

July 23, 2026

Dr. Ryan Schwarz, Medicaid Director
Commonwealth of Massachusetts Department of Health and Human Services
Office of Medicaid
1 Ashburton Place, 11th Floor Room 1109
Boston, MA 02128

Dear Dr. Schwarz:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Massachusetts' submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on November 30, 2024, and a final revised preprint was received on July 10, 2026. The proposal has a control name of MA_VBP_BHI.BHO.IPH.OPH_Renewal_20250101-20271231.

CMS has completed our review of the following Medicaid managed care SDP:

- Performance improvement initiative for the Clinical Quality Incentive for the rating periods covering January 1, 2025 through December 31, 2027, incorporated into the capitation rates through a separate payment term of up to \$800,000,000 for calendar year (CY) 2025, \$150,000,000 for CY 2026, and \$150,000,000 for CY 2027.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the [Medicaid Managed Care Rate Development Guide](#). The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, CY 2026 of this SDP proposal likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of a grandfathered SDP (as specified in item 4 of the current SDP preprint form for CY 2026) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal of this SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to:
StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
January 1, 2025 – December 31, 2027
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2025
3. Identify the managed care program(s) to which this payment arrangement will apply:
Accountable Care Partnership Program (ACPP), Managed Care Organization (MCO) Program, and Managed Behavioral Health Vendor (BH Vendor)
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: RY2025: \$800M; RY2026: \$150M; RY2027: \$150M
 - a. Identify the estimated federal share of this state directed payment: RY25: \$480M; RY26: \$90M; RY27: \$90M
 - b. Identify the estimated non-federal share of this state directed payment: RY25: \$320M; RY26: \$60M; RY27: \$60M

Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:
- ☐ The State is seeking approval of an amendment to an already approved state directed payment.
 - ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.
 - If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
January 1, 2023 - March, 31, 2023 (ACPP/MCO) April 1, 2023 - December 31, 2024 (ACPP/MCO) January 1, 2023 - December 31, 2024 (BH Vendor)
 - Please identify the types of changes in this state directed payment that differ from what was previously approved.
 - Payment Type Change
 - Provider Type Change
 - Quality Metric(s) / Benchmark(s) Change
 - ☒ Other; please describe:
This SDP includes the payment arrangement for both ACPP/MCO and the BH Vendor, which were previously submitted separately.
 - No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

All participating hospitals CQI directed payments will be determined by: 1) their pro-rata portion of Medicaid Gross Patient Service Revenues (GPSR) and 2) hospital performance on applicable measures. Hospitals submit their Medicaid GPSR by ACPP/MCO /BH Vendor to MassHealth on a quarterly basis. MassHealth will make an interim payment to each ACPP/MCO/ /BH Vendor based on estimated hospital GPSR proportions with each managed care entity and then reconcile to actual. MassHealth is using an aligned hospital measure set across fee-for-service and managed care Medicaid enrollees. The full CQI measure set used to evaluate hospital performance is described in related state plan pages (attached): Attachment 3.1-A pg01; Attachment 3.1-A pg02; Attachment 3.1-B; pg01; Attachment 3.1-B pg02; Attachment 4.19-A(1) pp. 1-72 & Exhibit 1 pp. 1-3; Attachment 4.19-B(1) pp. 1-41 & Exhibit 1 pp. 1-3; Supplement to Attachment 3.1-A page 1; Supplement to Attachment 3.1-A page 1a; Supplement to Attachment 3.1-B page 1; Supplement to Attachment 3.1-B page 1a.

- ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
- Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

For Massachusetts State Plan services, please see attached inpatient/outpatient hospital state plan pages, including the CQI state plan pages referenced above.

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

- a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

- b. ☐ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☒ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

- 11.** Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If “other” was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics). The payment arrangement is a performance improvement initiative. A participating hospital will receive up to its maximum CQI amount from ACPP, MCOs, and the BH Vendor based on the hospital's performance, including improvement towards and achievement of targets, on pre-determined CQI measures.
- 12.** In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#) when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☒

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	Measure Steward/ Developer ¹	Baseline ² Year	Baseline ² Statistic	Performance Measurement Period ³	Performance Target	Notes ⁴
<i>Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay</i>	<i>CMS</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8%</i>	<i>Example notes</i>
a. See Addendum						
b.						
c.						
d.						
e.						

- Baseline data must be added after the first year of the payment arrangement
- If state-developed, list State name for Steward/Developer.
- If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
- If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

- a. Please describe the methodology used to set the performance targets for each measure.**

As historically utilized by the ACO program, the State intends to determine an Attainment Threshold and a Goal Benchmark for each CQI measure. Benchmarks will be informed by national benchmarks, historical hospital performance and baseline performance. Attention will be given to the spread, distribution or variation in historical hospital performance. Benchmark values are not expected to change annually but will be monitored and reviewed, including for the following:

- Benchmarks that are excessively high or low relative to overall hospital performance or hospital class (e.g., Safety Net hospitals)
- Significant changes to practice standards and measure specifications impacting results, and
- Extenuating circumstances, e.g., the COVID-19 public health emergency.

Please see MassHealth SPA 4.19-A (1), Section III L. for more details on the performance assessment methodology for this payment arrangement.

- b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?**

Multiple provider performance measures are involved in the payment arrangement, where hospitals may receive partial or maximum eligible payment, depending on the level of performance target achieved. Please see MassHealth SPA 4.19-A (1), Section III L. for details on the performance assessment methodology used for this payment arrangement.

- c. For state-developed measures, please briefly describe how the measure was developed?**

All the measures used as part of this payment arrangement are standard measures of a provider's performance. Adaptations to any measures are based on adjustments allowable by the measure steward (e.g., defining the MassHealth or measure population), or additional information to complement and inform the standard measure (e.g., race/ethnicity data elements for chart-based measures, additional qualitative information to support the perinatal morbidity structural measure).

14. Is the State seeking a multi-year approval of the state directed payment arrangement?

☒ Yes ☐ No

- a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

RY25 (January 1, 2025- December 31, 2025); RY26 (January 1, 2026- December 31, 2026); RY27 (January 1, 2027- December 31, 2027).

- b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

- a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.
- b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.
- c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
- d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. Check all that apply; if none are checked, proceed to Section III.

- a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates*¹ (42 C.F.R. § 438.6(c)(1)(iii)(B))
- b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
- c. ☐ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

¹ Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

- a.** Check the basis for the fee schedule selected above.
 - i.** ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). ²
 - ii.** ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
 - iii.** ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
 - 1.** If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- b.** Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

- a.** ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- b.** Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- c.** Indicate the number of exemptions to the requirement:
 - i.** Expected in this contract rating period (estimate)
 - ii.** Granted in past years of this payment arrangement
- d.** Describe how such exemptions will be considered in rate development.

² Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

- a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)
- b. What is the magnitude of the increase (e.g., \$4 per claim or 3% increase per claim?)
- c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).
- d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

- a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☒ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

- b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Private acute hospitals

- c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Non-federal, non-state-owned public hospitals are not included in the CQI program. The one non-federal, non-state-owned public hospital participates in other state directed payments that include similar hospital performance incentives.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

This payment arrangement directs ACPP, MCO and BH Vendor expenditures using the same methodology and terms of performance for each private acute hospital. The performance under this payment arrangement of all participating acute hospitals will be assessed using applicable CQI measures as described in this preprint and in the referenced SPA.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

- a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).
b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).
c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☒

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
<i>Ex: Rural Inpatient Hospital Services</i>	<i>80%</i>	<i>20%</i>	<i>N/A</i>	<i>N/A</i>	<i>100%</i>
a. See Addendum					
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- a. ☐ Medicare payment/cost
- b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) (*Please note, this rate cannot include supplemental payments.*)
- c. ☒ Other; Please define: **Average Commercial Rate**

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

- 26.** Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column “Pass-Through Payments” in Table 2.

- 27.** Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Data Owner: Massachusetts Center for Health Information and Analysis (CHIA)

Data Source: Massachusetts All Payer Claims Database (MA APCD) Data

Datapoints: CY22 Commercial Allowed Amount and Service Units, Projected CY25 Medicaid Allowed Amount, Claim Counts, and Service Units.

Methodology:

o Non-Institutional: Repriced Medicaid utilization at Commercial unit costs levels for applicable HCPCS codes.

o Institutional: Average Base Payment Levels from Plans to Providers was developed by comparing the average admit cost from the FY22 Commercial data to the projected CY25 and CY26 Medicaid data.

o Effect on Total Payment Level of SDP is the dollar impact of the SDP divided by the estimated commercial inpatient/outpatient class.

o Effect on Total Payment Level of other SDPs is the total value of the other inpatient/outpatient SDPs as a percentage of the estimated commercial inpatient and outpatient claims.

- 28.** Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

The state ensures that all state directed payments align with MassHealth's managed care quality strategy and works closely with its actuary to ensure that payments are appropriate and reasonable. These directed payments are expected to support quality by ensuring that hospitals receive value-based payments to support the State's goal of promoting safe and high-quality care to members served by ACPP, MCOs and the BH Vendor.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

- 29.** States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

- i.** What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

2nd Amended and Restated Accountable Care Partnership Plan (ACPP) Contract and the 7th Amended and Restated Managed Care Organization Contract (MCO), Managed Behavioral Health Vendor Contract (BH Vendor)

- ii.** Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Sections 2.9.M and 4.3.E of both the ACPP and MCO contracts; Sections 2.7.F.5 and 4.11 of the BH Vendor contract

- b.** If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MCR-MA-ACPP-20250101-20251231-CERTIFICATION-20241220	12/30/2024	Yes	Page 56
ii. MCR-MA-MCO-20250101-20251231-CERTIFICATION-20241220	12/30/2024	Yes	Page 50
iii. MCR-MA-MBHP-20250101-20251231-CERTIFICATION-20241223	12/30/2024	Yes	Page 27
iv.			
v.			

Please note, states and actuaries should consult the most recent [Medicaid Managed Care Rate Development Guide](#) for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- b. ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The methodology for the value based CQI payment arrangement is better suited to a separate payment term, due to the timing and methodology for calculating CQI performance and related directed payments. This approach is consistent with other Massachusetts SDPs.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- a. ☐ State general revenue
- b. ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- c. ☒ Health Care-Related Provider tax(es) / assessment(s)
- d. ☐ Provider donation(s)
- e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

- b.** ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- c.** Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by provider taxes/assessments (option c in Question 34),

- a.** Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the “75/75” test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Massachusetts Hospital Assessment 2023-2027	Inpatient hospital services and outpatient hospital services	Yes	No	Yes		No
ii.						
iii.						
iv.						
v.						

- b.** If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. See Massachusetts Hospital Assessment 2023-2027	12/4/2025	Approved	05/06/2026
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

- a.** Is the donation bona-fide? ☐ Yes ☐ No
- b.** Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, “In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340.”
40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:
- a. A hyperlink to State’s most recent quality strategy: <https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download>
 - b. The effective date of quality strategy. October 1, 2025
41. If the State is currently updating the quality strategy, please submit a draft version, and provide:
- a. A target date for submission of the revised quality strategy (month and year):
 - b. Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

- 42.** To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
<i>Example: Improve care coordination for enrollees with behavioral health conditions</i>	<i>Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%</i>	5
a. 1. Achieve a healthy population, delivering high-quality pediatric, preventive, and perinatal care.	1.3 Manage quality and access to maternal health	17
b. 2. Advance progress on high-impact acute and chronic condition areas to improve safe, effective, high-value care.	2.1 Improve the health of populations with acute and chronic conditions that are key contributors to co-morbidities 2.2 Manage populations impacted by mental health and substance use disorders 2.3 Promote member safety	17
c. 3. Enable coordinated and efficient quality care for all members across the continuum of services and settings of care.	3.1 Manage timely, smooth transitions in care between inpatient and outpatient settings 3.3 Reduce unnecessary hospitalizations by Improving coordination and delivery of care in the community	18
d. 4. Enhance person-centered care through elevating member voice and improving member experience and engagement with their health care.	4.2 Understand and improve the member experience of populations or members that have complex care needs	18

- 43.** Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement supports MassHealth's quality strategy goals and objectives tied to clinical quality and patient experience measure(s) and the state's value-based care objectives. MassHealth uses a data-driven approach to identify opportunities for improvement and to incentivize providers to improve inpatient and outpatient care for Medicaid members being cared for at the Commonwealth's acute hospitals. Given the breadth of the CQI measures and the time and effort required to successfully meet the CQI benchmarks, the state recognizes that it will take a coordinated, multi-year strategy to meet the objectives laid out in the Quality Strategy and in the state's CQI program. An evaluation of each hospital's measure-specific performance against pre-established CQI performance targets will be conducted annually to identify improvement in member care and outcomes.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#), when applicable.

- a.** ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

- b.** Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes ¹
<i>Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34%</i>	<i>Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year</i>	<i>Example notes</i>
i. See addendum				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

- c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

While this payment arrangement is not new, the measure slate has been updated to align with quality programs across the agency. Table 8A of the addendum has been updated.

PREPRINT SUBSECTION IIA: VALUE-BASED PAYMENT/DELIVERY SYSTEM REFORM
ADDENDUM TABLE 1.A. PAYMENT ARRANGEMENT PROVIDER PERFORMANCE MEASURES

Column1	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target*	Notes
a.	Alcohol Use – Brief Intervention Provided or Offered	Other (specify in "Notes" column)	CY 2023	27%	Year 1-3	60%	The Joint Commission
b.	Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge	Other (specify in "Notes" column)	CY 2023	61%	Year 1-3	75%	The Joint Commission
c.	Follow-up after ED visit for Substance Use (7 and 30 Day)	National Committee for Quality Assurance	CY 2023	7 Day: 35% 30 Day: 47%	Year 1-3	7 day: 45% 30 day: 55%	
d.	Follow-up After Hospitalization for Mental Illness (7 and 30 Day)	National Committee for Quality Assurance	CY 2024	Expected Q4 2025	Year 1-3	7 day: 40% 30 day: 60%	
e.	Cesarean Birth, NTSV	Other (specify in "Notes" column)	CY 2022	25%	Year 1-3	22%	The Joint Commission
g.	Safe Use of Opioids – Concurrent Prescribing	Centers for Medicare & Medicaid Services	CY 2023	18% (unweighted mean)	Year 1-3	14%	
h.	Medication Continuation Following Inpatient Psychiatric Discharge	Centers for Medicare & Medicaid Services	CY 2023	59%	Year 1-3	65%	
i.	Screening for Metabolic Disorders	Centers for Medicare & Medicaid Services	CY 2023	85% (unweighted mean)	Year 1-3	93%	
j.	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	National Committee for Quality Assurance	CY 2023	96.0%	Year 1-3	97%	
k.	Unexpected Newborn Complications in Term Infants	Other (specify in "Notes" column)	CY 2023	36 per 1,000	Year 1-3	<=50 per 1,000	The Joint Commission
l.	Pediatric All-Condition Readmission	Other (specify in "Notes" column)	CY 2023	3% (unadjusted rate)	Year 1-3	Better or no different than the state average (based on hospital's adjusted rate)	Description: Rate of 30-day readmission for hospitalizations at general acute care hospitals for patients less than 18 years old. This measure has case-adjustment. Measure Steward: Boston Children's Hospital Center of Excellence for Pediatric Quality Measurement Initial Population: General acute care hospitalizations for patients less than 18 years of age. Numerator Statement: The first unplanned admission to any acute care hospital within 30 days of discharge from a prior hospitalization at an acute care hospital. Denominator Statement: Initial population. Denominator exclusions: Hospitalizations in specialty and non-acute-care hospitals.
m.	Follow-up After ED Visit for Mental Illness (7 and 30 Day)	National Committee for Quality Assurance	CY 2023	7 Day: 69% 30 Day: 77%	Year 1-3	7 day: 85% 30 day: 90%	
n.	Healthcare-Associated Infections: CLABSI	Centers for Disease Control and Prevention	CY 2022	0.799	Year 1-3	(SIR) value <= to 1 or no different than other hospitals (nationally) or not statistically significantly greater than the MassHealth	
o.	Healthcare-Associated Infections: CAUTI	Centers for Disease Control and Prevention	CY 2022	0.880	Year 1-3	(SIR) value <= to 1 or no different than other hospitals (nationally) or not statistically significantly greater than the MassHealth	
p.	Healthcare-Associated Infections: MRSA	Centers for Disease Control and Prevention	CY 2022	0.662	Year 1-3	(SIR) value <= to 1 or no different than other hospitals (nationally) or not statistically significantly greater than the MassHealth	
q.	Healthcare-Associated Infections: CDI	Centers for Disease Control and Prevention	CY 2022	0.649	Year 1-3	(SIR) value <= to 1 or no different than other hospitals (nationally) or not statistically significantly greater than the MassHealth	
r.	Healthcare-Associated Infections: SSI for Colon and Abdominal Hysterectomy	Centers for Disease Control and Prevention	CY 2022	0.934	Year 1-3	(SIR) value <= to 1 or no different than other hospitals (nationally) or not statistically significantly greater than the MassHealth	
s.	Patient Experience and Engagement-HCAHPS	Agency for Healthcare Research and Quality	CY 2022	68.0%	Year 1-3	Composite Score = Average of the top box scores	
t.	Severe Obstetric Complications-SOC	Other (specify in "Notes" column)	CY 2024	254 per 10,000 (unweighted average rate)	Year 2-3	Better or no different than the average state rate	The Joint Commission
	*Performance target column represents performance goals for the program, with entities evaluated on their progress toward these targets. The performance assessment methodology for the program is outlined in Section 3 of Appendix J in the RY2025 Acute Hospital RFA and determines criteria for partial or full achievement on the measure.						
	RY25 Acute Hospital RFA Available Here						

PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)	Rating Year
a.	Inpatient Hospital Services - ACPP	66.8%	8.1%	22.40%	0.00%	97.3%	RY25
b.	Outpatient Hospital Services - ACPP	40.2%	7.4%	14.30%	0.00%	61.9%	RY25
c.	Inpatient Hospital Services - MCO	66.8%	0.7%	29.80%	0.00%	97.3%	RY25
d.	Outpatient Hospital Services - MCO	40.2%	0.5%	21.20%	0.00%	61.9%	RY25
e.	Inpatient Hospital Services - MBHP	34.3%	2.1%	20.00%	0.00%	56.4%	RY25
f.							
g.	Inpatient Hospital Services - ACPP	66.8%	1.5%	21.90%	0.00%	90.2%	RY26, RY27
h.	Outpatient Hospital Services - ACPP	40.2%	1.4%	13.90%	0.00%	55.5%	RY26, RY27
i.	Inpatient Hospital Services - MCO	66.8%	0.1%	23.30%	0.00%	90.2%	RY26, RY27
j.	Outpatient Hospital Services - MCO	40.2%	0.1%	15.20%	0.00%	55.5%	RY26, RY27
k.	Inpatient Hospital Services - MBHP	34.3%	0.4%	19.90%	0.00%	54.6%	RY26, RY27

PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS
ADDENDUM TABLE 8.A. EVALUATION MEASURES, BASELINE AND PERFORMANCE TARGETS

Column1	Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes	2024 Results
i.	Follow-up After ED Visit for Substance Use	CY2023	7-day: 38.0% 30-day: 50.2%	2% increase from previous year (both sub-measures)		7-day - 41.9% 30-day - 56.5%
ii.	Follow-up After Hospitalization for Mental Illness	CY2023	7-day: 42.6% 30-day: 66.6%	2% increase from previous year (both sub-measures)		7-day - 46.3% 30-day - 70.4%