MassHealth

Comprehensive Quality Strategy

Effectiveness Evaluation

Commonwealth of Massachusetts

Executive Office of Health and Human Services

Office of Medicaid

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Introduction

The Commonwealth of Massachusetts, Executive Office of Health and Human Services (EOHHS) Office of Medicaid is pleased to submit the **Comprehensive Quality Strategy (CQS) Effectiveness Evaluation** ("Evaluation") for the MassHealth CQS published in June 2022 ("CQS") and covering the three-year period of Calendar Years (CY) 2022 through 2024.

In accordance with 42 CFR §438.340(c)(2), EOHHS evaluates the effectiveness of the CQS at least every three years to assess whether MassHealth has met or made progress on its quality strategy goals. This Evaluation will use data reflecting a quality performance measurement period for Measurement Years (MY) 2020 through 2022 (1/1/20 – 12/31/22). MassHealth did not include MY2023 data in this evaluation. In MY2023 MassHealth adopted new methodology to calculate the Child and Adult Core Set Measures. This change in methodology, reflecting CMS' updated mandatory core measure requirements for MY2023, resulted in the inclusion of the fee for service population and continuous enrollment across MassHealth instead of an individual product, therefore making MY2023 results incomparable to prior years. Additionally, MY2023 represented a new contract cycle for our ACO and MCO programs which resulted in changes in participating plans and quality measure slates. MassHealth intends to use MY2023 data as their baseline performance in the updated Quality Strategy anticipated in Q2/Q3 of 2025.

Following the CMS guidance provided in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit published in June 2021, this Evaluation will:

1. Describe the methodology used in the evaluation.
2. List the quality goals laid out in the MassHealth CQS and the quality measures associated with each goal.
3. Provide baseline and subsequent year data for each quality measure included in this report for each of the three years in the CQS period, indicating where improvements have been made, and where opportunities for improvement remain.
4. Discuss areas where improvement goals have not been met, with reference to modifications to MassHealth quality strategy approach in the most recent CQS (submitted to CMS in June 2022).
5. Assess the extent to which MassHealth CQS measures are consistent with and aligned across goals, objectives, and programs.
6. Summarize MassHealth performance on the CMS Adult and Child Core Measure Sets.
7. Summarize MassHealth responsiveness to EQR recommendations.

MassHealth Managed Care Programs

MassHealth operated the managed care programs[§§] or managed care plans (MCPs) listed below during the time period covered by the CQS. Performance by these MCPs is the focus of this Evaluation.

Detail on current MCPs is found in the current Comprehensive Quality Strategy (CQS), available on the MassHealth quality reports and resources webpage: www.mass.gov/info-details/masshealth-quality-reports-and-resources. The MCPs are as follows:

Accountable Care Organization (ACO) Program: ACOs are a network of primary care providers who work in partnership with hospitals, specialists, LTSS providers, and state agencies to coordinate all a member's care. ACOs focus on improving this coordination, better engaging members in their care, and

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[§§] All summaries of contract provisions in this document are for information purposes only. Interested parties should refer to the contracts for the contractual terms and applicable conditions. Nothing in this document should be read to alter or amend any contractual obligation. To the extent any discrepancies or conflicts exist between this document and the contract, the language of the contract controls.

integrating behavioral health care, medical care, long-term services and supports, and health-related social services. ACOs are accountable for the quality of care, member experience and cost of care for members. MassHealth has three ACO delivery models.

- **Accountable Care Partnership Plan (ACPP):** ACPPs are groups of primary care providers (PCPs) who work with just one managed care organization to create a full network of providers that includes PCPs, specialists, behavioral health providers, and hospitals.

- **Primary Care ACO (PCACO):** PCACOs are groups of primary care providers or PCPs forming an ACO responsible for members' care and the coordination of care. PCACOs work directly with MassHealth to provide primary care to members and to coordinate the full range of services available to them. PCACOs work with the MassHealth network of specialists and hospitals. PCACO members receive behavioral health services through the state's Managed Behavioral Health Vendor.

Managed Care Organization (MCO) Program – A capitated model for managed care eligible members under the age of 65.

Primary Care Clinician (PCC) Plan Program – A primary care case management model of managed care for members under the age of 65 and without any third-party insurance. Members receive behavioral health services through the Managed Behavioral Health Vendor. MassHealth includes the PCC Plan (a PCCM) in the managed care strategy where appropriate.

Managed Behavioral Health Vendor – A capitated behavioral health (BH) model that provides and/or manages behavioral health services to members of the PCC Plan and PCACOs, children in state custody and certain children enrolled in MassHealth, including children who have commercial insurance as their primary insurance.

Integrated Care Programs – To bring more integrated, coordinated, and person-centered care options to dually eligible members, MassHealth operates two programs for such members ages 21 to 64 at the time of enrollment, and age 65 or older, respectively:

- **One Care –** One Care is an integrated, comprehensive care option for persons with disabilities, ages 21-64 at the time of enrollment, who are eligible for both MassHealth and Medicare. One Care members receive both MassHealth and Medicare services, including all medical and behavioral health services and long-term services and supports, through health plans that promote the provision of integrated care.
- **Senior Care Options (SCO)** – Dual Eligible Special Needs Plans (D-SNP) for MassHealth and dual eligible members aged 65 and older. SCO plans provide full range of medical, behavioral health, and long-term services and supports. SCO offers quality health care by combining health services with social support services. SCO coordinates care and specialized geriatric support services along with respite care for families and caregivers.

In accordance with the managed care rule, the Accountable Care Partnership Plan, MCO, One Care and SCO programs are considered MCOs, and for the purposes of this document, will be referred to as managed care entities (MCEs). Primary Care ACOs are considered primary care case management entities (PCCM entities). The PCC Plan is considered a PCCM. MassHealth's Managed Behavioral Health Vendor, which serves members enrolled in the PCC Plan and Primary Care ACOs, and certain other populations is a Prepaid Inpatient Health Plan (PIHP) and is also referred to as Managed BH Vendor in this document. MassHealth does not contract with any Prepaid Ambulatory Health Plans (PAHPs) as

defined in 42 CFR 438.2. The CQS under 42 CFR 438.340 relates, but is not limited to, MCEs, PIHPs, and to PCCM entities as described in 42 CFR 438.310(c)(2).

Though not required to comply with managed care rules, the CQS includes the PCC Plan (a PCCM) in the managed care strategy and evaluation where appropriate.

Evaluation Methodology

The evidence base for this CQS evaluation includes MassHealth quality measure performance rates from the three-year period from Measurement Year (MY) 2020 through 2022 (1/1/2020 – 12/31/2022). MassHealth used three major criteria in selecting quality measures for inclusion in this Evaluation:

1. Alignment with the original quality strategy goals and objectives, as presented in the CQS;
2. Alignment with the CMS Core Measure Sets, as recommended in CMS's Medicaid and CHIP Managed Care Quality Strategy Toolkit; and
3. Alignment with measure slates used to assess MCP contract performance.

In evaluating performance, MassHealth looked at:

1. Change in measure rates from baseline year (MY 2020) to comparison year (MY 2022), and directionality over the three measurement periods (MY 2020-MY 2022) and
2. Comparison of MassHealth measure rates for MY 2022 to national benchmarks (e.g., NCQA Quality Compass National Medicaid and Medicare 75th percentile rate), and program specific benchmarks.

For each measure, MassHealth noted whether MassHealth's aggregate performance (weighted mean across plans) in MY 2022 was equal to, or better than, the identified benchmark. If not, MassHealth considered whether the MassHealth rate had improved from MY 2020 to MY 2022 using the "Gap to Goal" methodology outlined in CMS's guidance to Medicare-Medicaid programs on Quality Withhold methodology (available at MMP Quality Withhold Technical Notes for DY 2 through 12). Where MassHealth's MY 2022 measure rate met/exceeded the benchmark or met/exceeded the Gap to Goal improvement target, MassHealth indicated this by highlighting the cell containing either the benchmark or the Gap to Goal target, as appropriate.

The body of this report will present data on only a subset of measures that clearly relate to the quality goals referenced in the CQS. For some objectives, MassHealth provides a narrative response for which there is not a quantifiable metric to meaningfully evaluate progress, or where MassHealth is still in the process of developing a methodology to assess performance, as is the case with health disparity reductions.

The metrics used to evaluate the effectiveness of the quality strategy are closely aligned with the measure slates used to assess MCP contract performance. As a general practice, MassHealth uses standardized measure sets to evaluate both statewide and contract-level quality performance, drawing primarily on the Adult and Child Core Sets and HEDIS measures. MassHealth has endeavored to align quality measures used to assess MCP performance across the organization wherever possible. MassHealth modifies or adapts measures where appropriate to reflect the unique program populations served.

A set of appendices at the end of this Evaluation provides detailed performance data for contractually required quality metrics and the CMS Adult and Child Core Sets.

MassHealth CQS Quality Goals, Measures and Performance

Table 1: MassHealth Quality Goals and Objectives: Improve Healthcare Delivery, Experience, and Outcomes

Promote better care: Promote safe and high-quality care for MassHealth members		
1.	1.1	Focus on timely preventative, primary care services with access to integrated care and community-based services and supports
	1.2	Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations
	1.3	Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care
Promote equitable care: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience		
2.	2.1	Improve data collection and completeness of social risk factors (SRF), which include race, ethnicity, language, disability (RELD) and sexual orientation and gender identity (SOGI) data
	2.2	Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs, and assessment of member health-related social needs
	2.3	Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities
Make care more value-based: Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care		
3.	3.1	Advance design of value-based care focused on primary care provider participation, behavioral health access, and integration and coordination of care
	3.2	Develop accountability and performance expectations for measuring and closing significant gaps on health disparities
	3.3	Align or integrate other population, provider, or facility-based programs (e.g., hospital, integrated care programs)
	3.4	Implement robust quality reporting, performance and improvement, and evaluation processes
Promote person and family-centered care: Strengthen member and family-centered approaches to care and focus on engaging members in their health		
4.	4.1	Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate

	Promote better care: Promote safe and high-quality care for MassHealth members
4.2	Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports
4.3	Utilize member engagement processes to systematically receive feedback to drive program and care improvement
	Improve care through better integration, communication, and coordination across the care continuum and across care teams for our members
5. 5.1	Invest in systems and interventions to improve verbal, written, and electronic communications among caregivers to reduce harm or avoidable hospitalizations and ensure safe and seamless care for members
5.2	Proactively engage members with high and rising risk to streamline care coordination and ensure members have an identified single accountable point of contact
5.3	Streamline and centralize behavioral health care to increase timely access and coordination of appropriate care options and reduce mental health and SUD emergencies

To evaluate progress toward meeting the CQS goals and objectives, MassHealth assessed performance using the results of measures in the Core Sets and where applicable, other program specific metrics. As noted above, if a quantifiable metric to meaningfully evaluate progress is not available, or MassHealth is still in the process of developing methodology to assess performance related to that objective, MassHealth provides a narrative response

Tables 2-6 present measure rate results for each goal and objective. Narratives on attainment, and progress towards attainment of, goals follow the rate presentations.

Quality Goal 1: Promote better care: Promote safe and high-quality care for MassHealth members

Table 2: Quality Goal 1 Measures and Performance

Objective 1: Focus on timely preventative, primary care services with access to integrated care and community-based services and supports

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal

Timeliness of Prenatal Care	84.3%	88.6%	89.3%	88.3%	N/A***
Immunization for Adolescents (combo 2)	44.0%	45.4%	48.1%	40.9%	N/A***
Childhood Immunization Status Combo 3	75.8%	74.7%	75.1%	68.9%	N/A***
Childhood Immunization Status Combo 10	52.1%	52.9%	49.2%	37.6%	N/A***
Asthma Medication Ratio	69.7%	63.7%	64.1%	70.8%	69.8%
Oral Health Evaluation	N/A	51.3%	52.5%	43.3%†††	N/A***
Screening for Depression and Follow-Up	36.4%	41.1%	43.0%	49.3%†††	37.7%
Influenza Immunization (ages 18-64)	46.6%	47.4%	49.1%	46.1%	N/A***

Objective 2: Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Controlling High Blood Pressure	56.8%	64.4%	68.7%	67.3%	N/A***
HgbA1c Control for Patients with Diabetes - Poor Control (lower score is better performance)	43.3%	39.1%	33.4%	33.5%	N/A***
Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.5%	42.0%	42.1%	42.0%	N/A***
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	48.1%	46.7%	48.3%	49.0%	49.0%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	73.2%	77.7%	76.6%	82.3%	74.2%
Antidepressant Medication Management (ages 18-64) (continuation)	40.7%	46.1%	47.7%	48.5%	41.7%
Antidepressant Medication Management (ages 65+) (continuation)	65.1%	67.6%	75.6%	71.2%	N/A***

Objective 3: Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Behavioral Health Community Partner Engagement	10.5%	11.8%	10.6%	12.2%†††	11.5%

*** N/A = Gap to Goal does not apply because either MassHealth MY 2020 or MY 2022 performance was above MY 2022 benchmark

††† Where National Benchmarks were not available, program specific benchmarks were used

LTSS Community Partner Engagement	4.9%	8.1%	7.5%	9.2%†††	5.9%
Access to LTSS Coordinator within 90 days of enrollment	99.6%	98.1%	68.9%	95.0%†††	N/A***
MLTSS-7	1.71	1.84	1.78	1.0†††	N/A***
MA-PDP CAHPS Care Coordination	N/A	83.0% (Baseline)	84.0%	85.0%†††	84.0%

MassHealth has achieved Goal 1 by successfully completing the three objectives. MassHealth met or surpassed national benchmarks (75th percentile) or the Gap to Goal improvement target for most of the measures used to assess each objective. Areas that demonstrate strong performance include preventive care for children, prenatal care, dental evaluation, and care of acute and chronic conditions. Of note, MassHealth's performance exceeded national benchmarks or gap to goal targets for all measures of behavioral healthcare. Opportunities for continued progress include strengthening access to and engagement with coordinated behavioral health and LTSS services.

Quality Goal 2: Promote equitable care: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience

Table 3: Quality Goal 2 Performance

Objective 1: Improve data collection and completeness of social risk factors (SRF), which include race, ethnicity, language, disability (RELD) and sexual orientation and gender identity (SOGI) data
Objective 2: Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs, and assessment of member health-related social needs
Objective 3: Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities
Objectives 1-3 Narrative As part of its continued 1115 waiver, MassHealth engaged in developing a program focused on promoting high quality equitable care for all its members. Program implementation began in 2023 and will run through 2027. Key strategies of the implementation plan that support Objectives 1-3 include working with providers and plans (e.g., Accountable Care Organizations, hospitals, community behavioral health centers, managed care plans) to: • Collect standardized, complete RELD SOGI data on members • Stratify the rates of key quality measures by RELD SOLGI categories to identify disparities in care, and opportunities for closing those gaps. Key quality measures focus on perinatal health (e.g., severe maternal morbidity, newborn complications), acute and chronic conditions (e.g., cardiovascular, and diabetes) and behavioral health (e.g., follow-up care after hospitalizations and ED visits for members with substance use disorders and with serious mental illness). • Conduct health-related social needs screening in inpatient and outpatient settings to allow for identification of member needs at the point of service. • Identify the need for accommodations and ensure that those accommodations are provided in delivering care to members with disabilities.

To further promote health equity for the maternal population, a doula program was developed for late 2023 implementation, thereby expanding member access to doulas. For the justice involved population, partnerships have been developed and progress has been made to ensure coverage, access to, and continuity of care for the population in transition from correctional facilities to the community setting. In 2024, MassHealth received federal approval to enroll incarcerated individuals in MassHealth 90-days pre-release, thus ensuring no gaps in access to coverage.

MassHealth is on track to achieve Goal 2, making strong progress toward promoting equitable care. MassHealth completed planning and initiated provider/managed care plan engagement activities to begin HQEIP program implementation in 2023. MassHealth developed data standards and commenced collection of SRF data. Standardizing data collection will result in higher quality data, which will then be used to stratify quality measures and better enable identification of opportunities to address disparities in the future. Doula coverage and pre-release enrollment of the justice involved population have been implemented to support increased access and continuity of care for these populations.

Quality Goal 3: Make care more value-based: Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care

Table 4: Quality Goal 3 Measures and Performance

Objective 1: Advance design of value-based care focused on primary care provider participation, behavioral health access, and integration and coordination of care

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Timeliness of Prenatal Care	84.3%	88.6%	89.3%	88.3%	N/A***
Controlling High Blood Pressure	56.8%	64.4%	68.7%	67.3%	N/A***
HgbA1c Control for Patients with Diabetes - Poor Control	43.3%	39.1%	33.4%	33.5%	N/A***
Asthma Medication Ratio	69.7%	63.7%	64.1%	70.8%	70.7%
Screening for Depression and Follow-Up Plan	36.4%	41.1%	43.0%	49.3%†††	37.3%
Plan All-Cause Readmission (18-64 years, lower score is better performance)	1.1461	1.1803	1.1750	0.8982	1.1361
Plan All-Cause Readmissions (ages 65+, lower score is better performance)	1.1493	1.1558	1.2467	0.9199	1.1393

Objective 2: Develop accountability and performance expectations for measuring and closing significant gaps in health disparities

Narrative A key component of MassHealth's health quality and equity incentive program (HQEIP), is developing accountability with plans and providers through performance expectations (goals for improvement) and

performance assessment focused on measuring and closing gaps on health disparities at a statewide and individual entity level (e.g., hospitals, plans, ACOs, CBHCs). Through the stratification of quality measure, performance of sub-populations is analyzed to identify opportunities and incentives to advance performance in disparities reductions.

Strategies to support closing gaps include implementation of interventions through performance improvement projects (PIPs) The current focus of the PIPs is to identify and address potential disparities within the maternal population (e.g., prenatal and post-partum care, severe maternal morbidity), acute and chronic conditions (e.g., hypertension and diabetes) and follow-up/continuity of care between the inpatient and outpatient care settings (e.g., hospitals, primary care and community behavioral health centers). Further, the HQEIP PIPs also have a shared accountability component through which ACOs and hospitals who have overlapping patient populations partner together to work toward a shared equity goal.

Objective 3: Align or integrate other populations, provider, or facility-based programs (e.g., hospital, integrated care programs)

Narrative
Annually, MassHealth revisits its quality goals and priorities which includes an assessment of the current quality measures and their performance across value-based and non-value-based programs and across populations. During the period of 2023-2024, MassHealth embarked on a process to focus on quality priorities which resulted in increased alignment of performance measures across programs and settings. Where alignment was not feasible, MassHealth identified complementary measures that support key priorities or unique program populations and still maintained consistency across programs.

Examples of alignment achieved:
- Reduction in the number of performance measures in program specific measure slates in value-based contracts reflecting updated and more focused priorities.
- Predominant use of standard measures (with few exceptions for unique populations), applicable and comparable across populations, including increased adoption of CMS core measures.
- Aligned statewide and program goals for integration (shared accountability) and quality improvement in value-based contracts across settings with a focus on priority populations and condition areas (e.g., maternal health, acute and chronic conditions, coordination of care, behavioral health) and aligned measures and approaches toward performance assessment.

Objective 4: Implement robust quality reporting, performance and improvement, and evaluation processes

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Timeliness of Prenatal Care	84.3%	88.6%	89.3%	88.3%	N/A***
Controlling High Blood Pressure	56.8%	64.4%	68.7%	67.3%	N/A***
Follow-Up Care for Children Prescribed ADHD Medication (Initiation)	45.7%	44.5%	46.4%	48.1%	46.7%
Follow-Up Care for Children Prescribed ADHD Medication (Continuation)	54.8%	54.7%	54.4%	59.8%	55.8%

Follow-Up Care for Children Prescribed ADHD Medication	73.2%	77.7%	76.6%	82.3%	74.2%
Influenza Immunization (ages 18-64)	46.6%	47.4%	49.1%	46.1%	N/A***

MassHealth has made strong progress towards meeting Goal 3, meeting or surpassing national benchmarks (75th percentile) or the Gap to Goal improvement target for most of the measures used to assess this goal. Objective 2 has been achieved with the development and implementation of MassHealth's health quality and equity incentive program (HQEIP), which has established accountability and performance expectations associated with addressing and closing the disparity gaps in the quality of care. Objective 3 has been achieved in establishing more aligned and focused measure slates for the start of new programs (e.g., ACO, hospital programs) and core measure reporting for 2023.

Quality Goal 4: Promote person and family-centered care: Strengthen member and family-centered approaches to care and focus on engaging members in their health

Table 5: Quality Goal 4 Measures and Performance

Objective 1: Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
CAHPS how well doctors communicate	91.5%	91.7%	94.0%	94.0%	N/A***
CAHPS customer service	89.0%	87.6%	90.7%	91.1%	90.0%
Integrated care CAHPS: Getting Needed Care	80%	79%	78%	80%†††	N/A*

Objective 2: Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Willingness to Recommend- CG-CAHPS	85.2%	85.3%	84.5%	92.0%†††	86.2%
Communication- CG-CAHPS	87.1%	87.6%	86.9%	92.0%†††	88.1%
Integration of Care-CG-CAHPS	78.1%	78.6%	78.1%	85.0%†††	79.1%
Knowledge of Patient- CG-CAHPS	81.6%	82.0%	81.5%	85.0%†††	82.6%
Medicare Advantage Prescription Drug Plan CAHPS:	89%	85%	89%	83%†††	N/A***

Rating of health plan					
Medicare Advantage Prescription Drug Plan CAHPS: Care coordination	N/A	83% (Baseline)	84%	85%†††	83.2%
Medicare Advantage Prescription Drug Plan CAHPS: Customer service	91%	90%	90%	87%†††	N/A***

Objective 3: Utilize member engagement processes to systematically receive feedback to drive program and care improvement.

Narrative Response

MassHealth engaged members through internal and external processes to help drive improvements in programs and care. Member-focused councils (e.g., One Care Implementation Council, MassHealth Member Advisory Committee) have met on a scheduled cadence. MassHealth also is invited to meet periodically with disability advocates and with eligibility advocates. Through these processes, groups discuss a range of topics to drive annual program development, implementation and quality improvement. Topics have included understanding the health care needs and challenges of the population, quality improvement and experience of care priorities, identification of key quality measures for specific programs for monitoring and accountability, and review of quality performance and actionability for next steps to improve care. MassHealth also requires its contracted plans and hospitals to engage members through consumer advisory and patient family advisory councils to enable additional shared feedback and input from members.

Performance on Goal 4 has stabilized with performance beginning to trend upward. For Goal 4, MassHealth has made strong progress in achieving the associated objectives. MassHealth met or surpassed national benchmarks (75th percentile) or met the Gap to Goal improvement target for approximately half of the measures used to assess this goal. The impact of COVID where there were real barriers with members accessing routine in-person care was a clear factor in lower than benchmark performance and improvements. Benchmarks used for program specific measures (absent of national benchmarks) were established based on historical performance prior to the public health emergency (COVID) and were challenging to achieve. Post PHE, the goal for stable and gradual improvement is expected with a return to accessible face-to-face member care, and with fewer provider resources focused on PHE. Member engagement processes also were impacted by PHE where there was a pause in engagement processes, with limited ability to engage with members and slow recovery or new processes (e.g., use of remote meetings).

Quality Goal 5: Improve care through better integration, communication, and coordination across the care continuum and across care teams for our members

Table 6: Quality Goal 5 Measures and Performance

Objective 1: Invest in systems and interventions to improve verbal, written, and electronic communications among caregivers to reduce harm or avoidable hospitalizations and ensure safe and seamless care for members

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Screening for Depression and Follow-Up Plan	36.4%	41.1%	43.0%	49.3%†††	37.3%
Follow-Up Care for Children Prescribed ADHD Medication (Initiation)	45.7%	44.5%	46.4%	48.1%	46.7%
Follow-Up Care for Children Prescribed ADHD Medication (Continuation)	54.8%	54.7%	54.4%	59.8%	55.8%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	73.2%	77.7%	76.6%	82.3%	74.2%
Plan All-Cause Readmission (18-64 years)	1.1461	1.1803	1.1750	0.8982	1.1361
Plan All-Cause Readmissions (ages 65+)	1.1493	1.1558	1.2467	0.9199	1.1393

Objective 2: Proactively engage members with high and rising risk to streamline care coordination and ensure members have an identified single accountable point of contact

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.5%	42.0%	42.1%	42.0%	N/A***
Follow-Up Care for Children Prescribed ADHD Medication (Initiation)	45.7%	44.5%	46.4%	48.1%	46.7%
Follow-Up Care for Children Prescribed ADHD Medication (Continuation)	54.8%	54.7%	54.4%	59.8%	55.8%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	73.2%	77.7%	76.6%	82.3%	74.2%
Antidepressant Medication Management (Acute, Ages 18-64)	54.8%	62.0%	64.7%	66.1%	55.9%
Antidepressant Medication Management (Acute, Ages 65+)	78.9%	79.7%	85.4%	85.1%	N/A***

Objective 3: Streamline and centralize behavioral health care to increase timely access and coordination of appropriate care options and reduce mental health and SUD emergencies

Measure	MassHealth MY2020 Rate (Baseline)	MassHealth MY2021 Rate	MassHealth MY2022 Rate	National Benchmark MY2022 75th	Gap to Goal
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	48.1%	46.7%	48.3%	49.0%	49.0%
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	17.5%	16.7%	18.3%	18.8%	18.5%
Follow-Up After Emergency Department Visit for Alcohol and	22.9%	21.3%	43.1%	30.3%	N/A***

Other Drug Abuse or Dependence (7-day)					
Follow-Up After Hospitalization for Mental Illness (7-day)	45.8%	43.3%	40.3%	39.5%	N/A***
Follow-Up After Emergency Department Visit for Mental Illness (7-day)	73.5%	74.5%	72.9%	45.1%	N/A***

MassHealth made significant progress towards achieving Goal 5 by accomplishing a majority of the objectives. MassHealth met or surpassed national benchmarks (75th percentile) or met the Gap to Goal improvement target for more than 50% of measures used to assess this goal. The areas with the strongest performance fell within the behavioral health domain and specifically included, follow-up care, chronic disease management among those with mental health diagnoses, and depression management. Opportunities for continued progress include strengthening initiation and engagement of alcohol, opioid, or other drug abuse or dependence treatment, plan all-cause readmission, and follow up care for children prescribed ADHD medication.

CMS Child and Adult Core Set Performance

Below are summaries of MassHealth's reporting on the 2023 Adult and Child Core Measure Sets and an indication of how MassHealth's rates compare to those reported by other states. Measures in the 2023 Core Measure Sets generally report on services delivered in CY2022. Measures are included in the table below only for measures which meet CMS' standards for data quality and on which at least 25 states reported.

CHILD CORE 2023 MEASURE SET

MassHealth reported all 27 measures in the 2023 Child Core Measure set (note, this number includes measures calculated by CMS from other data sources).

Rates for 26 measures met the criteria for being reported by CMS across all states. In December 2024, CMS issued a chart pack that indicated into which quartile a state's rate for any measures fell, as compared with the rate from all other states that reported on that measure.

In the table below, measures where MassHealth rates fall into the bottom two quartiles are highlighted in red.

Table 7: MassHealth Child Core Measure Set Percentile Ranking

Measure Name	MA Quartile 2023 Core Set
Well-Child Visits in the First 30 months of Life – both sub measures	1
Child and Adolescent Well-Care Visits – all sub measures	1
Childhood Immunization Status – MMR, Flu, Combination 3 and Combination 10	1
Immunizations for Adolescents – HPV, Combination 1	1
Developmental Screening in the First Three Years of Life	1
Chlamydia Screening in Women Ages 16 to 20	1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – all sub measures	1
Prenatal and Postpartum Care: Timeliness of Prenatal Care	1

Live Births Weighing Less than 2500 Grams (Measure calculated by CMS using other data sources)	2
Low-Risk Cesarean Delivery (Measure calculated by CMS using other data sources)	3
Contraceptive Care – Postpartum Women Ages 15-20	N/A
• Most/Moderately Effective Methods - 3- and 60-days PP	1
• LARC Methods – 3- and 60-days PP	1
Contraceptive Care – All Women Ages 15-20	N/A
• Most/Moderately Effective Methods	1
• LARC	2
Asthma Medication Ratio	N/A
• Ages 5-11	4
• Ages 12-18	4
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis Ages 3 months to 17 years	1
Ambulatory Care: ED Visits	2
Follow-up After Emergency Department Visit for Substance Use - 7 and 30 days	1
Follow-up After Emergency Department Visit for Mental Illness – 7 and 30 days	1
Follow-up After Hospitalization for Mental Illness – 7 and 30 days	1
Follow-up Care for Children Prescribed ADHD Medication – Initiation and Continuation sub measures	2
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	1
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total and separate glucose and cholesterol sub measures	1
Oral Evaluation, Dental Services	1
Topical Fluoride for Children	1
Sealant Receipt on Permanent First Molars – all 4	1
CAHPS 5.1H Child Version	N/A
• Percent of children always getting needed care	3
• Percent of children who always got care quickly	4
• Percent of children whose doctor always communicated well	3
• Percent of children whose health plan's customer service always gave helpful information and was courteous and respectful	4
• Percent of children whose personal doctor was rated 9 or 10	2
• Percent of children whose specialist was rated 9 or 10	4
• Percent of children whose health care was rated 9 or 10	3
• Percent of children whose health plan was rated 9 or 10	4

ADULT CORE 2023 MEASURE SET

MassHealth reported 30 of the 34 measures in the 2023 Adult Core Measure set. Rates for 30 measures met the criteria for being reported by CMS across all states. In December 2024, CMS issued a chart pack that indicates into which quartile a state's rate fell, as compared with the rate from all other states that reported on the measure.

In the table below, measures where MassHealth rates fall into the bottom two quartiles are highlighted in red.

Table 8: MassHealth Adult Core Measure Set Percentile Rankings

Measure Name	MA Quartile 2023
Breast Cancer Screening	1
Cervical Cancer Screening	1
Colorectal Cancer Screening – both age cohorts	1
Chlamydia Screening in Women Ages 21- 24	1
Flu Vaccinations for Adults ages 18-64	1
Prenatal and Postpartum Care: Postpartum Care	1
Contraceptive Care – Postpartum Women Ages 15-20	N/A
• Most/Moderately Effective Methods - 3- and 60-days PP	1
• LARC Methods – 3- and 60-days PP	1
Contraceptive Care – All Women Ages 21 - 44	N/A
• Most/Moderately Effective Methods	1
• LARC	1
Asthma Medication Ratio	N/A
• Ages 19-50	3
• Ages 51-64	3
Avoidance of Antibiotic Treatment for Acute Bronchitis and Bronchiolitis Age 18 and Older	1
Controlling High Blood Pressure	1
Comprehensive Diabetes Care: Poor A1c Control and A1c in control	1
Plan All-Cause Readmission	4
Diabetes Short-term Complications Admission Rate (PQI01)	1
COPD or Asthma in Older Adults Admission Rate (PQI05)	3
Heart Failure Admission Rate (PQ108)	2
Asthma in Younger Adults Admission Rate (PQI15)	2
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older	1
Follow-up After Emergency Department Visit for Substance Use - 7 and 30 days	1
Follow-up After Emergency Department Visit for Mental Illness – 7 and 30 days	1
Follow-up After Hospitalization for Mental Illness – 7 and 30 days	2
Initiation and Engagement of AOD Abuse or Dependence Treatment	N/A
• Initiation (total)	2
• Engagement (total)	2
Medical Assistance with Smoking and Tobacco Use Cessation	N/A
• Advising Smokers to Quit	1
• Discussing Cessation Medications	1
• Discussing Cessation Strategies	1
Antidepressant Medication Management	N/A
• Acute	1
• Chronic	1

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	3
Use of Pharmacotherapy for Opioid Use Disorder	1
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1
Use of Opioids at High Dosage in Persons Without Cancer	3
Concurrent Use of Opioids and Benzodiazepines	1

CAHPS 5.1H Adult Version

• Percent always getting needed care	3
• Percent who always got care quickly	3
• Percent whose doctor always communicated well	2
• Percent whose health plan's customer service always gave helpful information and was courteous and respectful	3
• Percent whose personal doctor was rated 9 or 10	3
• Percent whose specialist was rated 9 or 10	2
• Percent whose health care was rated 9 or 10	1
• Percent whose health plan was rated 9 or 10	3
National Core Indicators Survey (survey administered in MA by DDS)	3
• Everyday Choices Scale	4
• Always has a way to get places	3

For more details on Adult and Child Core Set Performance see Appendix C.

State Responsiveness to External Quality Review Organization (EQRO) Recommendations

MassHealth's CY 2024 External Quality Review reports (review period CY 2023) included several recommendations that the EQRO made to improve and revise the 2025 CQS and associated activities. The following section highlights those EQRO recommendations and MassHealth's responses.

EQR Recommendations and MassHealth Responses

Quality Strategy Recommendations

Recommendation #1: Recommendation towards achieving the goals of the Medicaid quality strategy: MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy.

MassHealth Response to Recommendation #1: MassHealth conducts a thorough evaluation of the effectiveness of the Quality Strategy on a triennial basis. In addition, MassHealth calculates the Adult and Child Core Measures annually, and then maps them to the five strategic goals objectives in order assess progress. We anticipate that moving forward MassHealth will share the results of this assessment with the Quality Strategy Management Committee and Executive leadership. We will also assess the feasibility of sharing progress publicly.

Performance Improvement Projects (PIPs) Recommendations: Massachusetts EQRO made several recommendations to the performance improvement projects process and they are listed below:

Recommendation #2: Standardized structure and reporting requirements should be established to define and describe PIP aims and interventions

Recommendation #3: All Plans should be required to conduct an initial barrier analysis at the outset of every PIP and document it in PIP proposal submission. Additionally, Plans should be required/expected to conduct additional analyses throughout the process as additional barriers are discovered.

Recommendation #4: For each PIP intervention, Plans should be required to track implementation progress with at least one intervention-specific process measure. Rates should be tracked/reported on at least a quarterly basis throughout the PIP cycle.

Recommendation #5: Plans should be required to document modifications made to interventions throughout the PIP cycle in a uniform fashion within the PIP template.

Recommendation #6: Plans should be required to document efforts to promote sustainability and spread in a standardized manner across all interventions (and PIPs) in the final PIP report.

MassHealth Response to PIP Recommendations: Most of the PIP recommendations focus on PIP development and reporting processes.   To address process recommendations, MassHealth worked closely with their EQRO to update and improve the PIP reporting process. Some of that work included improving the reporting template, offering technical assistance to plans, and increasing the rigor of the PIP implementation and reporting process. Technical assistance occurred through virtual trainings and individual meetings with plans to address specific areas of concern.

Performance Measure Validation Recommendations

Recommendation #7: Recommendation towards better medical record chart abstraction and encounter submission: ACPPs and MassHealth should enhance their oversight of the medical record review processes to ensure the accuracy of abstracted data reported by the ACPPs. ACPPs should ensure that the charts used for medical record abstraction are maintained and readily available for validation purposes. ACPPs and MassHealth should also improve oversight of encounters submitted by ACPPs to ensure data accuracy.

MassHealth Response to Recommendation #7: For medical record review, MassHealth does provide guidance, training, and technical assistance as necessary to the plans to support medical record abstraction for the hybrid measures. MassHealth does see an opportunity to better understand the process by which ACPPs and PCACOs abstract clinical data and may consider requiring them to upload medical records into the clinical repository tool. MassHealth's data integrity team works closely with our managed care plans to ensure encounter data is submitted correctly and according to MassHealth's specifications. As data integrity issues arise, MassHealth's Quality Office alerts the Data Integrity Office; the Data Integrity Team then works with the managed care plans to resolve any issues.

Recommendation #8: Recommendation towards better performance on quality measures: MassHealth should continue to leverage the quality measures data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions.

MassHealth Response to Recommendation #8: MassHealth annually reviews performance on quality measures to support quality improvement and performance management activities. MassHealth will continue these efforts and consider ways to expand the application of the quality measure data.

Compliance Review Recommendations

Recommendation #9: Recommendation towards better policy documentation: To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish and maintain well-defined policies and procedures.

MassHealth Response to Recommendation #9: MassHealth will continue to use its touch points, which include office hours, medical directors' meetings, performance management meetings, and individual interactions with plans to encourage the consistency in implementation of policies and procedures. We will also assess the contracts to explore whether additional language could be added to support the establishment and maintenance of well-defined policies and procedures.

Recommendation #10: Recommendation towards using plain language in contractual requirements: To improve clarity, accessibility, and compliance, MassHealth should use plain language and express contractual requirements in straightforward terms that can be easily understood by a broader audience.

MassHealth Response to Recommendation #10: MassHealth annually reviews its managed care contracts to ensure consistency and accuracy. MassHealth will use the results of the compliance audit to help identify any areas of ambiguity within the contracts and change the language, where necessary, for improved clarity.

Recommendation #11: Recommendation towards addressing gaps identified through the compliance review: To effectively address the areas of non-compliance, MassHealth should establish direct communication with the MCP to discuss the identified issue, provide the MCP with a detailed explanation of the requirements that were not being met, and collaborate to develop a resolution strategy.

MassHealth Response to Recommendation #11: MassHealth program management staff have contract management staff that have direct relationships with the plans to address identified gaps. MassHealth is in the process of establishing a more standardized process for specifically addressing and following up on areas of non-compliance with the plans.

Recommendation #12: Suggestion towards addressing program wide weakness in Care Coordination: MassHealth could consider addressing the gap in compliance related to care coordination, specifically in the area of care management process (ensuring timely assessments are completed, care plans are developed and updated per requirements, discharge planning is completed) and care plan documentation (assessments, care plans, member sign-off, etc.). While there were minor gaps in policy documentation across the MCPs, the key driver of lower compliance scores in this domain is found in the area of care management file reviews.

MassHealth Response to Recommendation #12: In Fall 2023, the Integrated Care Clinical Team launched the Clinical Performance Improvement (CPI) initiative. A key component of the CPI is to evaluate and improve Care Coordination Performance Management across our SCO and One Care plans. As part of this work, the team will be doing quarterly Denial, Appeal, and Grievance and Care Plan audits to evaluate the effectiveness of our plans' care coordination/management processes. Each of these audits will include a thorough review of selected members individualized care plans.

Network Adequacy Validation Recommendations

Recommendation #13: Recommendations towards network data integrity: The format of the submission templates should be adjusted to improve data submission accuracy and reduce duplications of the data

MassHealth Response to Recommendation #13: MassHealth worked with their EQRO to modify the data submission templates, which resulted in an improved submission process and better data quality. Some entities continued to have data issues, and we are exploring other opportunities for improvement.

Recommendation #14: Recommendations towards measurable network adequacy standards: MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access. MassHealth should share with MCPs the definitions of the network adequacy indicators that were identified for the purpose of this EQR

MassHealth Response to Recommendation #14: MassHealth has worked with the EQRO to arrive at clear, operational definitions of network adequacy standards and have documented those. MassHealth is still in the process of determining the best way to share operational definitions of network adequacy standards with the plans to ensure consistency of interpretation.

Recommendation #15: Recommendations towards better provider directories: The findings from the 2023 Provider Directory Audit should be used to improve and develop further network adequacy activities

MassHealth Response to Recommendation #15: MassHealth's ACO program sorted through the incorrect data that was identified through the Provider Directory Audit and shared it with all plans. They then conducted meetings with each plan go over the data.

In Spring of 2023, the Integrated Care Contract Management Team worked with CMS to implement an in-depth tracker for all SCO and One Care plans, which allows us to see all approvals, denials, appeals, grievances, etc. With this information, we use the Provider Directory Audit to evaluate out of network denial and low utilization from the view of provider directory usability and how availability and access is reflected in these directories. We review these data points monthly with our One Care Plans and every six weeks with our SCO plans. This review results in MassHealth requesting root cause analysis and in depth looks at network adequacy pain points.

Member Experience of Care Survey Recommendations

Recommendation #16: Recommendation towards better performance on CAHPS measures: MassHealth should continue to utilize CAHPS data to evaluate MCPs' performance and to support the development of major initiatives, and quality improvement strategies, accordingly

MassHealth Response to Recommendation #16: MassHealth reviews the CAHPS data annually and are included in the majority of our quality measure slates, including slates that are tied to quality incentive payments or withholds. CAHPS measures are also included as key performance indicators.

Recommendation #17: Recommendation towards sharing information about member experiences: IPRO recommends that MassHealth publish summary results from member experience surveys on the MassHealth Quality Reports and Resources website and make the results available to MassHealth Enrollees

MassHealth Response to Recommendation #17: MassHealth is in the process of updating its Quality website and anticipates sharing member experience data in the future.

Recommendation #18: Recommendation towards better performance on member experience of care measures: Considering the high scores and some measures reaching 100% satisfaction, MassHealth should discuss with MBHP a possibility of refining or expanding the survey to capture more nuanced feedback. MassHealth should work with MBHP to review complaints and grievances to identify additional survey questions and areas for improvement

MassHealth Response to Recommendation #18: MassHealth is in the process of revising its member experience strategy and will consider how to better work with MBHP to capture more nuanced feedback.

Recommendation #19: Recommendation towards adhering to CMS Child Core Set reporting guidance: To adhere to Medicaid Child Core Set reporting guidance issued by CMS, all measure-eligible Medicaid and CHIP beneficiaries would have to be included in the state reporting of the child CAHPS Health Plan survey measure. This includes children enrolled in multiple delivery systems, like managed care, primary care case management, and fee for service

MassHealth Response to Recommendation #19: MassHealth has modified its Core Measure calculation and reporting process to include mandatory MassHealth populations. Where data was unavailable for all applicable populations MassHealth followed the exemption request process and received approval from CMS to exclude certain relevant populations from specific measures. MassHealth continues to move forward with the same process for future Core Measure reporting cycles.

Recommendation #20: Recommendation towards an effective evaluation of ACO's performance on member experience measures: IPRO recommends establishing benchmarks for all member experience measures to enhance the effectiveness of performance evaluation and support continuous quality improvement

MassHealth Response to Recommendation #20: MassHealth is working to identify benchmarks for all member experience domain areas (category composite areas of experience) to enhance the effectiveness of the performance evaluation and support continuous quality improvement. Below are the 12 domain areas for which the state will include benchmarks based on a threshold and goal respectively, informed by ACO percentiles (e.g., 25th/75th, 25th/90th).

- Communication
- Knowledge of Patient
- Willingness to Recommend
- Integration of Care
- Office Staff
- Organizational Access
- Self-management Support
- Overall Provider Rating

- Trust

- Adult Behavioral Health (Adults 18+ only)

- Child Development (Children <18 only)

- Pediatric Prevention (Children <18 only)

Progress On Quality Strategy Goals and Objectives and Goal Revision

For this evaluation, MassHealth identified a set of quality measures, largely drawn from the CMS Adult and Child Core Measure Sets, to evaluate progress towards meeting the five Quality Strategy (QS) goals and their associated objectives. Additionally, MassHealth established a scoring rubric to describe achievement of each individual goal and objective, as well as the overall quality strategy, as noted below:

- *Achieved* – MassHealth met the MY2022 benchmark or Gap to Goal improvement target **more than 50%** of the time.
- *Making Progress* – MassHealth met the MY2022 benchmark or Gap to Goal improvement target **50%** of the time; or made significant progress towards implementing necessary processes needed to ensure future achievement.
- *Opportunity for Improvement* – MassHealth met the My2022 benchmark of Gap to Goal improvement target **less than 50%** of the time.

Table 9 summarizes the extent to which MassHealth achieved each individual QS goal and objective.

Table 9: Performance on Quality Strategy Goals and Objectives

Objectives	Number of Measures Improved	Scoring Designation

Goal 1: Promote safe and high-quality care for MassHealth members

Designation: Achieved

Objective 1: Focus on timely preventative, primary care services with access to integrated care and community-based services and supports	7/8	Achieved
Objective 2: Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations	6/7	Achieved
Objective 3: Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care	3/5	Achieved

Goal 2: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience

Designation: Making progress

Objective 1: Improve data collection and completeness of social risk factors (SRF), which include race, ethnicity, language, disability (RELD) and sexual orientation and gender identity (SOGI) data	Narrative	Making Progress
Objective 2: Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs, and assessment of member health-related social needs	Narrative	Making Progress
Objective 3: Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities	Narrative	Making Progress

Goal 3: Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care

Designation: Making progress

Objective 1: Advance design of value-based care focused on primary care provider participation, behavioral health access, and integration and coordination of care	4/7	Achieved
Objective 2: Develop accountability and performance expectations for measuring and closing significant gaps on health disparities	Narrative	Making Progress
Objective 3: Align or integrate other population, provider, or facility-based programs (e.g., hospital, integrated care programs)	Narrative	Making Progress
Objective 4: Implement robust quality reporting, performance and improvement, and evaluation processes	4/6	Achieved

Goal 4: Strengthen member and family-centered approaches to care and focus on engaging members in their health

Designation: Making progress

Objective 1: Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate	2/3	Making progress
Objective 2: Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports	3/7	Opportunity for Improvement
Objective 3: Utilize member engagement processes to systematically receive feedback to drive program and care improvement	Narrative	Making Progress

Goal 5: Improve care through better integration, communication, and coordination across the care continuum and across care teams for our members

Designation: Achieved

Objective 1: Invest in systems and interventions to improve verbal, written, and electronic communications among caregivers to reduce harm or avoidable hospitalizations and ensure safe and seamless care for members	2/6	Opportunity for Improvement
Objective 2: Proactively engage members with high and rising risk to streamline care coordination and ensure members have an identified single accountable point of contact	4/6	Achieved
Objective 3: Streamline and centralize behavioral health care to increase timely access and coordination of appropriate care options and reduce mental health and SUD emergencies	3/5	Achieved

As noted in Table 9 above, MassHealth fully achieved QS goals 1 and 5, meeting the MY2022 benchmark or Gap to Goal improvement target for 3 out of 3 and 2 out of 3 objectives respectively. Of the remaining three QS goals (2, 3, and 4), MassHealth has made progress towards achievement. For goal 2, the majority of MassHealth's work was primarily focused on building capacity and infrastructure to measure, track, and eventually reduce health care inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors. With the implementation of these processes, MassHealth expects to be able to objectively measure progress towards achievement of goal 2 in the future. For Goals 3 and 4, MassHealth performance on objectives was mixed, meeting the benchmark or improvement point target on some objectives, making progress towards implementing processes on the other objectives, and needing improvement on at least 1 objective.

While MassHealth is encouraged by the considerable progress it has made towards meeting its QS goals and objectives, opportunities for improvement remain particularly in the member experience (Objective 4.2) and communication and safety (Objective 5.1) domains. Since its primary aim is to achieve all goals and objectives, MassHealth intends to maintain several of the current quality goals, revising them, where appropriate, for clarity and to reflect evolving agency priorities.

Appendices

Appendix A: MassHealth Managed Care Plans

Appendix B: Quality Measure Performance (Contract Level), 2018–2020

Appendix C: CMS Adult and Child Core Measure Sets Performance (Calculated and Reported by MassHealth)

Appendix D: 2020 EQR Performance Improvement Projects (PIPs)

Appendix A: MassHealth Managed Care Plans

Program	MCP Type	Managed Care Authority	Name of Plan
Accountable Care Organization (ACO) **ACO (ACPP)**	MCE	1115	• Be Healthy Partnership • Berkshire Fallon Health Collaborative • BMC HealthNet Plan Community Alliance • BMC HealthNet Plan Mercy Alliance • BMC HealthNet Plan Signature Alliance • BMC HealthNet Plan Southcoast Alliance • Fallon 365 Care • My Care Family • Tufts Health Together with Atrius Health • Tufts Health Together with Beth Israel Deaconess Care Organization (BIDCO) • Tufts Health Together with Boston Children's ACO • Tufts Health Together with Cambridge Health Alliance (CHA) • Wellforce Care Plan
ACO (PCACO)	PCCM entity	1115	• Community Care Cooperative (C3) • Mass General Brigham • Steward Health Choice
MCO-Administered ACO	MCE	1115	• Lahey-MassHealth Primary Care Organization
Managed Care Organization (MCO)	MCE	1115	• BMC HealthNet Plan • Tufts Health Together
Senior Care Options (SCO)	MCE	1915(a)/1915(c)	• BMC HealthNet Plan Senior Care Options • Commonwealth Care Alliance • NaviCare (HMO) • Senior Whole Health • Tufts Health Plan Senior Care Options • United HealthCare
One Care	MCE	Demonstration	• Commonwealth Care Alliance • Tufts Health Plan Unify • United HealthCare Connected
PCC Plan	PCCM	1115	NA (MassHealth)
Behavioral Health Plan	PIHP	PIHP	• Massachusetts Behavioral Health Partnership (MBHP)

Appendix B: Quality Measure Performance (Contract Level), 2020-2022

Appendix B-3: Contract Level Performance, MY2020 (ACO and MCO Programs)

2020 quality measure performance for individual ACO and MCO plans is presented in Table B-3. Program-level totals are weighted means (WM). Please see Appendix A for a list of MassHealth's managed care plans.

- **"--" indicates that the measure or target was not available, not required, not collected, or not calculated.**
- **"NA" indicates that the rate was not included due to small denominator (n <30).**

Ref	2020 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
CIS	Childhood Immunization Status (combo 10)	57.1%	40.9%	58.4%	40.3%	51.3%	44.5%	64.3%	55.2%	70.4%	57.5%	61.1%	48.5%	61.9%	47.5%	64.9%	60.7%	52.3%	NA	38.5%	22.0%	55.1%
PPC	Timeliness of Prenatal Care	84.5%	82.3%	90.8%	67.6%	90.5%	95.9%	73.7%	82.5%	92.1%	57.6%	82.2%	77.1%	85.9%	81.7%	89.0%	85.6%	83.7%	70.4%	75.0%	64.0%	86.0%
IMA	Immunization for Adolescents (combo 2)	44.6%	15.7%	39.2%	38.7%	47.2%	54.1%	33.3%	23.6%	56.0%	45.5%	56.8%	40.4%	55.8%	56.6%	63.7%	28.7%	35.5%	NA	31.9%	21.8%	42.0%
EOHHS /ADA	Oral Health Evaluation	44.7%	39.6%	49.2%	49.9%	38.8%	48.0%	50.5%	40.3%	46.9%	46.3%	38.5%	44.1%	44.3%	36.8%	42.5%	48.1%	42.8%	33.1%	41.2%	37.2%	43.2%
EOHHS	Health-Related Social Needs Screening	18.4%	6.3%	6.3%	3.4%	6.1%	5.6%	19.5%	14.6%	14.4%	47.4%	29.4%	18.7%	0.2%	13.4%	23.6%	17.3%	2.2%	0.0%	-	-	-
CBP	Controlling High Blood Pressure	61.4%	59.4%	69.1%	58.2%	60.6%	61.6%	65.5%	57.9%	60.3%	59.7%	57.4%	68.9%	69.0%	70.8%	51.3%	68.6%	68.1%	54.7%	39.0%	25.9%	52.1%
AMR	Asthma Medication Ratio	59.5%	68.9%	79.9%	77.6%	57.3%	58.5%	63.5%	59.0%	51.2%	73.0%	54.2%	65.5%	50.4%	47.6%	57.6%	55.9%	55.9%	47.7%	55.7%	50.8%	57.3%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	40.8%	41.8%	32.4%	34.8%	41.8%	40.3%	35.1%	31.3%	46.6%	65.9%	43.1%	40.0%	31.8%	37.9%	42.6%	37.8%	48.1%	42.6%	53.4%	67.8%	39.1%
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.2322	1.5292	1.3217	1.5886	1.1258	1.0737	1.2513	1.1819	1.3088	1.2928	1.3510	1.0038	1.4405	1.0783	1.2497	1.1740	1.1020	1.2006	8.3%	5.3%	11.2%
EOHHS	Risk adjusted ratio (obs/exp) of ED visits for members 18-65 identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	1.4560	1.3665	1.3107	1.4966	1.1816	1.4016	1.2682	1.5251	1.7839	1.7350	1.5331	1.2101	1.3772	1.2107	1.5674	1.3215	1.5447	1.3974	1.2168	1.2584	1.1782
EOHHS	Risk adjusted ratio (obs/exp) of Acute Unplanned Admissions for Individuals with Diabetes (Adult)	0.6570	0.6277	0.5244	0.6138	0.5639	0.7258	0.6553	0.7006	0.7347	0.7999	0.6482	0.5866	0.8183	0.6209	0.6572	0.6486	0.7040	0.7911	0.7379	0.7472	0.7295

Ref	2020 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	46.4%	59.6%	58.0%	39.8%	53.2%	36.1%	36.3%	48.8%	63.1%	31.5%	49.0%	47.1%	57.7%	42.1%	47.0%	41.5%	41.4%	55.0%	54.4%	56.3%	52.8%
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	15.9%	22.0%	13.0%	14.1%	16.4%	13.1%	12.0%	13.1%	17.0%	5.7%	17.9%	19.3%	17.1%	18.1%	17.6%	13.3%	15.1%	15.5%	21.7%	21.7%	21.6%
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	48.2%	39.4%	49.3%	37.0%	49.8%	32.9%	47.1%	39.1%	56.5%	54.6%	46.7%	64.6%	51.6%	52.6%	49.3%	52.6%	46.6%	48.6%	44.8%	46.2%	43.8%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	73.1%	68.9%	84.9%	74.5%	75.8%	66.8%	77.1%	65.4%	70.0%	84.4%	70.3%	75.7%	66.1%	79.2%	72.7%	73.9%	68.9%	69.4%	73.0%	70.4%	74.9%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.7%	18.4%	27.7%	35.9%	37.7%	61.0%	50.3%	NA	33.3%	37.0%	41.1%	33.3%	52.8%	48.8%	40.8%	34.1%	38.8%	NA	28.1%	16.3%	30.7%
DSF	Screening for Depression and Follow-Up Plan	37.1%	8.7%	25.0%	25.6%	39.3%	22.8%	16.1%	35.4%	31.8%	57.5%	36.0%	8.8%	39.2%	92.0%	48.3%	40.9%	33.9%	28.8%	–	–	–
DRR	Depression Remission or Response	3.4%	1.2%	NA	0.7%	1.1%	5.4%	0.0%	4.5%	0.7%	1.9%	7.2%	3.4%	5.0%	9.1%	9.5%	0.0%	1.2%	9.2%	–	–	–
EOHHS	LTSS Community Partner Engagement	4.9%	11.1%	6.8%	11.5%	2.7%	11.1%	4.9%	3.9%	5.1%	6.2%	4.3%	5.1%	2.7%	5.2%	6.8%	2.8%	3.6%	4.4%	4.5%	3.8%	5.2%
EOHHS	Community Tenure - BSP (Risk adjusted O/E ratio)	1.4001	0.7194	0.7741	1.0932	1.1979	0.8334	0.9439	1.1031	0.9283	0.7500	1.7257	1.4910	1.7097	1.4943	1.4492	1.5555	1.3731	1.1536	1.5260	1.9929	1.0077
EOHHS	Community Tenure - LTSS (non-BSP) Risk adjusted O/E ratio	1.9144	1.3621	1.1632	1.0303	1.3599	2.1370	1.5113	2.2548	2.0592	1.3107	2.3243	1.4286	3.2018	1.8086	1.8586	2.0781	2.1844	2.0115	1.9440	2.1147	1.7023
EOHHS	Behavioral Health Community Partner Engagement	10.5%	10.3%	17.0%	12.7%	12.4%	17.6%	16.2%	10.8%	7.5%	NA	11.4%	10.6%	12.9%	10.0%	8.3%	7.9%	10.2%	9.1%	4.1%	3.4%	4.7%
EOHHS	Adult: Overall Rating and Care Delivery: Willingness to recommend	85.2%	85.2%	87.5%	85.3%	81.2%	85.0%	87.6%	83.7%	83.8%	91.5%	83.0%	82.1%	82.8%	88.7%	82.3%	86.8%	86.1%	87.8%	–	–	–
EOHHS	Child: Overall Rating and Care Delivery: Willingness to recommend	90.9%	89.8%	92.3%	92.0%	87.6%	88.6%	93.6%	89.8%	91.0%	92.1%	89.0%	89.5%	89.7%	93.4%	86.8%	92.3%	93.2%	82.3%	–	–	–

Ref	2020 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
EOHHS	Adult: Overall Rating and Care Delivery: Communication	87.1%	86.3%	88.4%	86.8%	84.2%	87.5%	89.5%	85.2%	86.1%	93.4%	87.3%	84.5%	85.0%	89.4%	84.2%	88.0%	88.1%	87.8%	-	-	-
EOHHS	Child: Overall Rating and Care Delivery: Communication	91.2%	91.4%	91.3%	90.5%	90.4%	91.0%	93.7%	89.8%	89.9%	92.7%	89.9%	91.6%	89.7%	93.0%	87.2%	91.8%	93.4%	81.3%	-	-	-
EOHHS	Adult: Person-Centered Integrated Care: Integration of Care	78.1%	75.0%	80.6%	79.6%	71.7%	75.4%	80.4%	75.4%	72.4%	82.6%	74.8%	75.3%	74.2%	80.2%	72.0%	78.0%	78.0%	78.8%	-	-	-
EOHHS	Child: Person-Centered Integrated Care: Integration of Care	80.2%	84.5%	81.7%	75.6%	77.4%	77.0%	83.2%	78.4%	74.7%	82.2%	77.9%	79.7%	76.7%	84.2%	73.3%	78.4%	82.3%	64.3%	-	-	-
EOHHS	Adult: Person-Centered Integrated Care: Knowledge of Patient	81.6%	80.1%	82.8%	83.0%	78.7%	82.1%	84.0%	80.4%	80.0%	89.6%	80.8%	77.5%	79.8%	83.6%	78.1%	82.6%	82.8%	83.4%	-	-	-
EOHHS	Child: Person-Centered Integrated Care: Knowledge of Patient	87.2%	86.1%	87.5%	87.9%	85.6%	84.9%	89.8%	86.6%	86.7%	89.1%	85.5%	87.1%	83.8%	89.3%	84.0%	88.1%	89.2%	71.8%	--	-	-

Appendix B-1: Contract Level Performance, MY2021 (ACO and MCO Programs)

2021 quality measure performance for individual ACO and MCO plans is presented in Table B-1. Program-level totals are weighted means (WM), or medians when indicated with an asterisk (*). Please see Appendix A for a list of MassHealth's managed care plans.

- **"--" indicates that the measure or target was not available, not required, not collected, or not calculated.**
- **"NA" indicates that the rate was not included due to small denominator (n <30).**

Ref	2021 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
CIS	Childhood Immunization Status (combo 10)	55.7%	33.7%	65.0%	46.9%	41.4%	51.8%	62.5%	54.3%	64.2%	57.3%	55.8%	45.9%	52.1%	47.7%	61.4%	55.3%	53.5%	NA	40.4%	35.7%	42.1%
PPC	Timeliness of Prenatal Care	85.1%	88.1%	93.3%	73.7%	88.5%	95.9%	76.7%	80.8%	87.3%	48.9%	84.9%	68.5%	85.2%	88.8%	90.6%	81.1%	89.3%	58.0%	82.7%	63.6%	94.4%
IMA	Immunization for Adolescents (combo 2)	47.1%	14.2%	50.4%	44.8%	42.5%	45.6%	40.9%	25.3%	57.0%	50.9%	53.4%	43.1%	49.3%	53.8%	62.3%	33.6%	40.6%	NA	33.0%	22.9%	36.2%
CBP	Controlling High Blood Pressure	64.1%	66.4%	73.2%	70.6%	69.8%	58.6%	76.9%	64.0%	67.2%	50.7%	60.3%	70.6%	75.2%	73.5%	56.0%	67.6%	61.3%	60.8%	55.8%	52.2%	57.9%

Ref	2021 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
AMR	Asthma Medication Ratio	56.7%	47.9%	56.1%	56.5%	54.0%	56.7%	58.4%	57.2%	49.5%	68.3%	54.2%	65.2%	50.1%	53.0%	58.1%	54.2%	54.2%	52.2%	52.7%	54.2%	52.1%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	34.7%	33.2%	26.8%	34.5%	43.2%	32.5%	31.9%	26.2%	35.8%	70.0%	32.8%	39.0%	21.3%	32.5%	39.9%	26.2%	42.8%	38.9%	50.7%	53.3%	49.2%
EOHHS/ADA	Oral Health Evaluation	52.5%	45.4%	56.0%	55.1%	48.3%	55.1%	55.2%	51.0%	53.6%	53.6%	46.8%	52.2%	53.5%	44.2%	53.3%	55.4%	49.8%	42.8%	48.8%	46.9%	49.7%
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.2043	1.674	1.517	1.644	1.222	0.96	1.736	1.538	1.57	1.548	1.225	1.214	1.262	1.151	1.145	1.065	1.098	1.132	--	--	--
EOHHS	Health-Related Social Needs Screening	26.6%	2.7%	25.1%	32.1%	22.1%	7.5%	21.9%	11.0%	28.0%	58.2%	34.8%	25.3%	38.0%	38.1%	26.3%	22.1%	8.8%	0.0%	--	--	--
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	47.2%	61.0%	76.1%	37.0%	49.8%	35.9%	37.2%	50.9%	63.2%	35.5%	51.0%	43.1%	63.1%	42.5%	45.5%	42.4%	41.5%	53.7%	52.1%	52.4%	51.9%
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	15.8%	19.6%	17.1%	12.5%	15.4%	11.3%	13.6%	15.4%	18.7%	9.7%	18.6%	19.0%	20.8%	16.6%	16.1%	13.8%	14.3%	15.8%	20.4%	20.3%	20.4%
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	49.8%	45.5%	59.6%	41.0%	50.3%	28.8%	45.2%	41.2%	60.2%	48.5%	47.4%	50.9%	47.5%	45.9%	54.9%	54.2%	50.4%	45.8%	41.5%	40.5%	42.4%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	76.2%	75.8%	85.5%	78.4%	73.4%	77.4%	80.8%	66.5%	80.6%	86.5%	72.9%	74.3%	82.2%	73.9%	72.5%	76.3%	74.3%	79.3%	77.2%	74.1%	79.3%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	42.7%	35.5%	57.0%	29.0%	37.6%	33.3%	39.4%	30.0%	23.0%	40.7%	49.6%	46.5%	63.6%	53.3%	60.8%	34.3%	46.4%	NA	28.1%	31.9%	27.0%
ED-SMI	Risk adjusted ratio (obs/exp) of ED visits	1.5088	1.432	11.189	1.552	1.2	1.494	1.29	1.474	1.642	1.574	1.561	1.249	1.529	1.298	1.639	1.474	1.631	1.467	0.8009	0.8058	0.7970

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Ref	2021 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
	for members 18-65 identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions																					
DRR	Depression Remission or Response	6.4%	13.9%	8.2%	0.5%	3.4%	2.4%	5.6%	8.1%	1.5%	11.2%	10.8%	4.9%	28.8%	11.5%	9.5%	0.8%	1.3%	2.8%		--	--
EOHHS	LTSS Community Partner Engagement	8.1%	17.2%	4.6%	12.4%	6.6%	12.7%	17.4%	8.7%	6.3%	9.7%	7.6%	6.3%	7.0%	10.6%	9.8%	3.9%	5.95	10.2%	6.7%	3.7%	9.3%
EOHHS	Behavioral Health Community Partner Engagement	11.8%	8.7%	22.2%	23.7%	10.7%	17.3%	26.6%	16.5%	10.8%	NA	12.5%	9.7%	15.7%	10.3%	10.1%	11.5%	9.2%	7.3%	4.8%	4.5%	5.3%
EOHHS	Adult: Overall Rating and Care Delivery: Willingness to recommend	85.3%	87.3%	87.5%	86.3%	82.5%	84.4%	87.4%	84.7%	86.2%	90.9%	84.6%	78.6%	83.6%	86.5%	81.9%	88.7%	85.3%	85.1%	--	--	--
EOHHS	Child: Overall Rating and Care Delivery: Willingness to recommend	90.2%	88.9%	91.8%	91.4%	89.6%	87.1%	92.3%	87.3%	90.2%	92.5%	88.9%	86.0%	91.1%	90.4%	86.4%	92.4%	91.3%	79.1%	--	--	--
EOHHS	Adult: Overall Rating and Care Delivery: Communication	87.6%	88.9%	89.9%	88.3%	84.8%	87.0%	88.5%	86.8%	88.1%	91.9%	87.8%	81.8%	85.5%	88.8%	86.0%	89.6%	87.8%	86.2%	--	--	--
EOHHS	Child: Overall Rating and Care Delivery: Communication	90.8%	91.2%	91.8%	90.1%	89.9%	90.0%	92.4%	88.5%	91.1%	92.2%	90.6%	89.1%	87.9%	93.0%	87.8%	92.7%	91.9%	96.4%	--	--	--
EOHHS	Adult: Person-Centered Integrated Care: Integration of Care	78.6%	79.9%	80.5%	78.7%	72.7%	72.8%	81.2%	76.8%	76.3%	80.6%	76.4%	73.2%	76.8%	79.4%	75.2%	79.7%	78.0%	75.3%	--	--	--
EOHHS	Child: Person-Centered Integrated Care: Integration of Care	79.3%	77.0%	80.0%	78.0%	78.4%	74.0%	79.1%	74.9%	77.4%	80.2%	78.4%	79.3%	82.4%	78.2%	73.5%	78.3%	79.7%	89.2%	--	--	--
EOHHS	Adult: Person-Centered Integrated Care: Knowledge of Patient	82.0%	83.1%	83.2%	83.2%	79.4%	81.7%	82.8%	81.7%	82.9%	87.7%	81.3%	75.3%	79.3%	82.5%	79.9%	85.0%	82.3%	81.4%	--	--	--
EOHHS	Child: Person-Centered Integrated	86.6%	84.5%	87.9%	86.3%	84.7%	84.9%	88.7%	85.1%	86.0%	88.6%	85.9%	84.2%	86.1%	87.6%	83.0%	88.9%	87.7%	91.4%	--	--	--

Ref	2021 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
	Care: Knowledge of Patient																					

Appendix B-2: Contract Level Performance, MY 2022 (ACO and MCO Programs)

2022 quality measure performance for individual ACO and MCO plans is presented in Table B-2. Program-level totals are weighted means (WM). Please see Appendix A for a list of MassHealth's managed care plans.

- **"--" indicates that the measure or target was not available, not required, not collected, or not calculated.**
- **"NA" indicates that the rate was not included due to small denominator (n <30).**

Ref	2022 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
CIS	Childhood Immunization Status (combo 10)	52.5%	45.1%	60.4%	49.4%	36.0%	33.1%	56.2%	55.7%	56.1%	56.1%	53.6%	36.5%	49.3%	34.3%	58.2%	54.6%	48.3%	NA	32.7%	32.6%	32.8%
PPC	Timeliness of Prenatal Care	86.8%	88.6%	95.0%	74.4%	84.2%	96.0%	69.8%	83.7%	87.8%	63.7%	88.2%	73.9%	87.7%	92.9%	92.5%	75.0%	90.7%	78.1%	87.7%	84.6%	90.2%
IMA	Immunization for Adolescents (combo 2)	49.1%	11.3%	55.5%	54.5%	51.1%	46.2%	47.5%	25/1	54.8%	53.0%	57.1	48.7%	50.2%	53.0%	56.4%	36.7%	42.3%	NA	34.3%	21.6%	39.0%
EOHHS/ ADA (OHE)	Oral Health Evaluation	53.3%	36.5%	57.7%	55.1%	50.6%	54.3%	56.0%	57.7%	52.4%	54.2%	48.5%	54.5%	53.4%	46.5%	53.7%	56.0%	50.7%	42.8%	50.1%	48.4%	50.9%
EOHSS (HRSN)	Health-Related Social Needs Screening	29.5%	4.9%	22.6%	10.5%	22.4%	24.1%	37.5%	14.1%	42.3%	56.2%	38.9%	24.8%	42.1%	31.6%	28.7%	34.1%	8.8%	0.0%	--	--	--
CBP	Controlling High Blood Pressure	67.2%	67.9%	70.4%	67.2%	54.2%	69.3%	78.0%	67.4%	65.6%	62.3%	63.5%	68.4%	78.6%	70.1%	67.9%	60.9%	73.5%	68.6%	61.7%	67.4%	58.0%
AMR	Asthma Medication Ratio	60.7%	55.3%	58.9%	55.6%	58.4%	61.9%	61.5%	58.0%	52.1%	65.9%	61.9%	68.8%	64.0%	61.6%	63.4%	58.5%	58.0%	56.9%	54.3%	61.4%	50.9%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	34.1%	35.0%	25.3%	29.8%	38.3%	30.9%	30.0%	25.9%	32.9%	58.3%	29.8%	37.0%	19.5%	37.7%	37.0%	43.3%	36.2%	23.7%	35.5%	32.5%	37.5%
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.202	1.361	1.556	1.598	1.307	1.331	1.335	1.210	1.269	1.401	1.267	1.276	1.368	0.936	1.192	1.092	1.021	1.328	--	--	--
EOHHS (ED-SMI)	Risk adjusted ratio (obs/exp) of ED visits for members 18-65 identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	0.87	0.834	0.606	0.937	0.737	0.984	0.741	0.951	1.040	0.850	0.995	0.829	0.848	0.783	1.030	0.833	0.996	0.858	0.7660	0.7837	0.7529

Ref	2022 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	50.9%	54.9%	32.1%	41.9%	64.2%	38.5%	35.8%	49.9%	63.3%	51.4%	48.8%	46.2%	53.0%	38.9%	56.2%	44.6%	46.8%	51.1%	52.4%	55.7%	53.1%
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	22.9%	22.2%	12.4%	15.8%	36.4%	12.8%	18.6%	17.6%	19.3%	28.2%	19.2%	21.0%	22.5%	16.0%	32.8%	18.3%	22.6%	22.1%	23.1%	23.5%	22.7%
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	46.4%	48.4%	49.5%	39.5%	50.7%	35.5%	41.1%	42.0%	57.5%	52.2%	43.2%	51.5%	54.3%	48.0%	45.3%	48.4%	42.0%	47.5%	40.7%	41.1%	40.5%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	74.7%	73.9%	85.1%	80.7%	80.9%	74.7%	77.8%	71.8%	73.7%	83.9%	71.4%	69.4%	77.8%	71.6%	68.7%	75.2%	72.7%	74.7%	73.6%	72.7%	74.4%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	41.8%	30.0%	31.5%	32.8%	51.0%	52.1%	46.3%	NA	31.0%	41.0%	46.7%	42.4%	66.7%	34.9%	57.3%	33.8%	43.6%	NA	52.9%	49.0%	54.5%
DSF	Screening for Depression and Follow Up Plan	46.2%	26.8%	42.2%	41.1%	42.3%	38.4%	35.3%	43.6%	42.1%	63.0%	57.1%	28.7%	70.0%	44.5%	51.9%	41.9%	404%	34.1%	--	--	--
DRR	Depression Remission or Response	6.6%	6.0%	3.6%	7.0%	0.5%	5.6%	3.9%	9.2%	4.3%	8.2%	12.2%	9.1%	32.7%	2.4%	7.9%	2.4%	2.5%	5.3%	--	--	--
EOHHS	LTSS Community Partner Engagement	7.5%	6.3%	12.8%	23.4%	3.7%	13.6%	35.4%	13.0%	13.1%	14.7%	7.9%	6.8%	8.4%	9.0%	10.1%	7.4%	4.5%	10.5%	8.4%	4.5%	11.5%
EOHHS	Community Tenure - BSP (Risk adjusted O/E ratio)	0.8	0.6	0.5	0.8	0.7	0.7	0.5	0.7	0.5	0.5	1.1	1.0	1.0	0.9	1.1	1.2	1.2	0.7	0.8	1.1	0.5
EOHHS	Community Tenure - LTSS (non-BSP) Risk adjusted O/E ratio	1.1	0.8	0.5	1.0	0.8	1.3	0.7	1.2	1.1	0.9	1.4	1.0	1.2	1.0	1.9	1.6	1.7	1.1	0.9	1.0	0.8
EOHHS	Behavioral Health Community Partner Engagement	10.6%	15.3%	10.3%	26.6%	11.9%	13.3%	25.1%	12.0%	10.0%	NA	11.6%	7.3%	16.3%	14.2%	8.1%	10.0%	8.5%	8.8%	4.0%	4.3%	3.7%
EOHHS	Adult: Overall Rating and Care Delivery: Willingness to recommend	84.5%	86.1%	87.5%	85.6%	83.0%	83.2%	88.2%	84.3%	85.8%	91.7%	84.1%	75.0%	82.4%	86.9%	79.9%	88.0%	85.1%	84.1%	--	--	--
EOHHS	Child: Overall Rating and Care Delivery: Willingness to recommend	89.2%	82.8%	91.0%	91.2%	87.2%	86.2%	92.4%	87.5%	90.1%	91.6%	86.8%	79.0%	84.8%	92.4%	86.8%	90.8%	90.5%	NA	--	--	--
EOHHS	Adult: Overall Rating and Care Delivery: Communication	86.9%	87.4%	87.7%	88.5%	86.1%	85.9%	89.1%	86.4%	86.0%	92.5%	86.2%	80.2%	85.0%	88.1%	84.5%	89.9%	88.3%	86.4%	--	--	--
EOHHS	Child: Overall Rating and Care Delivery: Communication	90.4%	87.3%	91.6%	91.1%	89.8%	89.4%	91.7%	88.6%	88.0%	92.5%	89.3%	84.6%	88.6%	92.8%	89.0%	91.8%	90.9%	96.7%	--	--	--
EOHHS	Adult: Person-Centered Integrated Care: Integration of Care	78.1%	76.2%	79.8%	79.2%	75.8%	72.4%	81.5%	78.3%	77.0%	82.1%	74.9%	70.8%	74.7%	79.8%	72.7%	80.2%	77.6%	78.4%	--	--	--
EOHHS	Child: Person-Centered Integrated Care: Integration of Care	78.6%	76.1%	78.3%	77.6%	72.9%	73.3%	79.4%	76.3%	74.4%	80.7%	73.8%	79.6%	71.4%	80.7%	73.0%	78.4%	79.3%	95.2%	--	--	--
EOHHS	Adult: Person-Centered Integrated Care: Knowledge of Patient	81.5%	82.2%	82.7%	84.5%	80.6%	80.0%	84.6%	81.3%	80.6%	88.9%	80.6%	72.8%	78.5%	82.7%	78.4%	84.7%	82.9%	81.2%	--	--	--
EOHHS	Child: Person-Centered Integrated Care: Knowledge of Patient	86.2%	81.5%	87.5%	87.5%	85.0%	82.5%	88.1%	84.4%	83.5%	88.5%	85.1%	79.5%	82.0%	89.2%	84.3%	87.8%	87.3%	86.6%	--	--	--

Appendix B-6: Contact Level Performance, MY2020: (OneCare and SCO)

2020 Quality measure performance for individual One Care and SCO plans is presented in Table B-6. Program-level totals are weighted means (WM). Please see Appendix A for a list of MassHealth's managed care plans.

- **"--" indicates that the measure or target was not available, not required, not collected, or not calculated.**
- **"NA" indicates that the rate was not included due to small denominator (n <30).**

Chart B-6.1: One Care Contact Level Performance, MY2020

Ref	2020 Measure	Total OneCare	CCA OneCare	THP OneCare
CBP	Controlling High Blood Pressure	56.7%	58.4%	42.8%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	53.0%	53.5%	48.5%
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.0440	1.0029	1.3639
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	40.6%	40.6%	41.0%
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	11.4%	11.5%	10.4%
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	50.0%	50.6%	44.1%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	79.6%	79.5%	80.5%
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	70.8%	71.2%	67.1%
AAP MA-5	Access to Preventive/Ambulatory Health Services	96.2%	96.4%	93.9%
MMP CW-12	Medication Adherence for Diabetes Medications	85.0%	85.0%	83.0%
MMP CW13	Encounter Data Completeness	--	94.0%	88.0%
MMP CW7	Annual Flu Vaccination	71.0%	72.0%	69.0%

Chart B-6.2: SCO Contact Level Performance, MY2020

Ref	2020 Measure	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
CBP	Controlling High Blood Pressure	61.2%	57.9%	59.4%	57.7%	53.7%	54.0%	70.3%
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.1729	1.0711	1.0143	1.1841	1.0924	1.2503	1.2454
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	37.3%	NA	45.5%	25.5%	40.0%	37.8%	36.4%
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	61.0%	NA	69.7%	53.2%	53.3%	67.6%	60.0%
COL	Colorectal Cancer Screening	76.2%	69.4%	75.7%	61.7%	74.2%	63.9%	86.1%
PBH	Persistence of Beta-Blocker Treatment After Heart Attack	90.9%	NA	NA	NA	NA	NA	NA
PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids	74.5%	NA	73.8%	78.2%	73.9%	77.4%	70.9%
PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators	90.8%	NA	91.4%	94.3%	86.8%	91.5%	90.1%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	23.9%	NA	19.9%	22.5%	24.7%	25.3%	26.6%
TRC	Transitions of Care: Medication Reconciliation Post Discharge	54.3%	72.9%	49.6%	85.4%	43.6%	43.1%	57.2%
OMW	Osteoporosis Management in Women Who Had a Fracture	25.5%	NA	16.3%	43.8%	NA	NA	22.6%
DDE	Potentially Harmful Drug Disease Interactions in the Elderly (total) (lower rate is better)	32.4%	30.7%	31.1%	35.7%	31.2%	32.5%	32.9%
DAE - Total	Use of High-Risk Medications in the Elderly - Total (lower rate is better)	21.6%	17.8%	23.3%	25.0%	19.4%	18.3%	22.4%
AMM-A	Antidepressant Medication Management Acute	78.9%	87.2%	78.2%	78.4%	83.4%	71.7%	78.1%
AMM-C	Antidepressant Medication Management Continuation	65.1%	76.9%	64.6%	64.5%	74.1%	54.6%	62.0%
COA	Care for Older Adults: Advance Care Plan	77.0%	35.8%	70.4%	70.6%	97.4%	98.0%	65.1%

Appendix B-4: Contract Level Performance, MY2021 (One Care and SCO)

2021 Quality measure performance for individual One Care and SCO plans is presented in Tables B-4.1 and B-4.2 respectively.

- **"--" indicates that the measure or target was not available, not required, not collected, or not calculated.**
- **"NA" indicates that the rate was not included due to small denominator (n <30).**

Chart B-4.1: One Care Contract Level Performance, MY2021

Ref	2021 Measure	Total OneCare	CCA OneCare	THP OneCare
FVA	Annual Flu Vaccine	73.0%	71.7%	69.1%
CBP	Controlling High Blood Pressure	56.7%	67.1%	57.2%
CDC	Comprehensive Diabetes Care: Blood Sugar Controlled	54.7%	54.5%	56.9%
MA 1.3	Access to LTS Coordinator - Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment	98.2%	98.0%	100.0%
MA 5.1	Tracking of Demographic Information - Percent of members whose demographic data are collected and maintained in the MMP Centralized Enrollee Record (race/ethnicity/ primary language/homelessness/disability type/LGBTQ identity	67.2%	66.8%	70.8%
CMS – Core 2.1	Timely Assessment - Percent of members with an initial assessment completed within 90 days of enrollment	91.8%	93.0%	81.6%
MA 1.2	Documentation of Care Plan Goals - Percent of members with documented discussions of care goals	98.8%	100.0%	88.3%
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	66.2%	65.7%	70.7%
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	39.8%	40.0%	38.0%
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	11.9%	11.7%	13.3%
PCR (<65)	Plan All-Cause Readmission (observed/expected ratio) (18-64 years)	1.33	1.38	1.01

Chart B-4.2: SCO Contract Level Performance, MY2021

Ref	2021 Measure	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United SCO
COL	Colorectal Cancer Screening	79.1%	77.6%	78.8%	66.2%	75.7%	72.5%	88.1%
FVA	Influenza Immunization (age 65+)	80.0%	77.0%	78.0%	79.0%	79.0%	86.0%	81.0%
COA	Care For Older Adults: Advance Care Plan	49.6%	16.7%	33.2%	74.1%	41.2%	N/A	59.0%
TRC	Transitions of Care: Medication Reconciliation Post-Discharge	74.4%	82.1%	86.1%	89.5%	57.2%	55.7%	73.5%
PBH	Persistence of Beta Blocker Treatment After Heart Attack	83.6%	N/A	N/A	N/A	N/A	N/A	N/A
CBP	Controlling High Blood Pressure	70.7%	77.4%	74.7%	66.7%	56.7%	74.5%	76.7%
PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids	74.6%	68.5%	66.6%	78.5%	75.6%	77.5%	79.5%
PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators	89.3%	94.4%	87.8%	87.3%	N/A	93.4%	N/A
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.1%	N/A	22.0%	25.7%	19.4%	22.1%	22.8%
DAE	Use of High-Risk Medications in the Elderly - Total	21.6%	17.0%	25.6%	25.1%	18.3%	19.0%	21.4%
DDE	Potentially Harmful Drug Disease Interactions in the Elderly (total)	31.5%	29.3%	31.4%	36.3%	27.8%	31.4%	32.6%
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	39.3%	N/A	48.9%	38.9%	N/A	50.0%	19.1%
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	63.0%	N/A	70.5%	61.1%	N/A	77.8%	46.8%
PCR	Plan All-Cause Readmission (Observed/Expected Ratio)	1.2467	1.1640	1.4845	1.0457	1.1954	1.3668	1.1656
OMW	Osteoporosis Management in Women Who Had a Fracture	36.1%	N/A	38.5%	67.6%	20.5%	23.7%	43.2%
AMM-A	Antidepressant Medication Management Acute	85.4%	80.4%	80.6%	84.6%	92.4%	82.1%	79.2%
AMM-C	Antidepressant Medication Management Continuation	75.6%	68.6%	72.9%	68.0%	87.1%	68.1%	64.8%

Appendix B-5: Contact Level Performance, MY2022: (OneCare and SCO)

2022 Quality measure performance for individual One Care and SCO plans is presented in Table B-5. Program-level totals are weighted means (WM). Please see Appendix A for a list of MassHealth's managed care plans.

- **"--" indicates that the measure or target was not available, not required, not collected, or not calculated.**
- **"NA" indicates that the rate was not included due to small denominator (n <30).**

Chart B-5.1: One Care Contract Level Performance, MY2022

Ref	2022 Measure	Total One Care	CCA One Care	THP One Care	United One Care
FVA	Annual Flu Vaccine	69.0%	74.7%	68.7%	N/A
CBP	Controlling High Blood Pressure	72.6%	73.2%	67.3%	N/A
CDC	Comprehensive Diabetes Care: Blood Sugar Controlled	64.3%	63.7%	70.8%	N/A
MA 1.3	Access to LTS Coordinator - Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment	96.1%	99.9%	71.4%	33.7%
MA 5.1	Tracking of Demographic Information - Percent of members whose demographic data are collected and maintained in the MMP Centralized Enrollee Record (race/ethnicity/ primary language/homelessness/disability type/LGBTQ identity	73.7%	75.5%	70.0%	61.0%
CMS – Core 2.1	Timely Assessment - Percent of members with an initial assessment completed within 90 days of enrollment	88.5%	92.0%	90.8%	46.9%
MA 1.2	Documentation of Care Plan Goals - Percent of members with documented discussions of care goals	95.8%	100.0%	68.5%	99.1%
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	62.2%	62.2%	70.0%	45.4%
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	38.7%	38.9%	38.2%	N/A
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	10.7%	10.6%	11.1%	N/A
PCR (<65)	Plan All-Cause Readmission (observed/expected ratio) (18-64 years)	1.34	1.38	0.98	N/A

Chart B-5.2: SCO Contract Level Performance, MY2022

Ref	2022 Measure	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
COL	Colorectal Cancer Screening	79.1%	77.6%	78.8%	66.2%	75.7%	72.5%	88.1%
FVA	Annual Flu Vaccine (age 65+)	80.0%	78.0%	78.0%	80.0%	79.0%	82.0%	81.0%
COA	Care For Older Adults: Advance Care Plan	49.6%	16.7%	33.2%	74.1%	41.2%	N/A	59.0%
TRC	Transitions of Care: Medication Reconciliation Post-Discharge	74.4%	82.1%	86.1%	89.5%	57.2%	55.7%	73.5%
PBH	Persistence of Beta Blocker Treatment After Heart Attack	83.6%	N/A	N/A	N/A	N/A	N/A	N/A
CBP	Controlling High Blood Pressure	70.7%	77.4%	74.7%	66.7%	56.7%	74.5%	76.7%
PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids	74.6%	68.5%	66.6%	78.5%	75.6%	77.5%	79.5%
PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators	89.3%	94.4%	87.8%	87.3%	N/A	93.4%	N/A
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.1%	N/A	22.0%	25.7%	19.4%	22.1%	22.8%
DAE	Use of High-Risk Medications in the Elderly - Total	21.6%	17.0%	25.6%	25.1%	18.3%	19.0%	21.4%
DDE	Potentially Harmful Drug Disease Interactions in the Elderly (total)	31.5%	29.3%	31.4%	36.3%	27.8%	31.4%	32.6%
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	39.3%	N/A	48.9%	38.9%	N/A	50.0%	19.1%
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	63.0%	N/A	70.5%	61.1%	N/A	77.8%	46.8%
PCR	Plan All-Cause Readmission (Observed/Expected Ratio)	1.2467	1.1640	1.4845	1.0457	1.1954	1.3668	1.1656
OMW	Osteoporosis Management in Women Who Had a Fracture	36.1%	N/A	38.5%	67.6%	20.5%	23.7%	43.2%
AMM-A	Antidepressant Medication Management Acute	85.4%	80.4%	80.6%	84.6%	92.4%	82.1%	79.2%
AMM-C	Antidepressant Medication Management Continuation	75.6%	68.6%	72.9%	68.0%	87.1%	68.1%	64.8%

Appendix C: CMS Adult and Child Core Measure Sets Performance (Calculated and Reported by MassHealth)

Table C.1: Adult Core Measure Set Performance

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY22 Medicaid Bottom Quartile	MY22 Medicaid Median	MY22 Medicaid Top Quartile
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: 18-64	NR	57.2%	56.6%	40.1%	43.3%	54.4%
AMM	Antidepressant Medication Management – Acute: 18-64	54.8%	62.0%	64.7%	54.6%	58.8%	64.0%
AMM	Antidepressant Medication Management – Continuation: 18-64	40.7%	46.1%	47.7%	35.4%	41.8%	46.1%
AMR	Asthma Medication Ratio: Ages 19-50	47.4%	51.2%	55.6%	53.8%	57.8%	63.1%
AMR	Asthma Medication Ratio: Ages 51-64	54.4%	55.6%	59.9%	53.4%	58.0%	62.9%
AMR	Asthma Medication Ratio: Total 19-64	49.8%	52.6%	56.9%	53.1%	57.9%	62.4%
BCS	Breast Cancer Screening	63.2%	60.2%	63.7%	43.6%	48.8%	54.0%
COB	Concurrent Use of Opioids and Benzodiazepines	3.8%	3.6%	3.2%	16.0%	13.3%	9.7%
CBP	Controlling High Blood Pressure: 18-64	56.8%	64.4%	68.7%	52.1%	57.7%	62.1%
CCS	Cervical Cancer Screening	65.8%	65.3%	65.5%	44.6%	51.4%	58.3%
CHL	Chlamydia Screening in Women Ages 21-24	65.8%	68.8%	68.9%	52.0%	55.9%	64.1%
CCP	Contraceptive Care Postpartum Women Ages 21-44: Most/Moderate – 3 days	15.5%	14.5%	15.4%	8.7%	11.7%	13.6%
CCP	Contraceptive Care Postpartum Women Ages 21-44- Most/Moderate – 60 days	46.9%	45.5%	NR	34.1%	38.6%	41.3%
CCP	Contraceptive Care Postpartum Women Ages 21-44- LARC – 3 days	5.2%	4.3%	4.8%	0.9%	2.1%	3.0%
CCP	Contraceptive Care Postpartum Women Ages 21-44 LARC – 60 days	16.2%	16.3%	NR	9.1%	11.7%	13.9%
CCW	Contraceptive Care All Women Ages 21-44: Most/Moderately Effective	19.7%	16.9%	27.4%	21.2%	23.9%	25.9%
CCW	Contraceptive Care All Women Ages 21-44: LARC	5.7%	4.8%	5.4%	3.5%	4.3%	5.8%
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 day	22.9%	21.3%	43.1%	10.9%	15.5%	19.1%
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 day	33.1%	32.0%	56.1%	15.5%	23.8%	29.0%
FUH	Follow-Up After Hospitalization for Mental Illness -7 day: 18-64	45.8%	43.3%	40.3%	28.6%	33.9%	43.3%
FUH	Follow-Up After Hospitalization for Mental Illness - 30 day: 18-64	66.7%	66.0%	62.7%	48.3%	54.5%	64.9%
FUM	Follow-Up After Emergency Department Visit for Mental Illness – 7 day: 18-64	73.5%	74.5%	72.9%	29.2%	38.9%	52.6%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 day: 18-64	80.5%	80.4%	79.7%	42.9%	52.5%	63.5%
FVA	Flu Vaccinations for Adults Ages 18-64	46.6%	47.4%	49.1%	35.4%	40.5%	46.4%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY22 Medicaid Bottom Quartile	MY22 Medicaid Median	MY22 Medicaid Top Quartile
HBD	HgbA1c Control for Patients with Diabetes- Poor Control: 18-64	43.3%	NR	33.4%	48.9%	41.2%	36.8%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment - Initiation (18-64)	48.1%	46.7%	48.3%	41.0%	43.4%	47.7%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment - Engagement (18-64)	17.5%	16.7%	18.3%	10.5%	15.8%	18.5%
MSC	Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers to Quit	80.4%	74.3%	76.5%	64.6%	72.6%	74.4%
MSC	Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	62.2%	57.7%	61.7%	46.1%	49.9%	57.7%
MSC	Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	55.4%	49.9%	51.5%	40.5%	44.2%	49.3%
OHD	Use of Opioids at High Dosage in Persons Without Cancer	7.2%	7.5%	7.7%	9.0%	6.7%	3.2%
OUD	Use of Pharmacotherapy for Opioid Use Disorder	NR	78.9%	79.3%	51.6%	56.2%	71.0%
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.1461	1.1803	1.1750	1.1244	0.9752	0.8998
PPC	Prenatal and Postpartum Care – Postpartum Care	79.7%	81.1%	83.8%	65.1%	75.0%	78.6%
PQI01	Diabetes Short-Term Complications Admission Rate (per 100000 member months): 18-64	14.1	12.0	9.9	21.8%	17.2%	13.6%
PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 member months): 40-64	38.3	33.0	31.3	40.6%	29.8%	23.2%
PQI08	Heart Failure Admission Rate (per 100,000 member months): 18-64	16.5	16.5	18.1	33.4%	23.9%	17.1%
PQI15	Asthma in Younger Adults Admission Rate (per 100,000 member months): 18-39	5.2	4.2	2.8	4.7	3.1	2.2
SSA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	69.2%	69.4%	71.7%	56.8%	62.2%	67.1%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	73.2%	77.7%	76.6%	74.2%	77.1%	78.5%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY2022 National 75th	MY2022 National 90th
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: 65+	NR	75.0%	45.6%	36.1%	42.7%
AMM	Antidepressant Medication Management – Acute: 65+	78.9%	79.7%	85.4%	85.1%	87.8%
AMM	Antidepressant Medication Management – Continuation: 65+	65.1%	67.6%	75.6%	71.2%	75.2%
BCS	Breast Cancer Screening: Over 65	75.6%	71.6%	74.7%	77.9%	82.6%
CBP	Controlling High Blood Pressure: 65+	61.2%	68.1%	70.7%	78.2%	82.7%
CDF	Screening for Depression and Follow-up Plan – Ages 18 and Older	36.4%	41.1%	43.0%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 21-44- Most/Moderate – 90 days	NR	NR	54.6%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 21-44 LARC – 90 days	NR	NR	21.0%	NA	NA
COL	Colorectal Cancer Screening: 46-49	NR	NR	21.1%	NA	NA
COL	Colorectal Cancer Screening: 50-64	NR	64.3%	46.4%	77.6%	82.0%
COL	Colorectal Cancer Screening: 65+	NR	78.8%	79.1%	NA	NA
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 day: 65+	14.2%	13.6%	33.8%	29.5%	34.4%
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 day: 65+	22.6%	16.2%	50.7%	43.5%	50.7%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY2022 National 75th	MY2022 National 90th
FUH	Follow-Up After Hospitalization for Mental Illness -7 day: 65+	37.3%	37.6%	38.9%	32.8%	46.0%
FUH	Follow-Up After Hospitalization for Mental Illness - 30 day: 65+	61.0%	64.4%	62.5%	56.6%	67.7%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 day: 65+	63.8%	45.4%	63.6%	37.0%	47.6%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 day: 65+	72.4%	58.9%	72.7%	51.6%	61.1%
HBD	HgbA1c Control for Patients with Diabetes- Poor Control: 65+	28.9%	NR	22.5%	13.6%	10.5%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment -Initiation: 65+	38.9%	39.2%	40.2%	42.4%	50.8%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement): 65+	6.7%	5.3%	5.8%	5.2%	7.6%
PQI01	Diabetes Short-Term Complications Admission Rate (per 100000 member months): 65+	NR	NR	8.2	NA	NA
PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 member months): 65+	NR	NR	60.2	NA	NA
PQI08	Heart Failure Admission Rate (per 100,000 member months): 65+	NR	NR	139.6	NA	NA
CAHPS	Getting Needed Care	85.9%	79.7%	80.5%	84.5%	86.5%
CAHPS	Getting Care Quickly	83.4%	79.1%	80.0%	84.9%	86.9%
CAHPS	How Well Doctors Communicate	91.5%	91.7%	94.0%	94.0%	95.1%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY2022 National 75th	MY2022 National 90th
CAHPS	Customer Service	89.0%	87.6%	90.7%	91.1%	91.9%
CAHPS	Flu Vaccines	46.6%	47.4%	49.1%	46.1%	52.1%
CAHPS	Medical Assistance with Smoking and Tobacco Use Cessation- Advising Smokers To Quit	80.4%	74.3%	76.5%	76.9%	80.4%

Table C.2: Child Core Set Performance

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY22 Medicaid Bottom Quartile	MY22 Medicaid Median	MY22 Medicaid Top Quartile
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation	45.7%	44.5%	46.4%	36.4%	43.0%	49.4%
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation	54.8%	54.7%	54.4%	45.1%	54.1%	59.5%
AMB-ED	Ambulatory Care: Emergency Department Visits: Total 0-19 years	23.4/1000	29.4/1000	36.0/1000	36.2%	31.9%	26.0%
AMR	Asthma Medication Ratio: Ages 5 -11	73.8%	65.5%	65.7%	73.2%	77.3%	80.7%
AMR	Asthma Medication Ratio: Ages 12-18	65.1%	61.9%	62.5%	64.8%	68.8%	72.5%
AMR	Asthma Medication Ratio: Total Ages 5-18	69.7%	63.7%	64.1%	68.1%	73.1%	76.5%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1-17	36.5%	42.0%	42.1%	27.3%	33.2%	41.5%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1-17	76.3%	76.0%	76.6%	58.6%	62.6%	67.2%
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: Most/Moderate - 3 days	14.1%	9.9%	10.2%	3.8%	5.7%	8.5%
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: Most/Moderate - 60 days	49.7%	47.2%	NR	34.1%	39.4%	44.2%
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: LARC - 3 days	10.1%	5.8%	7.2%	1.6%	3.1%	4.9%
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: LARC - 60 days	25.3%	22.8%	NR	12.1%	15.3%	18.0%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY22 Medicaid Bottom Quartile	MY22 Medicaid Median	MY22 Medicaid Top Quartile
CCW	Contraceptive Care - All Women Ages 15 to 20: Most/Moderate Effective Methods	13.3%	9.2%	28.8%	19.1%	26.3%	29.3%
CCW	Contraceptive Care - All Women Ages 15 to 20: LARC	2.1%	1.3%	3.6%	2.7%	3.4%	4.7%
CHL	Chlamydia Screening in Women Ages 16 to 20	63.4%	66.7%	68.6%	42.7%	47.2%	58.1%
CIS	Childhood Immunization Status (Combo 3)	75.8%	74.7%	75.1%	56.4%	61.5%	67.6%
CIS	Childhood Immunization Status (Combo 10)	52.1%	52.9%	49.2%	26.9%	32.9%	39.2%
DEV	Developmental Screening in the First Three Years of Life	71.5%	72.5%	63.3%	27.3%	34.7%	51.6%
FUA	Follow-Up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence- 30 days	NR	16.3%	47.4%	6.0%	10.6%	16.3%
FUH	Follow-Up After Hospitalization for Mental Illness – 7 days	59.6%	60.3%	57.2%	40.1%	47.9%	57.5%
FUH	Follow-Up After Hospitalization for Mental Illness - 30 days	79.1%	82.1%	80.4%	62.1%	70.4%	79.6%
FUM	Follow-Up After Emergency Department Visit for Mental Illness- 7 days	NR	88.8%	87.1%	46.2%	54.6%	65.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness- 30 days	NR	91.9%	91.1%	63.6%	72.7%	76.9%
IMA	Immunization for Adolescents (combo 1)	86.8%	85.2%	85.1%	68.3%	75.2%	82.5%
OEV	Oral Evaluation, Dental Services (Total, ages 0-20)	NR	51.3%	52.5%	37.1%	43.2%	49.4%
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	84.3%	88.6%	89.3%	75.2%	81.5%	87.2%
SFM	Sealant Receipt on First Molars	66.3%	62.4%	60.8%	23.6%	32.9%	40.0%
TFL	Topical Fluoride for Children (Total, ages 1-20)	NR	44.6%	46.8%	16.8%	19.3%	23.3%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile (Total)	82.7%	81.7%	81.5%	59.1%	71.9%	81.0%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- Counseling for Nutrition (Total, ages 3-17)	78.9%	79.6%	76.1%	36.7%	63.6%	74.3%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- Counseling for Physical Activity (Total, ages 3-17)	71.9%	74.7%	71.3%	35.5%	58.4%	71.6%
W30	Well-Child Visits in the First 30 Months of Life – First 15 months	75.9%	73.6%	72.8%	51.3%	57.5%	61.0%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY22 Medicaid Bottom Quartile	MY22 Medicaid Median	MY22 Medicaid Top Quartile
W30	Well-Child Visits in the First 30 Months of Life – 15 -30 months	84.4%	80.7%	79.3%	60.4%	65.1%	71.6%
WCV	Child and Adolescent Well-Care Visits (Total, ages 3-21)	63.1%	67.1%	65.6%	42.6%	47.6%	54.4%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY2022 National 75th	MY2022 National 90th
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NR	NR	92.4%	80.4%	86.8%
AMB-ED	Ambulatory Care - Emergency Department Visits: <1 year	49.8/1000	66.3/1000	85.4/1000	NA	NA
AMB-ED	Ambulatory Care - Emergency Department Visits: 1-9 years	23.4/1000	30.8/1000	40.3/1000	NA	NA
AMB-ED	Ambulatory Care: Emergency Department Visits: 10-19 years	20.7/1000	24.6/1000	27.1/1000	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: Most/Moderate - 90 days	NR	NR	56.2%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: LARC - 90 days	NR	NR	27.3%	NA	NA
CDF	Screening for Depression and Follow-up Plan: Ages 12-17	41.1%	52.3%	59.1%	NA	NA
FUA	Follow-Up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence- 7 days	NR	11.3%	36.8%	26.3%	33.7%
IMA	Immunization for Adolescents (combo 2)	44.0%	45.4%	48.1%	40.9%	48.8%

Acronym	Measure Description	MY2020 Rates	MY2021 Rates	MY2022 Rates	MY2022 National 75th	MY2022 National 90th
LSC	Lead Screening in Children	NR	NR	81.1%	70.1%	79.3%
CAHPS	Getting Needed Care	NR	NR	79.0%	86.5%	89.3%
CAHPS	Getting Care Quickly	NR	NR	81.7%	89.5%	100.0%
CAHPS	How Well Doctor Communicate	NR	NR	95.7%	95.5%	96.1%
CAHPS	Customer Service	NR	NR	82.4%	89.9%	91.3%

Appendix D: 2023 EQR Performance Improvement Projects (PIPs)

Appendix D summarizes 2023 PIP topic areas, PIP topics, and provides example interventions. More information on the PIPs and the PIP validation process ad results is available in the EQR Annual Technical Reports, accessible on the MassHealth Quality reports and resources web page: www.mass.gov/info-details/masshealth-quality-reports-and-resources.

Appendix D-1: ACO (ACCP) Program PIPs 2023: Summary of Topic Areas, Goals, and Intervention Examples (26 PIPS: 13 contracts, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Care for Chronic Diseases	• **Aim/Goal** – Improve the control of high blood pressure • **Intervention Example** - Improve the provision of culturally and linguistically appropriate care • **Aim/Goal** – Improve comprehensive diabetes care • **Intervention Example** - Enhance outreach and engagement efforts with members of the Black and Hispanic community generally, including diabetes specific outreach
Vaccinations	• **Aim/Goal** – Increase year-over-year flu vaccination rates among Tufts Children's members • **Intervention Example** - Targeted appropriate member/family outreach for flu vaccination • **Aim/Goal** – Increase the Childhood Immunization Status (CIS) Combo 10 HEDIS measure for member < 2 years of age by 5% over baseline • **Intervention Example** - Partner with high-volume low performing provider sites to develop new reminder/scheduling systems for flu vaccines for members 6 months to 64 years old

PIP Topic	PIP Aim/Goal and Intervention Examples
Telehealth	• **Aim/Goal** – Reduce barriers to Behavioral Health telehealth services • **Intervention Example** - Optimizations of the integrated EMR (EPIC) tele-visit platform (MEND)
Substance Use Disorder Treatment	• **Aim/Goal** – Improve engagement in the AOD Treatment while focusing on both the initiation and engagement components of the IET measure • **Intervention Example** - Direct outreach and engagement of females identifying as Hispanic into AOD treatment based off AOD trigger diagnosis

Appendix D-2: MCO Program PIPs 2023: Summary of Topic Areas, Goals, and Intervention Examples (4 PIPS: 2 contracts, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Care for Chronic Diseases	• **Aim/Goal** - Improve comprehensive diabetes care • **Intervention Example** - Texting campaign to provide members with educational information about importance of HbA1c testing/control, exercise/healthy eating, and a member survey to solicit feedback and additional barriers related to HbA1c testing/control among members
Substance Use Disorder Treatment	• **Aim/Goal** - Improve member IET; providers improve their individual IET HEDIS score by 2% • **Intervention Example -** SUD strategic provider focused quality program
Perinatal Health	• **Aim/Goal** - Improve prenatal and postpartum care outcomes and reduce racial and ethnic health disparities around prenatal and postpartum care through member and provider focused activities • **Intervention Example -** Partner with Accompany Doula to enhance member experience and better-meet the diverse cultural and linguistic needs of members seeking maternal health care

Appendix D-3: SCO Program PIPs 2023: Summary of Topic Areas, Goals, and Intervention Examples (12 PIPS: 6 entities, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Care Coordination	• **Aim/Goal -** Increase the percentage of members who have a documented care plan by 5% • **Intervention Example -** Hire and train dedicated Transitions of Care nurse care manager (RN) • **Aim/Goal -** Increase the post-discharge medication reconciliation rate for members to at least 80% • **Intervention Example -** Collaborate with Network Inpatient Facilities to support best practice for dissemination of discharge information
Vaccinations	• **Aim/Goal -** Identify and understand barriers to flu vaccinations specific to different racial groups

PIP Topic	PIP Aim/Goal and Intervention Examples
	• **Intervention Example -** Educational flu vaccination outreach for SCO member populations at risk of experiencing disparities related to Race, Ethnicity or Language • **Aim/Goal -** Increase flu vaccination rate • **Intervention Example -** Encouraging member flu vaccinations via the Member incentive benefit program

Appendix D-4: OneCare Program P - IPs 2023: Summary of Topic Areas, Goals, and Intervention Examples (6 PIPS: 3 entities, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Vaccinations	• **Aim/Goal -** To increase flu immunization rates and reduce racial, and ethnic health disparities related to flu vaccination • **Intervention Example -** Cityblock health community paramedicine program • **Aim/Goal -** To improve influenza vaccination rates with a particular focus on population subgroups identified by a population analysis as having historically lower vaccination rates compared to the overall population vaccination rates and/or compared to the population subgroups with the highest vaccination rates • **Intervention Example -** The vaccine task force design and implementation of operational standards and practices for vaccine administration
Care Planning	• **Aim/Goal -** To connect with the female "unreachable"/disconnected (unengaged) members and integrate preventative wellness care gap closure for them when completing assessments and care plans resulting in improved clinical outcomes • **Intervention Example -** Engage female members in discussions of care goals to address preventive care gap closure care (although not limited to) for breast and cervical cancer screening when completing a comprehensive assessment and individualized member care plan
Follow-up Care	• **Aim/Goal -** To increase the number of follow-up appointments within 7-days of discharge following a behavioral health inpatient discharge • **Intervention Example -** Collaboration with inpatient and acute care facilities

Appendix D-5: MBHBP P - IPs 2023: Summary of Topic Areas, Goals, and Intervention Examples (2 PIPS: 1 entity, 2 projects)

PIP Topic	PIP Aim/Goal and Intervention Examples
Substance Use Disorder Treatment	• **Aim/Goal -** To increase the percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received initiation of AOD treatment and engagement of AOD treatment (IET) • **Intervention Example -** Expand the use of community support personnel (RC, RSN and CSP) for members in the IET cohort as a way of increasing rates of initiation and engagement in treatment

PIP Topic	PIP Aim/Goal and Intervention Examples
Telehealth	• **Aim/Goal -** To increase the utilization of telehealth as a modality for outpatient treatment within the context of the HEDIS FUH measure, which captures the rate of follow-up visits within 7 and 30 days for outpatient mental health care following discharge from inpatient mental health care • **Intervention Example -** Modify discharge form to allow inpatient (IP) providers to report telehealth as a type of appointment, including that telehealth capability was assessed with the member