sources indicate that revising or reorienting project components or metrics would improve and/or enhance the project;
2) Information that was believed to be available to achieve a metric or measure is unavailable or unusable, necessitating a modification to the hospital plan to revise or replace the metric/measure;
3) A hospital identifies superior information to demonstrate achievement of a metric and requests a modification to incorporate that data source;
4) External issues occur outside of the hospital's control that require the hospital to modify or replace a metric, measure, or component of a project;
5) New federal or state policies are implemented, or changes in Massachusetts market dynamics occur, that impact a DSTI project and a hospital seeks to update the affected project to reflect the new environment;
6) A hospital encounters an unforeseen operational or budgetary change in circumstances that impacts project components, metrics, and/or timelines;
7) A grace period request that meets the requirements of paragraph 22 below; and
8) Other acceptable reasons, subject to review and approval by EOHHS and CMS, that are reasonable and support the goals of the DSTI program.

c) With the exception of grace period requests, hospitals may request plan modifications at any time during the Demonstration renewal period. EOHHS shall take action on the plan modification request and submit recommended requests to CMS for approval within 15 days of receiving a modification request. CMS shall take action on the plan modification request within 30 days of receipt from EOHHS.

d) Plan modifications associated with grace period requests, including EOHHS and CMS review timeframes, are further addressed in paragraph 23 below.

22. **Projects Primarily Focused on Infrastructure**
Pursuant to STC 52(c)(4)(iii), projects that focus primarily on infrastructure will have further limited rollover ability as defined in the master DSTI plan. For the purposes of the plan modification, grace period, and carry-forward provisions outlined below, projects that focus primarily on infrastructure are defined as those projects where 75% or more of the project metrics over the 3-year period of the Demonstration are related to:

a) Building construction;

b) Equipment purchases, including hardware and other physical equipment (excluding HIT system software);

c) Environmental scans to identify frameworks and best practices to be utilized in the implementation of DSTI projects.

23. **Grace Periods**

a) Pursuant to STC 52(c)(4)(ii), a hospital that needs additional time to achieve a metric beyond the Demonstration year may be granted a grace period for up to 180 days from the end of the Demonstration year if it requests and receives approval for a plan modification as described in paragraph 22 above. However, no grace period is available for DY 17 beyond June 30, 2014. A hospital must have a valid reason, as determined by the Commonwealth and CMS, why it should be granted a grace period and demonstrate that the hospital is able to achieve the metric within the timeframe specified in the request. Acceptable reasons to approve a grace period request include:

   1) Additional time is needed to collect and prepare data necessary to report on a metric;

   2) Unexpected delays by third parties outside of hospital's control (e.g., vendors) impact the timing of a metric achievement date;

   3) A hospital can show that a metric is near completion (e.g., hospital has completed most of the steps building up to a metric achievement, and needs additional time to finalize the last steps);

   4) An approved plan modification delays the timing for completing an approved metric;

   5) Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the DSTI program.

b) A hospital is required to submit a grace period request in writing to EOHHS accompanied by a proposed plan modification, pursuant to paragraph 21 above. The hospital must submit the request 75 days prior to the end of the Demonstration year for which the grace period is being sought. EOHHS shall determine its recommended action on a grace period request and plan modification and submit the request to CMS, with its recommendation, within 15 days. CMS shall take action on the request within 30 days of receipt from EOHHS. Pursuant to STC 52(c)(4)(ii), the grace period request and plan modification must be decided by the Commonwealth and CMS 30 days prior to the end of the Demonstration year.

c) A hospital that requests a grace period related to a metric is not precluded from alternatively claiming the incentive payment associated with the same metric under the carry-forward policy described in paragraph 24.

d) If after submitting the grace period request, a hospital achieves the metric before June 30, the hospital may withdraw the grace period request and claim the incentive payment associated with the metric under the regular DSTI reporting process described in Section XII ("Reporting and Payments in DY 15, DY 16, and DY 17").

e) Allowable Time Periods for Grace Period Requests

1) Projects Not Primarily Focused on Infrastructure in Categories 1-3
With respect to incentive payments associated with a project that is not primarily focused on infrastructure as defined in paragraph 22 above, the allowable time period for a grace period is 120 days from June 30 for DY 15 and DY 16. No grace period is available for DY 17 beyond June 30, 2014.

2) Projects Primarily Focused on Infrastructure in Categories 1-3
With respect to incentive payments associated with a project that is primarily focused on infrastructure as defined in paragraph 22 above, the allowable time period for a grace period is 60 days from the June 30 for DY 15 and DY 16. No grace period is available for DY 17 beyond June 30, 2014.

3) Category 4
With respect to incentive payments associated with a measure in Category 4, the allowable time period for a grace period is 60 days from June 30 for DY 16. No grace period is available for DY 17 beyond June 30, 2014.

24. **Carry Forward and Reclamation**
Hospitals may carry forward unclaimed incentive payments in DY 15 and DY 16 for up to 12 months from the end of the Demonstration year and be eligible to claim reimbursement for the incentive payment according to the rules below. No carry-forward is available for DY 17.

a) Projects Not Primarily Focused on Infrastructure in Categories 1-3
With respect to incentive payments associated with projects in Categories 1-3 that are not primarily focused on infrastructure as defined in paragraph 22 above, if a hospital does not achieve a metric that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding associated with that metric for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed metric in addition to the corresponding metric associated with the year in which the payment is made, pursuant to STC 52(c)(4)(i). For purposes of carry-forward in this paragraph, a corresponding metric is a metric that is a continuation of a prior year metric and is readily quantifiable. Examples of corresponding metrics include:

1) A metric that shows a number or percentage increase in the same specific activity from the previous year;

2) Each metric in Category 4 is considered to have a corresponding metric, which is the exact same metric being reported in the subsequent year.

If there is no corresponding metric associated with the year in which the payment is made, the hospital will be able to carry forward the available incentive funding associated with the missed metric for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the

missed metric in addition to at least 25 percent of metrics associated with that project in the year in which the payment is made. If at the end of that subsequent Demonstration year, an eligible safety net hospital has not fully achieved a metric, it will no longer be able to claim that funding related to its completion of that metric.

b) Projects Primarily Focused on Infrastructure in Categories 1-3
With respect to incentive payments associated with projects in Categories 1-3 that are primarily focused on infrastructure as defined in paragraph 22 above, if an eligible safety net hospital does not achieve a metric that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding associated with that metric for up to 12 months and be available for full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed metric in addition to at least 50 percent of metrics associated with that project in the year in which the payment is made. If at the end of that additional Demonstration year, an eligible safety net hospital has not fully achieved a metric, it will no longer be able to claim that funding related to its completion of that metric.

c) Category 4 Measures
If an eligible safety net hospital does not report a measure in Category 4 that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding associated with that reporting measure for 12 months and be available for full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed reporting measure in addition to the corresponding measure within the year the payment is made. If at the end of that subsequent Demonstration year, an eligible safety net hospital has not fully achieved a metric, it will no longer be able to claim that funding related to its completion of that metric.

X. MASTER DSTI PROJECTS AND METRICS

25. **Projects in Categories 1-3**

This section presents a menu of Categories 1, 2, and 3 projects from which an eligible safety net hospital may select when designing its individual hospital DSTI plan. Within each project, a hospital may select from an array of process measures and improvement measures and include at least one process measure and one improvement measure for each project over the Demonstration period that support the goals of the project, and related metric(s). The mandatory Project 3.9, "Participate in a Learning Collaborate," will only have required process measures, as its purpose is to establish a forum for eligible DSTI safety net providers to learn from other providers that share similar goals and to support the development of a shared culture of continuous improvement and innovation, which will facilitate and enhance the individual hospital's efforts to advance the Triple Aim through their DSTI projects.

26. **Explanation of Terms for Categories 1-3**

a) Project Goal**:** This component describes the purpose of the project and how it supports the goals of the Category.

b) Potential Project Elements: This component lists example approaches/elements a hospital plan may adopt to implement the project goal.

c) Key Measures**:** This component includes the measures from which the eligible safety net hospital may choose:

1) Process Measures: These measures are key process steps leading towards a project's full implementation and results;

2) Improvement Measures: These measures represent the process results or other major milestones of the project.

d) Metric: For a measure selected, the hospital plan shall incorporate a related metric that may be tailored to the hospital plan. For example, a hospital may tailor a metric to target a specific population; or a hospital may include metrics based on an absolute number or metrics based on a percentage.

e) Data Source: The data source identifies appropriate sources of information that a hospital may use to support and verify the measure/metric. Hospital plans also may identify alternative sources appropriate to their individual hospital system and that provide better or comparable information.

27. **Category 4 Measures**

This section includes a menu of Category 4 measures related to population-focused improvements. The purpose of Category 4 is to evaluate the impact of the investments and system changes described in Categories 1, 2 and 3 through population-focused measures.

Category 4 metrics shall recognize that the population-focused objectives do not guarantee outcomes but result in learning, adaptation, and progress. As such, eligible safety net hospitals will measure and report on selected measures but will not have milestones associated with the achievement of specific improvements. Hospitals shall commence reporting Category 4 measures starting in Demonstration Year 16 (SFY 2013).

a) Common measures: All participating safety net hospitals will develop plans to report on a core set of Category 4 measures that are included in Section X, paragraph 31 below. Hospitals shall report on 11 Common Measures in Demonstration Year 16 (SFY 2013) and report on one additional Common Measure in Demonstration Year 17 (SFY 2014), for a total of 12 Common Measures in Demonstration Year 17.

b) Hospital-specific measures: For each project a hospital selects in its individual DSTI plan, the hospital shall elect at least one Category 4 hospital-specific measures up to a total of 15 Category 4 hospital-specific measures on which the hospital will include a plan to report, selected from the list included in Section X, paragraph 31 below. Project 3.9: Participate in a Learning Collaborative will not have associated Category 4 hospital-specific measures.

28. **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. Investments in patient care redesign efforts, such as patient navigators, alternative delivery sites, alternative office hours, etc.

Introduction

The fragmentation of the nation's health care delivery system has long been cited as one of the primary obstacles to achieving improved health outcomes while maintaining health care affordability. A 2008 report by the Commonwealth Fund pointed to the "cottage industry" nature of the U.S. health care system—characterized by fragmentation at the national, state, community, and practice levels: "There is no single national entity or set of policies guiding the health care system; states divide their responsibilities among multiple agencies, while providers practicing in the same community and caring for the same patients often work independently from one another."[13] Fragmentation hinders providers' ability to deliver high-quality, efficient care, especially for patients obtaining care from multiple providers in a variety of settings. It also leads to waste and duplication. The report specifically observed the following about the nation's current health care system:

- Patients and families navigate unassisted across different providers and care settings, fostering frustrating and dangerous patient experiences;
- Poor communication and lack of clear accountability for a patient among multiple providers lead to medical errors, waste, and duplication;
- The absence of peer accountability, quality improvement infrastructure, and clinical information systems foster poor overall quality of care; and,
- High-cost, intensive medical intervention is rewarded over higher-value primary care, including preventive medicine and the management of chronic illness.

The report recommended policies to promote greater organization of the delivery system to achieve gains in the quality and value of care, including payment reform, investments in health information technology, and government support to facilitate or establish the infrastructure for organized delivery systems, for example through assistance in establishing care coordination networks, care management services, after-hours coverage, health information technology, and performance improvement activities.

[13] Shih A, Davis K, et al. "Organizing the U.S. Health Care Delivery System for High Performance." *The Commonwealth Fund*. Aug. 2008.

Similarly, the Massachusetts Special Commission on the Health Care Payment System issued a set of payment reform recommendations in 2009 to promote a health care delivery system with features such as:

- Patient-centered care with a strong focus on primary care;
- An emphasis on clinical integration and attention to quality;
- Patient-centered medical home capacity; and,
- Hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need.[14]

Additionally, the U.S. Department of Health and Human Services adopted the goal of promoting integrated delivery systems under the "Triple Aim" framework, first articulated by Don Berwick in 2008:

- **Better Care:** improve the overall quality of the US health system by making health care more patient-centered, reliable, accessible, and safe.
- **Better Health**: improve the health of the U.S. population by supporting proven interventions to address behavioral and social determinants of health, and enhancing the quality of care delivered.
- **Lower Costs:** reduce the cost of the improved care delivery for individuals, families, employers, and the government.

A growing body of evidence shows strong support for the kinds of integrated care models being proposed by state and federal policymakers. Research comparing nations, states and regions within the U.S., and specific systems of care has shown that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care.[15] According to a 2006 study by the Commonwealth Fund, when adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The study also found that when primary care physicians effectively manage care in the office setting, patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications, leading to fewer avoidable hospitalizations.[16]

Other evidence suggests that integrating mental health care with primary medical care and other services can enhance patients' access to services, improve the quality and effectiveness of their care, and lower overall health care costs.[17] Research studies have increasingly evaluated the interface between physical and mental health, as well as integrated approaches

[14] "Recommendations of the Massachusetts Special Commission on the Health Care Payment System." *Massachusetts Special Commission on the Health Care Payment System.* July 16, 2009.
[15] Beal AC, Doty MM, et al. "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey." *The Commonwealth Fund*. June 2007.
[16] Ibid.
[17] APA Practice Organization. "Research roundup: Integrating physical and behavioral health interventions into psychological service delivery." ,*Practice Update.* Apr. 2011.

to mental and physical health care that have implications for the future of psychological practice.

In recognition of the importance of addressing the problems associated with the fragmented health care delivery system, Category 1 projects encourage greater organization and development of fully integrated delivery systems as a foundational aspect to health care delivery system transformation. It is a critical factor for the eligible safety net hospitals to advance their safety net systems for future success under payment reform. The array of projects within this category reflects differences in local health care environments and varied starting places among the safety net hospitals. Some of the Massachusetts safety net hospitals have more traditional inpatient hospital configurations with affiliated or independent provision of ambulatory care and physician services, while others have the full spectrum of primary care, ambulatory care, and physician services as part of the safety net hospital system's existing structure. As a result, the projects in Category 1 advance integration as appropriate for each individual provider. For example, some hospitals require foundational elements to address current gaps or systems needs to develop an integrated delivery system, while others are focused on expansion of PCMH models within their primary care practices. In addition to PCMH development, Category 1 projects embody other innovations in delivery system integration, such as integration of behavioral and physical health services in primary care practices or emergency departments, the use of culturally competent patient navigators to connect patients with the right care, and the creation of a practice support center to streamline administrative functions and increase access to care for patients. While the eligible safety net hospitals will begin implementing their Category 1 projects from different foundational capacities, they share a vision and commitment toward delivery system integration as a foundation toward transformation and improved health outcomes for safety net populations.

The eligible safety net systems may select from among the projects described below, as specified, for inclusion in their Category 1 DSTI plans.