Delivery System Reform Incentive Payment (DSRIP) Program

In accordance with STC 17.11 (Approval Period: October 1, 2022 through December 31, 2027), the Executive Office of Health and Human Services (EOHHS) of the Commonwealth of Massachusetts (MA) is submitting this Close-Out Report for Delivery System Reform Incentive Payment (DSRIP) expenditure authority.

Brief Background Information about the Demonstration

Name of the demonstration, approval date of the demonstration, and period of time the demonstration was active

The MassHealth Section 1115 Demonstration Waiver extension was approved by CMS on November 4, 2016 for the period of July 1, 2017 through June 30, 2022. The demonstration was consequently extended through September 30, 2022. The DSRIP program was extended until March 31, 2023 (into the following waiver period) to accommodate the extension of DSRIP Budget Period 5 to March 31, 2023 in alignment with the extended contract term for the state's then-contracted Accountable Care Organizations (ACOs).

Key issues that the state was trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the magnitude of the issue, and why the state selected this course of action to address the issues

DSRIP was designed to address Goals 1, 2, and 4 of the 2017-2022 Demonstration extension period:

(1) Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care; and
(2) Improve integration pf physical, behavioral, and long term services.
(4) Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals

During the decade leading up to the 2017-2022 Demonstration period, MassHealth experienced significant enrollment and spending growth in the context of a fee-for-service model for providers. The overall percentage of MassHealth spending in the state budget grew from 27% in 2007 to 42% in 2016[1].

In 2012, the Massachusetts Legislature passed a law to control healthcare spending growth while improving access and quality (Chapter 224 of Massachusetts Acts of 2012[2]). The law reflected the nation-wide consensus that fragmented, fee-for-service care contributes to waste, escalates costs, and

[1] Massachusetts Medicaid Policy Institute, "Budget Brief: FY2017 General Appropriations Act Budget for MassHealth (Medicaid) and Health Reform Programs." Blue Cross Blue Shield of Massachusetts Foundation, October 2016. Available online at FY2017 General Appropriations Act Budget for MassHealth (Medicaid) and Health Reform Programs | Welcome to Blue Cross Blue Shield of Massachusetts (bluecrossmafoundation.org)
[2] Chapter 224 Session Law - Acts of 2012 Chapter 224. Available at: https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

has a negative effect on quality of care. As such, the law required MassHealth to adopt alternative payment methods (APMs) to promote more coordinated, efficient care for its members.

MassHealth sought to fundamentally restructure its delivery system to move away from fragmented volume-driven care and toward integrated, accountable care models with the goals of improved quality and greater control over costs. The 1115 Waiver Demonstration effective July 1, 2017 authorized the formation of ACOs and Community Partners (CPs), both described below. The DSRIP program was included in the 2017-2022 Demonstration Period (and subsequently extended into the 2022-2027 Demonstration Period) to create financial incentives to better coordinate healthcare, incorporate services addressing health-related social needs, and promote community-based care. These incentives were funded by the DSRP funding streams directed to MassHealth ACOs and CPs, as described in more detail further in this section. Specifically, the ACO funding stream was divided into the startup/ongoing sub-stream supporting ACOs' development, infrastructure, and investments in new care delivery models; Flexible Services sub-stream; and the DSTI Glide Path sub-stream (more details below). CP DSRIP funding consisted of the Care Coordination, Infrastructure and Capacity Building, and Outcome-Based sub-streams (more details below).

During the2012-2017 Demonstration period, MassHealth took an early approach to the accountable care models by implementing the Delivery System Transformation Initiative (DSTI). DSTI provided funding to certain safety net hospitals to support delivery system changes and improve quality and access to care. While DSTI was discontinued in the 2017-2022 Demonstration, MassHealth restructured demonstration funding for safety net hospital systems to be more sustainable and aligned with value-based care delivery and payment incentives. The past recipients of DSTI funds (seven Massachusetts safety net hospitals) became eligible to receive reduced safety net provider payments. To address the resultant funding cliff and create a sustainable transition to these reduced funding levels, MassHealth established a "glide path" – the transitional DSRIP-funded payments provided to DSTI safety net hospitals, contingent on their participation in an ACO.

MassHealth also sought to address the existing gaps in statewide infrastructure and workforce capacity by implementing a number of DSRIP-funded Statewide Investments (SWIs). MassHealth was tackling the ongoing shortage of primary care and behavioral health providers in the state, particularly in community settings. To address this pervasive issue, MassHealth introduced a portfolio of student loan repayment, training, and recruitment SWIs designed to retain and expand the pool of providers and staff committed and prepared to care for patients in community settings. MassHealth also anticipated initial implementation barriers as ACOs and CPs were entering the integrated accountable care environment. A subset of SWIs was designed to provide technical assistance, trainings, and peer learning opportunities, as well as to support providers that were not yet ready to participate in an alternative payment method such as an ACO, but were interested in preparing for it. Finally, a group of SWIs was designated for bridging a gap in appropriate care delivery and improving accessibility for members with disabilities or those for whom English is not a primary language.

Brief description of the demonstration features and history of the implementation, including any amendments, extensions, renewals, or expansions of, the demonstration

The Massachusetts Delivery System Reform Incentive Payment (DSRIP) program was a new, one-time $1.8 billion investment program authorized through MassHealth's demonstration waiver effective July 1,

2017. While originally the DSRIP program was set to expire on June 30, 2022, it was extended through March 31, 2023. Years 1-4 referred to in this report correspond to calendar years 2018-2021, with Year 5 corresponding to the period January 1, 2022-March 31, 2023.

The DSRIP program was designed with the following goals in mind:

1. Implement payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care;
2. Improve integration among physical health, behavioral health, long term services and supports, and health-related social needs; and
3. Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals.

The DSRIP program sought to achieve the above goals through the creation of three ACO models, investment in Community Partners, investments in statewide infrastructure and workforce development, as well as, starting in 2020, investments in the Flexible Services Program. The $1.8B DSRIP funding was time-limited and decreased over the lifecycle of the program to incentivize the participating entities to implement sustainable programs that could be supported post-DSRIP by the new delivery models. Participation in DSRIP was contingent upon ACOs' and CPs' participation in MassHealth's payment and care delivery reform efforts.

DSRIP total funding of $1.8B was divided among four funding streams, with the majority of dollars directed to the first two streams:

1. 60% ($1B) of DSRIP funds were invested in Accountable Care Organizations (ACOs). ACOs are networks of primary care providers who work in partnership with hospitals and specialists to coordinate all of a member's medical care, long term services and supports, behavioral health care, and health-related social needs. DSRIP funding was used to support ACO-implemented programs with emphasis on care coordination, quality care, cost effectiveness, and member-centered care. This funding stream also included the Flexible Services funding and DSTI Glide Path funding. During the 2017-2022 Waiver, MassHealth launched 17 ACOs.
2. 30% ($547M) of DSRIP funds were invested in Community Partners (CPs). CPs are community-based behavioral health (BH) and long-term services and supports (LTSS) organizations that provide wrap-around expertise and support for the ACO members with the most complex needs. DSRIP funds were used by CPs to engage members with complex BH and LTSS needs, collaborate with ACOs to coordinate and improve care for those members, and to support CPs' infrastructure and capacity building. During the 2017-2022 Demonstration, MassHealth launched 27 CPs. A portion of the $547M was used to support infrastructure and capacity building of Community Service Agencies (CSAs) – community-based organizations providing targeted case management to eligible MassHealth members under 21 years of age with Serious Emotional Disturbances (SED). DSRIP funds supported 19 CSAs.
3. 6% ($115M) of DSRIP funds were directed to Statewide Investments (SWIs), described in more detail earlier in this section. SWIs are a set of direct state investments intended to efficiently scale up statewide infrastructure and workforce capacity in support of

MassHealth restructuring (e.g., workforce development, technical assistance) and high priority health issues (e.g., Emergency Department boarding, accommodations for members with disabilities).

4. Finally, a small portion of DSRIP funds ($75M) was allocated to support Statewide Operations and Implementation of the DSRIP program.

The DSRIP program was subject to an accountability framework, under which MassHealth is accountable to CMS for the achievement of delivery system reform goals. Failure to achieve these goals could result in the loss of a portion of DSRIP expenditure authority and, consequently, reduction of DSRIP expenditures by the State. While DSRIP expenditure authority decreased annually, the at-risk percentages of yearly DSRIP expenditure authority increased from 0% in the first year of the program to 20% in the last year of the program. State DSRIP Accountability is based on three domains:

1. MassHealth ACO/APM Adoption Rate – target percentages for the number of MassHealth ACO-eligible members who are enrolled in or attributed to ACOs or who receive service from providers paid under Alternative Payment Methods (APMs). These target percentages increase from the beginning of DSRIP to its end (25% in Year 1 to 45% in Year 5).
2. Reduction in State Spending Growth – targets for how much the State should reduce its spending growth for the ACO-enrolled population. The performance on this domain is calculated by comparing actual spending growth on a per member per month (PMPM) basis against a trended PMPM determined by applying an assumed 4.4% annual growth rate to a baseline year's PMPM. The reduction target percentages increase over the duration of DSRIP with no spending growth accountability in the first two years of the program, and ramping the target up over the remaining years up to 2.1% savings in Year 5.
3. Statewide Quality Performance – quality of care provided to the ACO-enrolled population, compared from one year to the next. Statewide Quality Performance is determined by performance in four quality domains across all ACOs: two Clinical Quality domains (Prevention & Wellness measures and Care Integration measures) and two Patient Experience Survey domains (Overall Rating & Care Delivery and Person-Centered Integrated Care measures). MassHealth assumed accountability for the Statewide Quality Performance domain beginning in Year 2 of DSRIP.

Due to the COVID-19 pandemic and the resultant public health emergency, State DSRIP Accountability and State Expenditure Authority at risk were both set to 0% for CY2020 according to the pandemic-related flexibilities made available by CMS. The State DSRIP Accountability framework resumed in 2021 and continued until the end of DSRIP.

ACOs, CPs, and CSAs that received DSRIP funds also were accountable to the State for their individual performance. A portion of DSRIP payments to ACOs, CPs, and CSAs was at risk and contingent on a number of performance and quality measures. The State withheld at-risk portions of yearly DSRIP payments to these entities and paid them retrospectively based on their individual DSRIP Accountability Scores. The portion of yearly DSRIP at risk funding increased annually to incentivize performance and future sustainability of DSRIP-funded programs.

ACO DSRIP funding was divided among four sub-streams: (1) Startup/Ongoing (Discretionary), a sub-stream supporting the non-primary care-specific investments, (2) Startup/Ongoing (Primary Care), (3)

DSTI Glide Path, described above, and (4) Flexible Services, described below. A portion of Startup/Ongoing (Discretionary) funding was held at risk from 5% at risk in Year 1 of the program to 50% at risk in Year 5, as was a portion of DSTI Glide Path funding: from 5% at risk in Year 1 of the program to 20% at risk in Year 5. The two remaining ACO sub-streams, Startup/Ongoing: Primary Care and Flexible Services, were not held at risk to encourage innovative programs in support of primary care infrastructure and health-related social needs (HRSNs).

ACO DSRIP Accountability was based on two components: (1) Quality, and (2) Total Cost of Care (TCOC). An ACO's quality score was the weighted sum of four domain scores: two that are based on Clinical Quality measures (Prevention & Wellness and Care Integration) and two that are Member Experience Survey measures (Overall Rating & Care Delivery and Person-Centered Integrated Care). In total, the ACO DSRIP quality measure slate comprised 22 measures. In the beginning of the DSRIP program, ACOs, CPs, and CSAs were accountable for accurately reporting the quality data to MassHealth ("Pay-for-Reporting" or P4R). Later in the program, these entities assumed financial accountability for actual performance on these measures ("Pay-for-Performance" or P4P).

The TCOC scores reflect individual ACO's TCOC performance for each year of the DSRIP program compared against a preliminary TCOC benchmark.

A portion of the ACO DSRIP funding stream was directed to the **Flexible Services Program (FSP)**, launched in January 2020. FSP is a focused program allowing ACOs to pilot innovative evidence-based approaches that address a member's health-related social needs with the goal of improving health outcomes and reducing the total cost of care for the member. Participating ACOs partnered with community-based organizations to develop and implement a set of FSP initiatives in housing (including pre-tenancy, tenancy-sustaining, and home modification supports) and nutrition domains. The FSP was not an entitlement program or a covered service, and served a subset of ACO members meeting the following eligibility criteria: enrollment in one of MassHealth ACOs, meeting at least one of the Health Needs Based Criteria (i.e., having a BH need or a complex physical health need, needing assistance with Activities of Daily Living or Instrumental Activities of Daily Living, having repeated Emergency Department use, or experiencing high-risk pregnancy), and meeting at least one of the Risk Factors (i.e., experiencing or being at risk of homelessness, or being at risk for nutritional deficiency due to food insecurity). MassHealth implemented a robust slate of FSP-specific performance metrics to monitor the progress toward achievement of FSP goals.

Like ACOs, **CPs and CSAs** received several DSRIP funding sub-streams. For Infrastructure and Capacity Building, a sub-stream providing infrastructure investments to advance CP and CSA capabilities to support their members and to form partnership with ACOs and MCOs, a portion of the annual funding was held at risk and based on CP's/CSA's performance with amounts at-risk increasing annually (from 0% at risk in Year 1 of the program to 70% in Year 5 for CPs, and from 0% in Year 1 to 20% in Year 5 for CSAs). CP Outcome-Based Payments were an incentive pool based on performance on avoidable utilization measures during Years 3 through 5 of the program. The CP Care Coordination Supports sub-stream was not held at risk.

CP/CSA DSRIP Accountability Scores were based on performance on the Quality measure slate comprising, in total, 13 measures for BH CPs, 9 measures for LTSS CPs, and 4 measures for CSAs. The measure slate was chosen with the goals of the DSRIP program in mind to promote member-driven, integrated, coordinated care and improving integration between physical health, behavioral health, LTSS, and HRSN. Similar to the ACO accountability framework, all CP/CSA Quality measures transitioned from P4R to P4P over the course of the DSRIP program.

To account for the impact that the COVID pandemic had on statewide quality performance, MassHealth implemented several ACO, CP, and CSA Quality reporting flexibilities per agreement with CMS, such as extending the reporting (as opposed to P4P) status for a subset of quality measures and adjusting select quality benchmarks.

DSRIP dollars also funded a series of **Statewide Investments (SWIs)** intended to strengthen healthcare infrastructure and workforce capacity across the state, and to support the success of ACOs, CPs, and CSAs in the accountable care environment.

DSRIP supported 8 Statewide Investments divided into three general categories:

- **Building and Training the Primary Care and BH Workforce** – investments aimed to support recruitment, retention, and training of primary care and BH providers, and the frontline healthcare workers in community-based settings:
    1. Student loan repayment program
    2. Primary Care/BH special projects program
    3. Investment in community-based training and recruitment
    4. Workforce development grants
- **Capacity Building for ACOs, CPs, and Providers** – investments aimed to provide direct technical assistance and shared learning opportunities for ACOs and CPs, as well as support for providers who are not yet participating in APMs to prepare for future APM adoption:
    5. Technical Assistance to ACOs and CPs
    6. Alternative Payment Methods Preparation Fund
- **Initiatives to Address Statewide Gaps in Care Delivery** – investments aimed to improve care provided to members with specific BH and accessibility needs through technology solutions and grant funding opportunities:
    7. Enhanced diversionary behavioral health activities
    8. Improved accessibility for people with disabilities or for whom English is not a primary language

Description of why the state is ending the demonstration

DSRIP was approved as a one-time time-limited program that could not be renewed. At the end of the DSRIP, MassHealth expected the ongoing costs of the program to be mitigated by the savings generated by the new care delivery models.

Summary of Implementation of the Demonstration

Describe the successes, achievements, and positive outcomes of the demonstration. Also describe innovative activities and/or promising practices that were implemented.

The DSRIP program was instrumental to successful implementation of MassHealth's most significant effort in 20 years in restructuring its delivery system. DSRIP incentive payments began shifting focus toward value-based integrated care and helped establish partnerships across delivery system silos. 17 of Massachusetts' biggest provider systems became ACOs, enrolling over 1.2M members as of 3/31/2023 (over 80% of eligible members). For the duration of the DSRIP program, over 180K of the most high-risk,

hard-to-reach members received enhanced care coordination from 27 Community Partners and 19 Community Service Agencies. The Flexible Services Program grew exponentially since its inception. All 17 MassHealth ACOs and 39 social service organizations stood up a total of 85 housing and nutritional programs serving over 29K unique members from January 2020 to March 2023.

ACOs and CPs used DSRIP funds to successfully design, stand up, and measure outcomes of multiple innovative programs, including multidisciplinary care management programs serving high-risk members, population health tools, and health equity-centered initiatives. While it will take years for programs to mature and show a population impact and tracking outcomes has been further complicated due to impact of the COVID pandemic, there have been some early promising trends. Interim findings show that ACOs helped strengthen member connection to primary care with PCP visits 9% higher for ACO members than non-ACOs in 2021. Furthermore, from 2018-2019, prior to the pandemic, ACOs decreased potentially preventable hospital admissions by 11% versus 2% for non-ACO plans.

In 2020, ACOs performed self-evaluations of their programs supported by DSRIP funds. ACOs reported through those evaluations that 70% of the 76 programs they implemented over the first two years of the waiver improved outcomes in at least half of outcomes measured, particularly for care management and quality-focused programs.

Over the duration of the DSRIP program, ACOs improved the quality of care being delivered, with quality scores generally high and improving during the pre-COVID period. Challenges faced by MassHealth ACOs with the onset of the pandemic made it unfeasible to meet pre-COVID quality targets, especially for quality measures based on in-person care. With CMS approval, MassHealth revised DSRIP quality benchmarks to more accurately reflect ACO and CP performance in 2020 and beyond. For quality measures that were challenging to meet, ACOs and CPs engaged in Performance Remediation Plans (PRPs) standing up a slate of quality improvement projects, the majority of which successfully achieved their initial project goals. Member experience has been consistently positive, with minor decreases in 2020 attributable to COVID-related access issues.

CPs new to the integrated accountable care framework used DSRIP funds to build up their operational and technological infrastructure to facilitate their care coordination work and data-informed quality improvement initiatives. CPs made significant gains in member outreach and engagement with early data showing a sustained impact on cost and utilization outcomes for CP enrollees. By Year 3 of the CP program, BH CP enrollees experienced a 20% decline in ED visits and a 31% decline in BH inpatient admissions since the start of the program, and risk-adjusted TCOC was 19% lower for BH CP enrollees post-graduation from the program vs. enrollees in the 12 months preceding enrollment in a CP.

The DSRIP program incentivized ACOs and CPs to boost their health equity efforts and build the systems for the ongoing health equity work. ACOs and CPs used DSRIP funding to enhance their demographic data collection, stratification, and analysis capabilities to identify and address health disparities. Some of the ACO initiatives informed by these findings focused on addressing maternal morbidity disparities, hypertension control disparities, and closing gaps in childhood immunizations. Several ACOs used DSRIP funds to support mobile clinics to provide healthcare services directly in hard-to-reach communities. DSRIP funding supported multiple initiatives directed at improving access to culturally and linguistically appropriate care, such as enhancing medical interpretation/translation services, developing appropriate member-facing educational materials, as well as training healthcare professionals and care coordinators on cultural competency, implicit bias, and other pertinent topics. Finally, given the focus population of

the CP Program (i.e., members with complex BH and LTSS needs) experience worse health outcomes than those without those needs, the CP program writ large directly advances health equity for those populations.

Over the first three years of the Flexible Services Program, it demonstrated early successes for certain ACO programs in diabetes management, reductions in emergency department (ED) visits, and ACO TCOC reductions. One ACO found for members receiving both housing and nutrition supports in 2020, they were able to increase the percent of members with A1C levels below 9% (74.8% to 79.7%) and decrease the average hemoglobin A1c levels of those members from 7.7% to 7.3%. Additionally, they found that of members that had received nutrition supports, only 8% had four or more ED visits, as compared to 31% of members in a comparison group. They also saw a statistically significant reduction in annualized TCOC for those members that had received nutrition supports (-$11,309) as compared to members that were eligible for supports but did not receive services (-$345). In 2021, they continued to see greater decrease in health care costs for members that received FS (-$4,092), than members who screened eligible but did not enroll (-$2,856) from 6 months pre-Flexible Services enrollment to 6 months post-Flexible Services enrollment.

Soon after its launch, the FS program became an integral part of ACOs' response to COVID as the pandemic exacerbated existing food and housing insecurity among MassHealth members. During the first year of the pandemic, MassHealth allowed ACOs a path to expedite program approval for programs meant to address these heightened needs. MassHealth approved several of these programs to provide nutrition supports such as medically tailored meals, food boxes, and nutrition vouchers to specifically meet the immediate needs of their members. Additionally, many ACOs launched their standard Flexible Services programs sooner than anticipated to help meet the growing needs of their members.

A more complete evaluation of the Flexible Services program will be included in the Independent Evaluation Summative Report of Massachusetts Medicaid 1115 Demonstration Extension 2017-2022.

Statewide Investments (SWIs) implemented a slate of highly popular initiatives. SWIs supported essential healthcare workforce development across the state which proved especially needed during the COVID-19 pandemic and the resultant statewide workforce crisis. Over the five years of the program, SWIs repaid over $8M in student loans for over 380 community-based clinicians, with 90% of total loan repayment recipients retained in safety net provider organizations – a result that was seen as vital by multiple provider organizations. Multiple community-based primary care and behavioral care provider organizations utilized SWI awards to implement innovative projects related to accountable care implementation. MassHealth awarded 20 grants and 38 Family Nurse Practitioner Residency Training grants that provided residency training opportunities for physicians and mid-level clinicians in community health centers. SWIs helped train hundreds of community health workers and peer specialists, key members of extended care teams who help engage members in their care. SWI technical assistance was a welcome support to ACOs and CPs as they were implementing and optimizing new programs, including health information technology infrastructure and data analytic capabilities, improved care coordination, advanced quality improvement efforts, and more. Multiple providers also used SWI dollars to improve accessibility for members with disabilities and language barriers. SWIs supported the ACO/MCO/CP Integration Learning Collaboratives to provide technical assistance, training, and sharing best practices around integrated care and member engagement. In parallel, MassHealth hosted a series of SWI Pop-Up series – mini-conferences aimed at enabling leaders, clinicians, and staff in ACOs and CPs to make deep dives into a variety of topics relevant to building their organizations, and

focused various aspects of member engagement, as well as medical/oral health integration. Please see the Independent Evaluation Interim Report of Massachusetts Medicaid 1115 Demonstration Extension 2017-2022[3] and the forthcoming Independent Evaluation Summative Report of Massachusetts Medicaid 1115 Demonstration Extension 2017-2022 for more details.

Describe the challenges, problems, barriers, limitations, undesired outcomes, and how each issue was addressed. Discuss the extent to which the problems were related to demonstration implementation (this may include external challenges as well). Provide a rationale, if applicable.
Describe any opportunities for improving the policy within and/or implementation of the demonstration.

Transitioning the MassHealth delivery system toward integrated, value-based care is a long, multifaceted process. As described above, the DSRIP program was instrumental to moving the state forward to achieve the goals of the 2017-2022 1115 Demonstration. As anticipated, however, this complex systemic transition was not without its challenges, especially in the context of the barriers posed by the COVID-19 pandemic. MassHealth applied lessons learned during the DSRIP program to enhance the ACO and CP programs in the 2022-2027 Demonstration.

While MassHealth made significant gains toward alternative payment methods, fee-for-service remained a widely accepted volume-based payment mechanism for primary care and specialist providers. MassHealth addressed this ongoing challenge by implementing a new primary care value-based sub-capitation payment model in the 2022-2027 Demonstration. Through sub-capitation, MassHealth is investing additional $115M per year in primary care to support enhanced care delivery expectations (e.g., team-based care, behavioral health integration, specific expectations for members under 21) and more provider flexibility in the delivery of care to meet their patients' needs.

Over the 5+ years of DSRIP, MassHealth was engaged in in-depth stakeholder communication to assess various challenges that ACOs and CPs encountered during the DSRIP program, especially those new to value-based contracting. Some of the actions taken over the course of DSRIP included increasing DSRIP payments to ACOs that serve populations with higher Medicaid/un-insured payer mix, risk-adjusting ACO capitation payments and TCOC benchmarks for ACOs with enrollees that have greater medical and social risk, as well as increasing CP payment rates. MassHealth also made significant updates to the ACO pricing model through extensive stakeholder workgroups in 2020. Most notably these updates included addition of a "market risk corridor", which adjusts ACO financial performance to ensure ACOs are primarily accountable for performance rather than at-risk for underlying fluctuations in the acuity of the Medicaid population. This model of ACO pricing stakeholder meetings continued through 2022, which advised on subsequent pricing model tweaks to ensure MassHealth's pricing policies were effective in meeting the goals of value-based care.

MassHealth increased flexibility regarding ACO/CP partnerships, including allowing ACOs to identify and refer members to CPs and allowing them to contract with fewer, "preferred" CPs, in an effort to improve provider buy-in and reduce administrative burden. As expected, health information technology and data sharing barriers posed a challenge to care coordination efforts. To mitigate these issues, MassHealth

[3] Available online at https://www.mass.gov/doc/cms-approved-interim-evaluation-report/download.

allocated significant infrastructure and technical assistance DSRIP funding, required ACOs and CPs to participate in Mass HIway (the statewide health information exchange program), implemented a data sharing framework, and maintained an effort of sharing member enrollment and claims information with ACOs and CPs.

In the 2022-2027 Demonstration, MassHealth continues to require ACOs and MCOs to partner with CPs. However, the program has shifted from a state-administered program to a core component of the ACO/MCO program. ACOs and MCOs are now required to pay CPs directly and are funded for doing so through their administrative payments from MassHealth. This change aims to transition CPs to a more sustainable funding model and to support ACOs/MCOs in managing enhanced care coordination for their members. MassHealth also expanded its requirements to CPs, including a requirement to perform HRSN screenings, a requirement for LTSS CPs to be organizing and leading the care team in alignment with requirements for BH CPs, and more.

The COVID-19 pandemic created significant challenges for the State's delivery system, disrupting patterns of care, changing clinical norms, impacting MassHealth enrollment, and putting pressure on the healthcare workforce. Massachusetts implemented multiple initiatives to mitigate the impact of the pandemic on members and providers. In accordance with federal guidance, MassHealth paused routine redeterminations of members' eligibility in March 2020, which increased ACO enrollment by 10% just by end of 2020. At the same time, cost and utilization significantly decreased in 2020 and beyond due to holds on elective procedures, postponed non-essential care, and members opting to defer care. MassHealth coordinated with ACOs and MCOs to improve member access and extend supports during COVID emergency: for example, plans were required to remove referral requirements for care and to cover outpatient COVID-19 testing, evaluation, and treatment services by out-of-network providers. MassHealth, ACOs, and CPs pivoted delivery system reform efforts to prioritize programs focused on rapid expansion of telehealth capability, member outreach and education, COVID testing and treatment, and addressing housing and nutrition needs. Early in the pandemic, MassHealth expanded technical assistance offerings to target telehealth assistance. In coordination with CMS, MassHealth made temporary changes to quality scoring methodology to preserve accountability for performance where possible while recognizing the inappropriateness of utilizing 2020 data as compared to other performance years.

The pandemic spotlighted longstanding inequities in the Commonwealth and across the country, accelerating ongoing MassHealth health equity initiatives. In 2019, MassHealth stood up a Health Equity Sub-Committee of the Delivery System Reform Implementation Advisory Council (DSRIC), a stakeholder group tasked with making recommendations to MassHealth related to waiver implementation inclusive of health equity considerations such as equity-oriented data collection. To ensure equitable access to Flexible Services, MassHealth required ACOs to collect and report demographic data for all members receiving Flexible Services and to use these data to identify and address disparities in access. In 2021, ACOs were required to describe their efforts regarding health equity in their DSRIP Full Participation Plans. In the 2022-2027 demonstration, the Commonwealth aims to further improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs (HRSN) and health disparities demonstrated by variation in quality performance. To support achievement of this goal, Massachusetts is centering equity alongside quality as a pillar of value-based care and as a priority for the state's health care system. To that end, MassHealth will implement aligned quality and equity initiatives across delivery system settings, with MassHealth's Managed Care Organizations, Accountable

Care Organizations, and acute hospitals accountable to annual performance on a comprehensive set of quality performance and equity performance metrics.

In the 2022-2027 demonstration, providers are incentivized to improve data collection and reporting on demographic and social risk factors such as race, ethnicity, language, disability status, sexual orientation, gender identity, and health-related social needs; implement evidence-based clinical interventions to improve quality and access, including for members with disabilities and members who prefer a language other than English for healthcare; and reduce disparities, in addition to continuing to be accountable for quality performance. MassHealth intends to implement interventions to address racial and ethnic disparities in maternal health, expand the Flexible Services and Community Supports Program to address HRSNs such as nutrition and housing, and to provide post-release transition supports for justice-involved members. MassHealth is strengthening coverage for members with disabilities, including streamlined access to CommonHealth coverage, required reporting of quality measures stratified by disability, and improvements to the LTSS CP program. MassHealth is also making targeted updates to eligibility to support coverage and equity, including a simplified process for adults with disabilities and at least 12 months of continuous eligibility for members experiencing homelessness and members recently released from a correctional facility.

As highlighted above, Massachusetts has been experiencing significant healthcare workforce shortages, particularly in the community setting, which were further exacerbated by the COVID-19 pandemic. MassHealth continued to make investments to strengthen primary care and behavioral care workforce via a slate of SWIs. Under the new demonstration, MassHealth is investing over $43M over five years in loan repayment and residency training programs with particular focus on strengthening and diversifying the primary care and behavioral health workforce in the state.

Update on the Transition Plan

Provide an update on how continued coverage for each population under the demonstration was addressed and what challenges were encountered, if any.

How was beneficiary coverage continued (e.g., through a transition to another Medicaid eligibility category, or referral to other coverage/programs.)?

Describe any challenges with and solutions for beneficiary eligibility, coverage, access to care, health outcomes, plan participation and arrangements, provider access, or financing or other arrangements.

Transitioning away from DSRIP did not have an impact on Medicaid eligibility as the program did not address member eligibility. MassHealth is incorporating lessons learned from DSRIP experience into its ongoing models of care under the new demonstration. With DSRIP funding sunsetting, MassHealth continues the ACO, CP, and Flexible Services programs, using more sustainable funding for the CP and FS programs. MassHealth is transitioning ~80% of DSRIP dollars to ongoing base funding that supports ACO and CP programs (e.g., supports for members with disabilities, embedded community health workers and peers in primary care, CP care coordination.)

MassHealth successfully re-procured 17 ACOs and 20 CPs for an operational start date of 4/1/23. As such, MassHealth's health plan coverage continued into the post-DSRIP period. As of 4/1/23, approximately 1.3M MassHealth members were transitioned to be served by new ACOs, and, of those, 35K members were served by new BH and LTSS CPs. MassHealth worked with ACOs to identify and

correct any assignment-related issues in the days following ACO launch. MassHealth and the ACOs also successfully completed a 90-day continuity of care period. Continuity of Care allowed members to more easily transition to their new health plan with access to their prior providers and temporarily relaxed prior authorization requirements to prevent interruptions to services for members. In preparation for the new CP program launch on 4/1/23, MassHealth increased engagement with CP leadership and stakeholders to support program transitions, including supporting non-continuing CPs in winddown and member transitions. To maintain continuity of care for CP enrollees during this transition period, MassHealth instituted a 90-day continuity period for all CP enrollees. During that period, all CPs were required to hold either full or time-limited agreements with all ACOs and MCOs in their service areas; disenrollments were only allowed under certain circumstances. MassHealth stood up a new prorated enrollment-based payment model and new reporting requirements for CPs and ACOs/MCOs. The first round of ACO/MCO payments to CPs was issued in June 2023. Additionally, on 7/3/23, MassHealth launched the Behavioral Health Community Partners Program in Nursing Facilities initiative, requiring BH CPs to provide enhanced care coordination for individuals in nursing facilities who have a positive determination of serious mental illness on their Level II Preadmission Screening and Resident Review (PASRR) evaluation and have received a 12-month determination (i.e., individuals appropriate for the nursing facility level of care for the next 12 months).

The Flexible Services Program is continuing in the new demonstration with a few newly approved components. MassHealth has expanded nutritional supports to a member's household if the eligible member is a child or a pregnant individual. Additionally, MassHealth has expanded FSP eligibility for members experiencing high risk pregnancies from 60 days post-partum to 12 months postpartum. Finally, MassHealth increased the allowable number of meals provided to eligible members from two meals a day, 5 days a week to three meals per day, 7 days a week. Per CMS approval, by 2025, Flexible Services will be expected to transition into the managed care delivery framework.

MassHealth continues to support healthcare workforce with new student loan repayment programs for community-based behavioral health providers ($20M) and primary care providers ($18.4M). Additionally, MassHealth is allocating $4.8M to the Family Nurse Practitioner Residency slots at the State's community health centers.

Budget Neutrality

Provide an updated budget neutrality spreadsheet with actual expenditures based on claims paid (can be claims paid as of a certain date).

Attached to this report please find the Budget Neutrality table as of August 23, 2023 with actual DSRIP expenditures through March 31, 2023.

For any unspent DSRIP funds, MassHealth will be processing recoupments later in 2023 to subsequently reconcile federal claiming.

DSRIP Expenditures Claimed through March 31, 2023 (in dollars)

	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	QE Sep 2022	QE Dec 2022	CY 2023	**TOTAL**
	DY 21	DY 22	DY 23	DY 24	DY 25	DY 26	DY 27	DY 28	
DSRIP Accountable Care Organizations (ACOs)	289,823,537	306,599,128	222,065,588	120,135,935	58,282,153	12,857,301	15,384,916	16,210,018	**1,041,358,576**
DSRIP Community Partners (CPs)	0	86,108,943	111,131,309	92,840,390	46,391,378	11,292,641	17,311,439	17,284,439	**382,360,539**
DSRIP Operations/ Implementation/Oversight	0	4,319,386	5,979,184	7,264,516	5,476,609	38,672	1,311,065	0	**24,389,432**
DSRIP Statewide Investments (SWI)	0	24,310,230	16,997,666	15,519,538	13,386,746	0	0	0	**70,214,180**
TOTAL	**289,823,537**	**421,337,687**	**356,173,747**	**235,760,379**	**123,536,886**	**24,188,614**	**34,007,420**	**33,494,457**	**1,518,322,727**