DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

February 26, 2026

Mr. Mike Levine, Medicaid Director
MassHealth, Commonwealth of Massachusetts
Department of Health and Human Services, Office of Medicaid
1 Ashburton Place, 11th Floor Room 1109
Boston, MA 02108

Dear Mr. Mike Levine:

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 29, 2024, and a final revised preprint was received on February 13, 2026. The proposal has a control name of MA_VBP_BHI.BHO_Renewal_20250101-20271231.

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

- The value based payment arrangement for the Behavioral Health Quality Incentive for the rating period covering January 1, 2025 to December 31, 2027, incorporated in the capitation rates through a separate payment term of up to $72 million for January 1, 2025 – December 31, 2025; $72 million for January 1, 2026 – December 31, 2026; and $72 million for January 1, 2027 – December 31, 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.

Based on CMS's preliminary determination, 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 is preparing a notice of proposed rulemaking to revise 42 CFR part 438 as required under section 71116. 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) 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 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.

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.

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

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.02.26 15:46:21 -05'00'

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:
   Prepaid Inpatient Health Plan (PIHP)
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: RY25: $72M; RY26: $72M; RY27: $72M
   a. Identify the estimated federal share of this state directed payment: $43.2M per year
   b. Identify the estimated non-federal share of this state directed payment: $28.8M per year

   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:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

RY19-RY22; RY23-RY24

c. 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:

☒ 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).

The payment arrangement is based on the utilization and delivery of services by non-federal, non-state-owned, public hospitals for enrollees covered under the Commonwealth ' s only Prepaid Inpatient Health Plan (PIHP). Cambridge Health Alliance (CHA) is the only qualifying hospital for this incentive program. The payment arrangement is described below:

The Commonwealth will specify the maximum allowable payment amount that it will direct the PIHP to pay to CHA during the contract year. In the case of the BHQI for Rating Years 25, 26, and 27, the amount will equal $72 million. The maximum payment amount earned by a participating hospital (i.e., the amount earned if a hospital attains a quality score of 100 percent) will be equal to the total amount directed to the designated class multiplied by the proportion of the class ' s total Medicaid managed care gross patient service revenue (GPSR), for which the specific hospital ' s Medicaid managed care GPSR, accounts during the contract year. Because CHA is the only hospital in this class, it could earn up to the full incentive amount of $72 million per year for Rating Years 25, 26, and 27.

The Commonwealth will calculate periodic lump sum payments based on: The Commonwealth ' s projection of CHA ' s Medicaid managed care GPSR during the contract year; CHA ' s expected performance (based on prior year or other data); A target for the PIHP to pay 90% of CHA ' s expected earned payments in advance of a final reconciliation after the contract year.

Within seven days prior to each scheduled lump sum payment described above, the Commonwealth shall make a payment to the PIHP. The Commonwealth ' s payment to the PIHP shall be equal to the sum of all payments that the PIHP makes to the provider. The Commonwealth may use any permissible source, including intergovernmental transfers, as the source of the non-federal share for PIHP payments.

a. ☒ 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.).

b. 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.

Related state plan pages: 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. 1-86 & Exhibit 1 pp. 1-3; Attachment 4.19-B(1) pp. 1-45 & 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. State Plan pages will be provided upon request.

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 based on the utilization and delivery of services by non-federal, non-state-owned, public hospitals for enrollees covered under the Commonwealth's only Prepaid Inpatient Health Plan (PIHP)to deepen care integration for its primary care-attributed MassHealth members. Payment will be tied to performance on specified quality measures related to behavioral health, care coordination and member engagement, appropriate utilization, and system transformation. This proposal seeks approval for a multi-year incentive program and will complement broader ACO accountability structures for total cost of care and quality performance.

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]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. See addendum Table 1A						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. 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.
4. 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.

This framework describes the method by which the performance score (used to calculate a participating provider ' s earned payments as a percent of the total maximum payment, measured over a 12-month period) is determined. The participating hospital must have available for review by EOHHS, upon request, all supporting data and back-up documentation. Hospitals will be required to report performance twice during the performance period; once at the midpoint for informational purposes, and once at the end of the period for performance scoring purposes.

Measure Slate

The quality performance measures are organized in a measure slate, which accounts for 100 percent of a participating provider ' s performance score. Performance measures include those related to behavioral health quality of care and behavioral health coordination of care.

Scoring

Scoring the Measure Slate:
Participating hospitals must perform at the annual target on half of all included measures in order to earn full payment (rounding up to the nearest integer number of measures in the event that a measure slate is not composed of a number of measures that is evenly divided by two). For example, if a measure slate has eleven measures, full payment on this measure slate would only be earned if participating hospitals fully attain at the annual target on six measures within that measure slate. The BHQI measure slate has a total of eighteen measures, of which nine measures must be achieved in order to earn full payment.

In the event that a participating hospital does not fully attain the minimum number of measures needed for full payment, partial credit would be awarded for some measures. The method for each is described in the next section titled " Scoring individual measures " and in Addendum Table 1.A. Payment Arrangement Provider Performance Measures, which includes the measure slate.

There may be some instances in which the denominator for a measure is determined to be too small for a hospital to be reasonably held accountable for performance on the measure. The number of measures excluded on this basis shall be subtracted from the number of measures that a hospital needs to attain within the measure slate in order to achieve full payment within the measure slate. For example, if one measure on the BHQI measure slate had insufficient sample size, a participating hospital would need to attain annual target performance on eight out of the seventeen measures with a sufficient number of observations. EOHHS will not tie performance to a measure in which the denominator falls below 30 for the entire performance period.

Scoring individual measures:
In general, there are two methodologies used to establish the annual performance target for an individual measure. The first is " Absolute " performance, where a benchmark level of performance is expected for all participating hospitals and payment is awarded upon achievement of that benchmark. The second is " Improvement " , where a hospital ' s annual target is based on a gap-to-goal methodology. Specifically, a hospital ' s annual target is equivalent to closing 10% of the gap between the hospitals ' most recent available historical baseline (which is the immediate prior year performance unless otherwise specified) and the benchmark or attainment of the benchmark. Column I in Addendum Table 1.A. Payment Arrangement Provider Performance Measures specifies how the annual performance target is set. The methodology used to establish the benchmark is derived from the following: available state benchmarks, national Medicaid benchmarks, and/or clinical assessment/literature review. Unless otherwise noted, the benchmarks in Addendum Table 1.A. Payment Arrangement Provider Performance Measures will remain fixed over the life of the incentive program.

Should a measure definition be updated by the measure steward, then there may be corresponding updates within the measure slate to the corresponding baseline, benchmark, and measurement scoring methodology. Such updates to specifications shall not

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?

See 13.a

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

N/A

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).

Non-federal, non-state-owned public hospitals contracting with the Commonwealth's only PIHP will be eligible to earn incentive payments. Cambridge Health Alliance (CHA) is the only public non-state hospital in the Commonwealth.

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 hospital is a state plan provider class that has a separate UPL reporting requirement.

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.

The payment arrangement is based on the utilization and delivery of services by non-federal, non-state-owned, public hospitals for enrollees covered under the Commonwealth's only Prepaid Inpatient Health Plan (PIHP). Cambridge Health Alliance (CHA) is the only qualifying hospital for this incentive program. The payment arrangement is described below:

a. The Commonwealth will specify the maximum allowable payment amount that it will direct the PIHP to pay to CHA during the contract year. In the case of the BHQI for Rating Years 25, 26, and 27, the amount will equal $72 million.

b. The maximum payment amount earned by a participating hospital (i.e., the amount earned if a hospital attains a quality score of 100 percent) will be equal to the total amount directed to the designated class multiplied by the proportion of the class's total Medicaid managed care gross patient service revenue (GPSR), for which the specific hospital's Medicaid managed care GPSR accounts during the contract year. Because CHA is the only hospital in this class, it could earn up to the full incentive amount of $72 million per year for Rating Years 25, 26, and 27.

c. The Commonwealth will calculate periodic lump sum payments based on:

i. The Commonwealth's projection of CHA's Medicaid managed care GPSR during the contract year;

ii. CHA's expected performance (based on prior year or other data);

iii. A target for the PIHP to pay 90% of CHA's expected earned payments in advance of a final reconciliation after the contract year.

d. Within seven days prior to each scheduled lump sum payment described above, the Commonwealth shall make a payment to the PIHP. The Commonwealth's payment to the PIHP shall be equal to the sum of all payments that the PIHP makes to the provider. The Commonwealth may use any permissible source, including intergovernmental transfers, as the source of the non-federal share for PIHP payments.

e. Following the PIHP contract year, performance under the contract will be determined and the actual payment amount earned by CHA will be calculated.

f. Final reconciliation: Based on the difference between the periodic lump sum amounts paid to the hospital during the PIHP contract year and the actual amount earned, the PIHP will be directed to make a final reconciliation payment to CHA. In the event that the lump sum payments made by the PIHP to the hospital during the contract year exceeded the total actual amount earned, the hospital will remit the excess payment to the PIHP as part of the final reconciliation.

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
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Inpatient Acute Hospital Services	33.6%	18.4	3.7		55.7
b. Outpatient Acute Hospital Services	76.5%	8.5%	12.1%		97.1
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:
• Non-Institutional: Repriced Medicaid utilization at Commercial unit costs levels for applicable HCPCS codes.
• 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 Medicaid data.
• Effect on Total Payment Level of SDP is the dollar impact of the SDP divided by the estimated commercial inpatient/outpatient class.
• 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.

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?

Managed Behavioral Health Vendor Contract

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

Sections 2.7.F.4. and 4.10

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-MBHP-20250101-20251231-CERTIFICATION-20241223	12/30/2024	Yes	Page 26
ii.			
iii.			
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.

When this payment arrangement was initiated in 2019 through the state's ACO contracts, it was authorized as a separate payment term. To ensure continuity of this payment arrangement, the state has maintained this approach for subsequent years.

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. RY25 Cambridge Public Health Commission	Public Instrumentality	$ 28,800,000.00	Yes	$8,671,170	Yes
ii. RY26 Cambridge Public Health Commission	Public Instrumentality	$ 28,800,000.00	Yes	$8,885,450 (estimate)	Yes
iii. RY27 Cambridge Public Health Commission	Public Instrumentality	$ 28,800,000.00	Yes	$8,885,450 (estimate)	Yes
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.						
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.			
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
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. 2. Advance progress on high-impact acute and chronic condition areas to improve safe, effective, high-value care.	2.2 Manage populations impacted by mental health and substance use disorders	17
b. 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	17
c.		
d.		

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.

Objective 2.2: The Commonwealth anticipates that primary care – behavioral health integration will be a key lever for CHA to achieve performance targets under this incentive. Specifically, a number of pediatric and adult behavioral health screening measures are included in the proposed measure slate, a critical input to enhanced integration and patient outcomes.

Objective 5.1: Achievement of many of the proposed performance metrics require seamless care coordination to facilitate member transitions between settings and control overall utilization.

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]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See Addendum Table 8A.				
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 in the addendum lists the measures that will be used to evaluate this payment arrangement.

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

Column 1	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes	How Measure Will be Scored
a.	SUB-1: Alcohol Use Screening (Inpatient Adult Psychiatric Discharges at Public Hospital); NQF 1661	Other (specify in "Notes" column)	CY2023	61.2%	Year 1-3	92.40% or 10% gap to goal improvement	Joint Commission NQF 1661 applied solely to inpatient psychiatry discharges	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
b.	SUB-2: Alcohol Use Brief Intervention Provided or Offered (during Inpatient Adult Psychiatric Hospitalization at Public Hospital); NQF 1663	Other (specify in "Notes" column)	CY2023	87.7%	Year 1-3	90.00% or 10% gap to goal improvement	Joint Commission NQF 1663 applied solely to inpatient psychiatry discharges	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
c.	SUB-3: Alcohol & Other Drug Use Disorder – Treatment Provided/Offered at Discharge (for Inpatient Adult Psychiatric Discharges at Public Hospital); NQF 1664	Other (specify in "Notes" column)	CY2023	35.1%	Year 1-3	75.00% or 10% gap to goal improvement	Joint Commission NQF 1664 applied solely to inpatient psychiatry discharges	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
d.	SMD Screening for Metabolic Disorders (for Inpatient Psychiatry)	Centers for Medicare & Medicaid Services	CY2023	68.7%	Year 1-3	93.00% or 10% gap to goal improvement		IIMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
e.	Screening and Brief Intervention for Alcohol Use for adults across all primary care sites (outpatient measure); NQF 2152	Other (specify in "Notes" column)	CY 2023	66.2%	Year 1-3	achievement / maintenance 65.00% or 10% gap to goal improvement	American Medical Association Once the target is met, maintenance is achieved by performing at or above the target.	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)

Column 1	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes	How Measure Will be Scored
f.	Screening and Brief Intervention for Drug Use for adults across all primary care sites (outpatient measure)	Other (specify in "Notes" column)	CY 2023	77.2%	Year 1-3	achievement / maintenance 65.00% or 10% gap to goal improvement	NQF 2152, adapted to include substance use Description: Percentage of patients, aged 18 years or older, who were screened and received brief counseling for drug use at least once during the measurement period Numerator: patients identified in the denominator who were screened for unhealthy drug use at least once during the measurement period Denominator: Patients 18 years of age, or older, at the end of the two-year look-back period and who were seen twice for any visits, or who had at least one preventive care visit Once target is met, maintenance is achieved by performing at or above the target.	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
g.	Monitoring Depression Care with Validated Assessment Tools (Ages 12+)	Other (specify in "Notes" column)	CY 2023	77.8%	Year 1-3	85.00% or 10% gap to goal improvement	Description: Percentage of patients aged 12 years and older with depression, who had a completed validated assessment in the 12-month measurement period. Numerator: Patients in the denominator, who had a completed a validated assessment during the measurement period. Denominator: Patients,12 years and older with an encounter diagnosis of depression (major depression, depression, postpartum depression, or dysthymia) in the measurement period.	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
h.	Screening for Depression and Follow-Up Plan; NQF 0418	Centers for Medicare & Medicaid Services	CY 2023	57.8%	Year 1-3	58.00% or 10% gap to goal improvement		IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
i.	Screening and Brief Intervention for Alcohol and Drug Use for adolescents (across all core primary care sites)	Other (specify in "Notes" column)	CY 2023	25.7%	Year 1-3	50.00% or 10% gap to goal improvement	NQF 2152, adapted to apply to new age range for adolescents Description: Percentage of pediatric patients, aged 12-17 years, who were screened for alcohol and drug use at least once during tthe measurement period using a systematic screening method, and either received brief counseling if identified as an unhealthy alcohol user or drug user Numerator: Patients in the denominator who were screened and received brief treatment for alcohol or drug use at least once during the measurement period Denominator: Pediatric patients, aged 12-17 years during the two-year look-back period, who who had at least one preventive care visit in the hospital's primary care sites"	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)

Column 1	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes	How Measure Will be Scored
j.	Developmental Screening in the First Three Years of Life (DEV-CH); NQF 1448	Oregon Health & Science University	CY 2023	69.3%	Year 1-3	achievement / maintenance 60.00% or 10% gap to goal improvement	Once target is met, maintenance is achieved by performing at or above goal	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
k.	FUH Follow-up after hospitalization for mental illness – 7 days (related to Inpatient psychiatry discharges at the public hospital system); NQF 0576 (7 day)	National Committee for Quality Assurance	CY 2023	20.6%	Year 1-3	40.00% or 10% gap to goal improvement		IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
l.	FUM Follow-up after emergency department for mental illness – 7 days (related to emergency department visits at the public hospital system); NQF 3489 (previously NQF 2605)	National Committee for Quality Assurance	CY 2023	23.9%	Year 1-3	59.46% or 10% gap to goal improvement		IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
m.	Medical Assistance with Smoking & Tobacco Use Cessation (Ambulatory); NQF 0028	National Committee for Quality Assurance	CY 2023	43.3%	Year 1-3	75.11% or 10% gap to goal improvement		IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
n.	Percentage of Behavioral Health Home target population patients who have a care plan	National Committee for Quality Assurance	CY 2023	97.1%	Year 1-3	achievement / maintenance 85% or 10% gap to goal [small denominator]	Description: Percentage of Behavioral Health Home target population patients (adult patients with serious mental illness) who have a care plan or treatment plan. Numerator: Patients identified in the denominator who have an up-to-date brief care plan in the EMR Denominator: Patients in the Behavioral Health Home target population	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)

Column 1	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes	How Measure Will be Scored
o.	Referrals to Community and/or Social Services: Percentage of public hospital's MassHealth inpatients (inpatient psychiatry units) who screened positive for HRSN need(s) who received a referral for community and/or social services	Other (specify in "Notes" column)	CY 2023	84.6%	Year 1-3	85% or 10% gap to goal	The referral to community/social services measure is related to the HRSN screening measure #16 above as it links to the patients who screen positive for HRSN needs. Description: Percentage of inpatient psychiatry patients in the hospital's delivery system who screened positive for HRSN need(s) and who received a referral for community and/or social services Numerator: Patients in the denominator who were referred to community and/or social services Denominator: Inpatient psychiatry patients in the hospital's delivery system who screened positive for HRSN need(s) within the measurement year	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
p.	Caregiver Depression Screening (across all core primary care sites); NQF 1401	National Committee for Quality Assurance	CY 2023	61.6%	Year 1-3	75.00% or 10% gap to goal improvement		IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
q.	Percent of patients with Substance Use Disorder (SUD) who were received treatment with Extended Clinical Care Team	Other (specify in "Notes" column)	CY 2023	35.0%	Year 1-3	40.00% or 10% gap to goal improvement	Description: Percent of patients with Substance Use Disorder (SUD) in measurement period) who received treatment with Extended Clinical Care Team Numerator: Patients in the denominator who had a completed encounter that was with an extended clinical care team member Denominator: Patients with an SUD visit diagnosis (serious/severe SUD) in the measurement period	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
r.	Adult Wellbeing Screening (annual screening for behavioral health wellbeing for adult patients in primary care)	Other (specify in "Notes" column)	CY 2023	65.4%	Year 1-3	68% or 10% gap to goal improvement	Definition: Percent of patients 18 and older receiving screening through the Adult Wellbeing Questionnaire during the 12-month measurement period. Numerator: Patients in the denominator who completed the Adult Wellbeing Questionnaire, during the 12-month measurement period. Denominator: Patients aged 18 years and older, engaged in any primary care provider visit during the 12-month measurement period.	IMPROVEMENT Full credit: close 10% Gap to Goal, attainment at benchmark, or maintenance at or above benchmark Partial credit: % of targeted improvement achieved (minimum of 80% if above median state or national Medicaid performance)
	*Note: The methodology used to establish the benchmark is derived from the following: available state benchmarks, national Medicaid benchmarks, and/or clinical assessment/literature review.							

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	2023 Evaluation Data	2024 Evaluation Data
i.	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided/Offered at Discharge; NQF 1664	CY2023	43%	75.0% or 10% gap to goal improvement	NQF 1664 applied solely to the inpatient psychiatry discharges	42.60%	42.90%